Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) 8
FINAL PLAN

February 15, 2013
Regional Healthcare Partnership 8

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Table of Contents

Texas Healthcare Transformation and Quality Improvement Program 1

Section I. RHP Organization 5

Section II. Executive Overview of RHP 19

- Healthcare Environment 19
  - Patient Population 19
  - Health Systems and Providers 19
- Key Health Challenges 20
- RHP Goals and Vision, and Plans for Achieving the Goals 20

Section III. Community Needs Assessment 31

- Community Needs Assessment Approach 31
- Demographics 31
  - Population/Age 31
  - Race/Ethnicity 32
  - Income 32
  - Education 34
  - Employment 35
- Health Coverage 35
- Healthcare Infrastructure and Environment 36
  - Hospital Sizes & Costs 37
  - Potentially Preventable Hospitalizations 37
- Services & Systems 40
- HPSA Designations 40
- Current DHHS-funded Initiatives 40
- Projected Changes during Waiver Period 42
- Key Health Challenges 43
  - Poor access to primary care 43
  - Poor access to behavioral/mental health services 44
- Summary of Key Community Needs 45

Section IV. Stakeholder Engagement 53

- RHP Participants Engagement 53

RHP 8 Organization 53
RHP 8 Approach to Stakeholder Engagement 53
Engagement During the Planning Processes 54
RHP Engagement Beyond Plan Submission 54
Public Engagement 55
Public Comment on RHP Plan 56
Section V. DSRIP Projects 59
RHP Plan Development 59
RHP 8 Requirements 59
Pass 1 / Pass 2 59
RHP 8 Goals 60
Process for Project Evaluation and Selection 61
Category 4 Exemptions 61
U.S. Department of Health & Human Services (DHHS) Funding 62
Project Valuation 62
Category 1 Infrastructure Development - Narratives & Tables 65
Category 2 Innovation and Redesign - Narratives & Tables 249
Category 3 Quality Improvements - Narratives & Tables 457
Category 4 Population-Focused Improvements - Narratives & Tables 677
Section VI. RHP Participation Certifications 715
Addenda

Section I. RHP Organization

Table 1-1. RHP PARTICIPANT & STAKEHOLDER INFORMATION						
RHP Participant Type	**Texas Provider Identifier (TPI)**	**Texas Identification Number (TIN)**	**Ownership Type**	**Organization Name**	**Lead Representative**	**Lead Representative Contact Information**
Anchoring Entity						
Academic Health Science Center	1985236-01	3-70-9709709-3-000	state owned	Texas A&M Health Science Center – Round Rock	Janice Ehlert *Project Director*	jehlert@tamhsc.edu 512-341-4975 3950 North A.W. Grimes Blvd, S211B Round Rock, TX 78665
IGT Entities						
Academic Health Science Center	1985236-01	3-70-9709709-3-000	state owned	Texas A&M Health Science Center – Round Rock	Dr. Lee Ann Ray *Chief of Staff, Office of the President*	ray@tamhsc.edu 979-436-9105 8441 State Hwy. 47 Bryan, Texas 77807
County	187472901	1-74-6000348-0-048	non-state owned public	Bell County	Jon Burrows *County Judge*	jon.burrows@co.bell.tx.us 254-933-5105 101 West Central Avenue Belton, TX 76513
County	N/A	1-74-6000454-6-004	non-state owned public	Burnet County	Donna Klaeger *County Judge*	countyjudge@burnetcountytexas.org 512-756-5400 220 S Pierce St # 116 Burnet, TX 78611
County	N/A	1-74-6001564-1-007	non-state owned public	Lampasas County	Wayne Boultinghouse *County Judge*	wayne.boultinghouse@co.lampasas.tx.us 512-556-8271 PO Box 88 Lampasas, TX 76550
County	N/A	1-74-6001626-8-010	non-state owned public	Llano County	Wayne Brascom *County Judge*	llanocountyjudge@co.llano.tx.us 325-247-7730 801 Ford Street, Room 101. Llano, Texas 78643
County	119643801	1-74-6000978-4-000	non-state owned public	Williamson County	Dan Gattis *County Judge*	dgattis@wilco.org 512-943-1550 710 Main St Georgetown, TX 78626
Health District	088334001	1-74-6000348-0-003	non-state owned public	Bell County Public Health District	Bonnie Scurzi *Interim District Director*	bscurzi@bellcountyhealth.org 254-773-4457 254-394-2600 cell 201 N. 8th Street Temple, TX 76502

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Health District	126936702	1-74-2896906-1-000	non-state owned public	Williamson County and Cities Health District	Dr. Chip Riggins *Executive Director & Health Authority*	criggins@wcchd.org 512-943-3600 312 Main St. Georgetown, TX 78626
Hospital Authority	NA	1-74-2878130-0-000	non-state owned public	Llano County Hospital Authority	Kevin Leeper *CEO, Llano Memorial*	kleeper@llanomemorial.org 325-247-7868 200 W. Ollie Street Llano, Texas 78643
Hospital District	NA	1-74-2701699-7-001	non-state owned public	Rockdale Hospital District	Carl Hudson *Board Chairman*	carljhudson@yahoo.com 512-446-4502 1700 Brazos P. O. Box 1010 Rockdale, Texas 76567
Local Mental Health Authority	126844305	1-74-2795332-2-000	non-state owned public	Bluebonnet Trails Community Services	Andrea Richardson *Executive Director*	andrea.richardson@bbtrails.org 512-244-8335 1009 North Georgetown Street Round Rock, TX 78664
Local Mental Health Authority	133339505	1-75-1294432-7-000	non-state owned public	Center for Life Resources	Dion White *CEO*	dion@cflr.us 325-646-9574 x255 408 Mulberry Street Brownwood, TX 76801
Local Mental Health Authority	081771001	1-74-1801332-6-002	non-state owned public	Central Counties Services	Eldon Tietje *CEO*	eldon.tietje@cccmhmr.org 254-298-7007 304 S. 22nd St. Temple, TX 76501
Local Mental Health Authority	133340307	1-74-2822017-6-001	non-state owned public	Hill Country MHDD	Linda Werlein *Executive Director*	lwerlein@hillcountry.org 830-792-3300 819 Water St # 300 Kerrville, TX 78028
Performing Providers						
Health District	088334001	1-74-6000348-0-003	non-state owned public	Bell County Public Health District	Bonnie Scurzi *Interim District Director*	bscurzi@bellcountyhealth.org 254-773-4457 254-394-2600 cell 201 N. 8th Street Temple, TX 76502
Health District	126936702	1-74-2896906-1-000	non-state owned public	Williamson County and Cities Health District	Dr. Chip Riggins *Executive Director & Health Authority*	criggins@wcchd.org 512-943-3610 211 Commerce Blvd # 109 Round Rock, TX

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Local Mental Health Authority	1268443-05	1-74-2795332-2-000	non-state owned public	Bluebonnet Trails Community Services	Andrea Richardson *Executive Director*	andrea.richardson@bbtrails.org 512-244-8335 1009 North Georgetown Street Round Rock, TX 78664
Local Mental Health Authority	133339505	1-75-1294432-7-000	non-state owned public	Center for Life Resources	Dion White *CEO*	dion@cflr.us 325-646-9574 x255 408 Mulberry Street Brownwood, TX 76801
Local Mental Health Authority	081771001	1-74-1801332-6-002	non-state owned public	Central Counties Services	Eldon Tietje *CEO*	eldon.tietje@cccmhmr.org 254-298-7007 304 S. 22nd St. Temple, TX 76501
Local Mental Health Authority	133340307	1-74-2822017-6-001	non-state owned public	Hill Country MHDD	Linda Werlein *Executive Director*	lwerlein@hillcountry.org 830-792-3300 819 Water St # 300 Kerrville, TX 78028
Private Hospital	183086102	1-20-5220791-2-010	private	Little River Healthcare System	Jeff Madison *CEO*	jmadison@lrhealthcare.com 512-446-4502 1700 Brazos Avenue Rockdale, TX 76567
Private Hospital	137249208	1-741166904-1-324	private	Scott and White Memorial Hospital	William Galinsky, *VP – Govt Finance*	wgalinsky@sw.org 254-215-9063 2401 South 31st Street MS-AR-M148 Temple, Texas 76508
Private Hospital	220798701 (formerly 020840701)	1-273026151-3-000	private	Scott and White Hospital - Llano (formerly Llano Memorial Hospital)	Kevin Leeper *CEO*	kleeper@llanomemorial.org 325-247-7868 200 W. Ollie Street Llano, Texas 78643
Private Hospital	094151004	1-74-1109643-5-009	private	Seton Highland Lakes Hospital	Arie Dejong *VP/COO*	adejong@seton.org 512-715-3000 200 County Road 340A # 1 Burnet, TX 78611
Private Hospital	020957901	1-74-2781812-9-045	private	St. David's Round Rock Medical Center	Cindy Sexton *VP & CFO*	cindy.sexton@hcahealthcare.com 512-482-4162 18th Floor 98 San Jacinto Blvd Austin, TX 78701

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UC Only Hospitals						
Private Hospital	021215102	1-20-1915868-7-000	private	Cedar Crest Hospital & RTC	Ingrid Whipple *CEO*	Ingrid.whipple@bca-corp.com 254-939-4007 3500 IH 35 Belton, TX 76513
Private Hospital	192622201	1-20-3904667- 2-000	private	Cedar Park Regional Medical Center	Brad Holland *CEO*	brad_holland@cedarparkregional.com 512-528-7001 1401 Medical Parkway Cedar Park, Texas 78613
Private Hospital	094119702	1-74-2225672-1-000	private	Metroplex Health System	Russ Weaver *Director of Managed Care*	russ.weaver@ahss.org Southwest Region - Adventist Health System 11801 S. Freeway Burleson, Texas 76028 817-551-2701
Private Hospital	149073203	1-74-2225672-1-007	private	Rollins Brook Community Hospital	Russ Weaver *Director of Managed Care*	russ.weaver@ahss.org Southwest Region - Adventist Health System 11801 S. Freeway Burleson, Texas 76028 817-551-2701
Private Hospital	190123302	1-203749695-2-002	private	Scott & White Hospital - Round Rock	Ernie Bovio CEO	ebovio@swmail.sw.org 512-509-0400 300 University Boulevard Round Rock, TX
Private Hospital	194106401	1-74-1109643-5-090	private	Seton Medical Center Williamson	Michelle Robertson *President, CEO*	mrobertson@seton.org 512-324-4057 201 Seton Parkway Round Rock, TX 78665
Other Stakeholders						
Private Hospital	136327710	1-741595711-1-001	private	Scott & White Hospital - Taylor	Ernie Bovio *CEO*	ebovio@swmail.sw.org 512-509-0400 305 Mallard Lane Taylor, TX 76574
County Medical Associations				Bell County Medical Society	William Walton, MD *President*	wwalton@swmail.sw.org 254-742-3700 409 W Adams Ave Temple, TX 76501-4211 www.bellcms.com

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County Medical Associations				Burnet-Lampasas County Medical Society	M. Kelly Green, MD *President*	blcms@yahoo.com 512-715-3130 200 CR 340A #2 Burnet, TX 78611-4528 http://www.burnetlampasascms.org
County Medical Associations				Central Texas County Medical Society	Gwendolyn J. Allen, MD *President*	heather.l.johnson@verizon.net 325-646-5296 1604 14th Street Brownwood, TX 78601-5314
County Medical Associations				Hays-Blanco-Caldwell County Medical Society	John E. Lee Sang, MD *President*	tricountycms@gmail.com 512-537-6726 1301 Wonder World Drive San Marcos, TX 78666-7533 http://www.tricountyms.org
County Medical Associations				Llano County Medical Society	Skylar S. Forrister, MD *President*	sforrister@swmail.sw.org 325-247-4131 102 E Young Street Llano, TX 78643-1349
County Medical Associations				Milam County Medical Society	John M. Weed III, MD *President*	jweed@lrhealthcare.com 512-446-4545 602 N Main Rockdale, TX 76567-2323
County Medical Associations				Williamson County Medical Society	John Sherman, MD *President*	wcmstx@yahoo.com 512-367-3523 602 High Tech Drive Georgetown, TX 78626-8185 http://www.wcms-tx.org
Regional Medical Director				Texas Department of State Health Services	Lisa Cornelius *Regional Medical Director – HSR 7*	lisa.cornelius@dshs.state.tx.us 254-778-6744 office, 512-578-6696 Blackberry 2408 S 37th Street Temple, TX 76504
Local Health Department				Milam County Health Department	Patsy Gaines *Director*	pgaines@milamcounty.net 254-697-7039 209 S. Houston Cameron, TX 76520
Urgent Care Clinic				Doctors Express	Bell County	3614 SW HK Dodgen Loop Temple,TX 76504
Urgent Care Clinic				Elms Creek Family-Urgent Care Clinic	Bell County	3816 S Clear Creek Rd Ste E Killeen, TX 76549

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Urgent Care Clinic				Freedom Urgent Care	Bell County	300 W Central Texas Expy Ste 115 Harker Heights, TX 76548
Urgent Care Clinic				Belton Urgent Care Clinic	Bell County	309 Lake Rd Belton, TX 76513
Urgent Care Clinic				Killeen Family Health & Urgent Care Clinic	Bell County	4520 E Central Texas Expy Ste 101 Killeen, TX 76543
Urgent Care Clinic				Scott & White Urgent Care Clinic - Killeen	Bell County	5702 East Central Texas Expressway Killeen, TX
Urgent Care Clinic				First Med Minor Emergency Center	Bell County	1905 SW H K Dodgen Loop Temple, TX 76502
Urgent Care Clinic				Temple HealthExpress Walk-In Clinic	Bell County	937 Canyon Creek Drive Temple, TX 76502
Urgent Care Clinic				Healing Arts Community Health Center of Blanco and Canyon Lake	Blanco County	4520 Highway 281 South Blanco, TX 78606
Urgent Care Clinic				Texas Hill Urgent Care Center	Burnet County	1701 U.S. 281 Marble Falls, TX
Urgent Care Clinic				NextCare Urgent Care	Williamson County	12701 Ranch Road 620 N Austin, TX 78750
Urgent Care Clinic				Urgent & Family Care at Avery Ranch	Williamson County	10625 West Parmer Lane Austin, TX 78717
Urgent Care Clinic				Texas Hills Urgent Care - Cedar Park	Williamson County	351 Cypress Creek Rd Cedar Park, TX 78613
Urgent Care Clinic				Med Spring Urgent Care	Williamson County	1335 E Whitestone Blvd Cedar Park, TX 78613
Urgent Care Clinic				NextCare Urgent Care	Williamson County	900 N Austin Ave Ste 105 Georgetown, TX 78626
Urgent Care Clinic				Stat Med Emergent Care	Williamson County	902 N Austin Ave Ste 102 Georgetown, TX 78626
Urgent Care Clinic				Concentra Urgent Care	Williamson County	117-B Louis Henna Blvd. Round Rock, TX 78664
Urgent Care Clinic				Urgent Care Plus	Williamson County	1240 E. Palm Valley Blvd. Round Rock, Texas 78660
Urgent Care Clinic				Scott and White Urgent Care Hester’s Crossing	Williamson County	2000 S Interstate 35 Round Rock, TX 78681
Urgent Care Clinic				NextCare Urgent Care	Williamson County	1240 E Palm Valley Blvd Round Rock, TX 78664
Urgent Care Clinic				St David's Urgent Care Round Rock	Williamson County	1700 E Palm Valley Blvd Ste 370 Round Rock, TX 78664

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Urgent Care Clinic				Austin Regional Clinic Round Rock	Williamson County	940 Hesters Crossing Round Rock, TX 78681
Urgent Care Clinic				Med Spring Urgent Care	Williamson County	1820 Gattis School Road Round Rock, TX 78664
FQHC				Lone Star Circle of Care - Behavioral Health at Harker Heights	Bell County	775 Indian Trail, Suite 200 Harker Heights, Texas 76548 254-892-0022
FQHC				Lone Star Circle of Care - Family and Children's Clinic at Clear Creek	Bell County	2300 South Clear Creek Suite 105 Killeen, Texas 76549 254- 554-3494
FQHC				Lone Star Circle of Care - Family and Children's Clinic at Harker Heights	Bell County	200 Nola Ruth Harker Heights, Texas 76548 254-698-6629
FQHC				Lone Star Circle of Care - Lone Star Circle of Care at Santa Fe	Bell County	600 S. 25th Street Temple, Texas 76504 1-877-800-5722
FQHC				Scott & White/Lone Star Circle of Care - Sparta Road Pediatric Clinic	Bell County	255 Sparta Road Belton, Texas 76513 1-877-800-5722
FQHC				Lone Star Circle of Care - Dell Children's Circle of Care Pediatrics at Whitestone	Williamson County	1730 E. Whitestone Blvd., Suite 101 Cedar Park, TX 78613 1-877-800-5722
FQHC				Lone Star Circle of Care - Dell Children's - Pediatrics at Hutto	Williamson County	123 Ed Schmidt Blvd. Suite 140 Hutto, Texas 78634 1-877-800-5722
FQHC				Lone Star Circle of Care - Lake Aire Medical Center - Behavioral Health - Family Medicine - Pediatrics - Senior Health	Williamson County	2423 Williams Drive Suite 103 Georgetown, Texas 78628 1-877-800-5722
FQHC				Lone Star Circle of Care - Dell Children's - Pediatrics at Whitestone	Williamson County	1730 E. Whitestone Blvd, Suite 101 Cedar Park, Texas 78613 1-877-800-5722

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FQHC				Lone Star Circle of Care - Georgetown Women's Center	Williamson County	1900 Scenic Drive Georgetown, TX 78626 877-800-5772
FQHC				Lone Star Circle of Care - Georgetown Dental Center	Williamson County	2411 Williams Drive - Ste. 111 Georgetown, Texas 78626 512-864-1445
FQHC				Lone Star Circle of Care	Williamson County	701 E University Ave Georgetown, TX 78626 (512) 863-8768
FQHC				Lone Star Circle of Care	Williamson County	2120 N Mays St Ste. 430 Round Rock, TX 78664 (512) 255-5120
Rural Health Clinic				Scott & White Clinic-Horseshoe Bay	Burnet County	100 Pecan Crossing Horseshoe Bay, TX 78657 (830)598-4405
Rural Health Clinic				Scott & White Clinic-Marble Falls	Burnet County	706 Avenue G Kingsland, TX 78639 325)388-3515
Rural Health Clinic				Seton Bertram Healthcare Center	Burnet County	160 North Lampasas St Bertram, TX 78605 512)355-2678
Rural Health Clinic				Seton Burnet Healthcare Center	Burnet County	200 County Rd 340 A Suite 2 Burnet, TX 78611 (512)715-3009
Rural Health Clinic				Seton Highland Lakes Marble Falls Health	Burnet County	700 Highway 281 Marble Falls, TX 78654 (830)693-2500
Rural Health Clinic				Seton Highland Lakes Care-A-Van	Burnet County	3201 S Water Street Burnet, TX 78611 830)693-2600
Rural Health Clinic				Family Medicine Rural Health Clinic	Lampasas County	207 West Avenue E Lampasas, TX 76550 512)556-3621
Rural Health Clinic				Scott & White Clinic-Kingsland	Llano County	2112 Hwy 1431, Suite 5 Kingsland, TX 78639 325)388-3515
Rural Health Clinic				Seton Healthcare Center Lampasas	Lampasas County	1205 Central Texas Expressway Lampasas, TX 76550 (512) 556-5362

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Rural Health Clinic				Scott & White Hoerster Clinic-Llano	Llano County	102 E Young Llano, TX 78643 325)247-4131
Rural Health Clinic				Central Texas Hospital Medical Services Clinic	Milam County	908 N Crockett Cameron, TX 76520 (254)697-6591
Rural Health Clinic				Little River Healthcare Cameron Clinic	Milam County	708 N Crockett Cameron, TX 76520 (254)697-6554
Rural Health Clinic				Little River Healthcare Rockdale Clinic	Milam County	602 North Main Rockdale, TX 76567 (512)446-4555
Rural Health Clinic				Milam Medical Center	Milam County	725 Taylor Banc Plaza Rockdale, TX 76567 (512)446-0800
Rural Health Clinic				Family Practice Clinic Of Mills County	Mills County	1501 W Front Street Goldthwaite, TX 76844 (325)648-2850
Rural Health Clinic				Mills County Medical Clinic	Mills County	1510 Hanna Valley Rd Goldthwaite, TX 76844 (325) 648-2263
Rural Health Clinic				One Source Health Center-San Saba	San Saba County	403 West Wallace San Saba, TX 76877 915)372-5701
Rural Health Clinic				Scott & White Clinic-San Saba	San Saba County	2005 W Wallace Suite 200 San Saba, TX 76877 (325)372-5163
Clinic				Body of Christ Community Clinic	Bell County	2210 Holland Rd Belton, TX 76513 (254) 939-9500
Clinic				Hillcrest Clinic-Belton	Bell County	255 Sparta Rd Belton, TX 76513 (254) 202-2000
Clinic				Scott & White Clinic-Belton	Bell County	1505 N Main St Belton, TX 76513 (254) 933-4040
Clinic				Family Medicine Clinic	Bell County	813 S Amy Ste 101 Harker Heights, TX 76549 (254) 690-7546

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Clinic				Scott & White Harker Heights Clinic	Bell County	907 Mountain Lion Cir Harker Heights, TX 76548 (254) 953-7700
Clinic				Family & Children's Clinic	Bell County	2300 S Clear Creek Rd Ste 105 Killeen, TX 76549 (254) 690-1475
Clinic				Greater Killeen Free Clinic	Bell County	309 North 2nd Street Killeen, TX 76541 (254) 519-3898
Clinic				Killeen Clinic	Bell County	3801 Scott And White Dr Killeen, TX 76543 (254) 680-1100
Clinic				King's Daughters Clinic	Bell County	401 W Jasper Dr Killeen, TX 76542 (254) 554-8334
Clinic				Family Practice Clinic	Bell County	1717 SW HK Dodgen Loop Ste 114b Temple, TX 76502 (254) 778-0328
Clinic				King's Daughters Clinic	Bell County	1717 SW H K Dodgen Loop Ste 119 Temple, TX 76502 (254) 298-2400
Clinic				Scott & White Northside Clinic	Bell County	409 W Adams Ave Temple, TX 76501 (254) 742-3700
Clinic				Scott & White Westfield Clinic	Bell County	7556 Honeysuckle Temple, TX 76502 (254) 742-7400
Clinic				Temple Free Clinic	Bell County	1905 Curtis B Elliott Dr Temple, TX 76501 (254) 771-3374
Clinic				Blanco Regional Clinic	Blanco County	825 4th St Blanco, TX 78606 (830) 833-5581
Clinic				Ramsey Clinic	Blanco County	P.O. Box 349 Johnson City, TX 78636 Phone: (830) 868-4033
Clinic				Scott & White Burnet Clinic	Burnet County	101 E Jackson St Burnet, TX 78611-310 (512) 756-7510

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Clinic				Scott & White Marble Falls Clinic	Burnet County	706 Avenue G Marble Falls, TX 78654-5866 (830) 693-8234
Clinic				Fresenius Medical Care Lampasas	Lampasas County	1202 Central Texas Expressway Lampasas, TX 76550 (512) 556-4101
Clinic				Ford Street Clinic	Llano County	1100 Ford St Llano, TX 78643-2309 (325) 247-3715
Clinic				Scott & White Cameron Clinic	Milam County	101 Lafferty Ste B Cameron, TX 76520 (254) 605-1100
Clinic				Family Care Center	Milam County	1700 Brazos Avenue Rockdale, Texas 76567 (512) 446-4545
Clinic				Fresenius Medical Care Rockdale	Milam County	300 Josie Ln Rockdale, TX 76567 (512) 446-5400
Clinic				Pecos Street Clinic	Milam County	1700 Brazos Avenue Rockdale, Texas 76567 (512) 430-6486
Clinic				Goldthwaite Family Medical Clinic	Mills County	1219 Parker St Goldthwaite, TX 76844 (325) 648-2862
Clinic				MinuteClinic Diagnostic of Austin	Williamson County	4426 Williams Dr Georgetown, Texas 78628 866-389-2727
Clinic				Richards Memorial Diagnostics – Georgetown	Williamson County	1528 Leander Road Georgetown, TX (512) 863-0782
Clinic				Scott and White Georgetown Central Clinic	Williamson County	603 W. University Georgetown, TX 78626 (512) 509-9550
Clinic				Georgetown Medical Clinic	Williamson County	3201 S. Austin Avenue Georgetown, TX 78626 (512) 930-4593
Clinic				Scott & White Georgetown Clinic – Sun City	Williamson County	4945 Williams Dr Georgetown, TX 78633 (512) 819-0500

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Clinic				Austin Regional Clinic	Williamson County	151 Exchange Blvd Ste 700 Hutto, TX 78634-5383 (512) 846-1244
Clinic				Scott & White Hutto Clinic	Williamson County	120 County Road 119 Hutto, TX 78634-5358 (512) 509-9500
Clinic				MinuteClinic Diagnostic of Austin	Williamson County	1855 Gattis School Rd. Round Rock, Texas 78664 (866) 389-2727
Clinic				Rediclinic Texas	Williamson County	1700 E. Palm Valley Blvd. Round Rock, Texas 78664 (512)255-8933
Clinic				Rediclinic Texas	Williamson County	16900 RR 620 Round Rock, Texas 78681 (866) 607-7343
Clinic				Austin Regional Clinic	Williamson County	2000 S. Mays Round Rock, Texas 78664 (512) 244-9024
Clinic				Legends Medical Clinic	Williamson County	3000 Joe Dimaggio Blvd Ste 35 Round Rock, TX 78665 (512) 733-6464
Clinic				Round Rock Medical Clinic	Williamson County	405 Old West Dr Round Rock, TX 78681 (512) 255-3631
Clinic				Sacred Heart Community Clinic	Williamson County	620 Round Rock West Dr Round Rock, TX 78681 (512) 827-7422
Clinic				Samaritan Health Ministries	Williamson County	700 W. Whitestone Blvd. Cedar Park, TX 78630 512-331-5828
Clinic				Scott & White Round Rock West Clinic	Williamson County	16420 Route 620 Round Rock, TX 78681 (512) 250-7000
Hospice				Family Hospice	Bell County	1801 West Trimmier Road Killeen, TX 76541
Hospice				Lighthouse Hospice	Bell County	1616 Azalea Drive Temple, TX 76502
Hospice				New Century Hospice	Bell County	451 East Central Texas Expressway Harker Heights, TX 76548

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Hospice				Vista Care Hospice	Bell County	2626 South 37th Street Temple, TX 76504
Hospice				Seton Highland Lakes Hospice	Burnet County	409 Industrial Boulevard Burnet, TX 78611
Hospice				Lighthouse Hospice	Burnet County	608 Gateway Central Marble Falls, TX 78654
Hospice				Girling Hospice Burnet	Burnet County	1803 East Polk Street Burnet, TX 78611
Hospice				Spring Oaks Nursing & Rehab	Lampasas County	901 Central Texas Expressway Lampasas, TX 76550
Hospice				Llano Memorial Hospice	Llano County	1100 Ford Street Llano, TX 78643
Hospice				Standards Hospice	Milam County	1502 W 4th St Cameron, TX 76520
Hospice				Abiding Care Hospice	Williamson County	2006 Carriage Club Drive Cedar Park, TX 78613
Hospice				Hospice Austin	Williamson County	102 Morrow Street Georgetown, TX 78626
Hospice				Interim Healthcare	Williamson County	111 West 9th Street Georgetown, TX 78626
Hospice				Lighthouse Hospice	Williamson County	2913 Williams Drive Georgetown, TX 78628
Hospice				Lighthouse Hospice	Williamson County	1217 Ranch Road 2243 Georgetown, TX 78628

Section II. Executive Overview of RHP

Regional Healthcare Partnership 8 (RHP 8) is a nine-county partnership located in the Central Texas region. This RHP is contained within Health Service Region 7 as defined by the Texas Department of State Health Services and consists of Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba and Williamson Counties.

Healthcare Environment

RHP 8 is a large area, covering 8,547 square miles, and has a population density of 100.73 residents per square mile[1] compared to a statewide density of 95.92. A map of the region is included in Addendum 1A.

Patient Population

The total population for RHP 8 was 860,803 with Bell and Williamson Counties consisting of about 85% of RHP 8's residents according to the 2010 Census. These two counties are similar to Texas in terms of age distributions. However, the other counties in RHP 8 tend to have older populations, with Blanco, Burnet, Lampasas, Milam and Mills counties all having almost twice the Texas average for residents over 65 years of age. Over 31% of Llano County's population is over 65.

A large percentage of RHP 8 is uninsured. According to County Health Rankings (2010), only Bell, Llano, and Williamson Counties are below Texas' rate of 26%. Mills (30.5%) and San Saba (34.5%) Counties have the highest percentages of uninsured adults. These two counties also have higher rates than the Texas average of uninsured children. Burnet, Llano, and San Saba Counties all had higher percentages of children participating in the Children's Health Insurance Program (CHIP) than the State of Texas as seen in Table 3-3.

Health Systems and Providers

RHP 8 has the benefit of several large hospital systems: Seton Healthcare Family, St. David's Healthcare, Scott & White Healthcare, and Community Health Systems. These systems have their largest hospitals in RHP 8 in Williamson and Bell Counties. There also are several smaller hospitals, primarily in Burnet and Llano Counties. There are a numerous primary care clinics (see Table 1-1), and four local mental health authorities within RHP 8.

RHP 8 has a full continuum of care, which includes health promotion, primary care, specialty care, chronic disease management, labor and delivery, general and specialty surgery, intensive care, behavioral healthcare services, rehabilitation, emergency care, and many others. RHP 8 also has a large number of health professionals. However, the most comprehensive services are available through the hospital systems in the more populous Bell and Williamson Counties. Healthcare resources are less abundant in the rural counties of RHP 8.

[1] Texas Workforce Commission County Narrative Profiles
http://www.texasindustryprofiles.com/apps/cnp/index.asp

In most cases, limited primary care can be obtained locally but more preventative screenings and specialty care must be accessed in the more populous areas or other regions. This can create transportation issues for many residents in RHP 8, result in long waits to access certain types of care, and cause some residents to not receive the necessary health care.

Key Health Challenges

The key health challenges in RHP 8 are similar to other areas in Texas. Addressing these health care needs will require broad system transformation and collaboration among healthcare providers and organizations. The broad key health challenges in RHP 8 include:

- Poor access to primary care,
- Poor access to behavioral/mental health services, and
- Lack of coordinated care, especially for those with multiple needs.

Access to quality primary care is a challenge because health care is concentrated in the Interstate Highway 35 corridor counties of Williams on and Bell. There are significantly fewer healthcare professionals in the more rural areas in RHP 8, which are primarily west of I-35. Professionals in these rural areas are frequently stretched very thin, making access difficult. Since the population is less dense, providers must cover more territory. More specialized care in these areas can be all but impossible to obtain. Access to primary care is an issue in Williamson and Bell Counties as well since population growth is outpacing the growth in the number of health care professionals. Accessing care can beespecially challenging for those who are under or uninsured.

Access to behavioral health and mental health services is also a large concern. There are four local mental health authorities in RHP 8, but they are challenged to keep up with demand. Transportation issues can again make seeking services inconvenient, at best. RHP 8 is challenged with meeting the behavioral health needs of veterans and their families, the changing needs of high functional autistic individuals and others who have limited or no access to behavioral health services.

RHP 8 lacks coordinated care, especially for those with multiple needs. This causes residents, especially those who have multiple needs or have limited access to services to use inappropriate and more expensive services, such as the emergency department or emergent services. In particular, RHP 8 has individuals with chronic disease, individuals with co-occurring mental health and chronic disease and individuals with intellectual disabilities and mental health issues that face significant challenges in locating providers that can handle their needs.

Each of these key challenges, if resolved, would provide better quality of life and reduce the burden on RHP 8 justice systems, hospitals and Emergency Departments (ED).

RHP Goals and Vision, and Plans for Achieving the Goals

The overarching goal of RHP 8 is to transform the local and regional health care delivery systems to improve access to care, efficiency, and effectiveness. Specifically, RHP 8 will address

the key challenges listed above and will aim to resolved these by reaching four primary goals. The plans for achieving those goals are listed with the goals below:

1) **Improving access to timely, high quality care for residents, including those with multiple needs;**
   Providers in RHP 8 will achieve this goal by expanding the availability and capacity of primary care in the region, as well as expanding the services are available through primary care providers. In addition to new primary care sites and expanded clinic hours, providers will enhance urgent medical advice, target disparity groups with evidence based health promotion, disease prevention, and chronic care management, and increase behavioral health by extending it through primary care providers. Many of these new services aim to improve patient satisfaction, an indicator of quality of care.

2) **Increasing the proportion of residents with a regular source of care;**
   The expansion of primary care capacity in RHP 8 will provide opportunities for residents to establish a regular source of care. In addition to availability, enhancing the availability of urgent medical advice will promote patients' seeking out a medical home. New patient navigation programs will show residents who are currently without a regular source of care to available primary care providers.

3) **Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and**
   The coordination of care in RHP 8 will better address the community needs by integrating primary and behavioral health services, integrating behavioral health services with services for the intellectually and developmentally disabled, and creating patient navigation programs to ensure residents who tend to access more inappropriate settings of care can develop a regular source of care.

4) **Reducing inappropriate utilization of services.**
   Given the largely rural nature of RHP 8, inappropriate utilization of services is a critical issue as many needed services simply are not available locally. All of the activities described under Goals 1, 2 and 3 above, are expected to reduce inappropriate utilization of the Emergency Department (ED), the Justice System and Emergency Medical Services. The expansion of primary care availability and accessibility, care coordination through patient navigation, targeted behavioral health services, and evidence-based health promotion/disease prevention targeting high risk and disparities populations all serve to get people into the right care at the right time. Specific outcomes of interest include appropriate utilization of the ED and reducing the ambulatory care sensitive admission rate.

Table 2-1. RHP CATEGORY 1 & 2 PROJECTS				
Project Title (include unique RHP project ID number)	**Project Area**	**Brief Project Description**	**Related Category 3 Outcome Measures**	**Estimated Incentive Amount (DSRIP)**
Category 1: Infrastructure Development				
126844305.1.1 Bluebonnet Trails	1.12.2	Expand the number of community based settings where behavioral health services may be delivered in **underserved areas**	126844305.3.1 IT-6.2 Other Outcomes Improvement Target: Percent improvement over baseline of patient satisfaction scores	$1,346,438
126844305.1.2 Bluebonnet Trails	1.13.1	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	126844305.3.2 IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate	$5,854,701
126844305.1.3 Bluebonnet Trails	1.13.1	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	126844305.3.3 IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings	$1,280,625
126844305.1.4 (PASS 2) Bluebonnet Trails	1.13.1	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	126844305.3.6 IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate	$4,103,836
126844305.1.5 (PASS 2) Bluebonnet Trails	1.12.2	Expand the number of community based settings where behavioral health services may be delivered in underserved areas	126844305.3.7 IT-10.1 Quality of Life	$2,019,656

Table 2-1. RHP CATEGORY 1 & 2 PROJECTS				
Project Title (include unique RHP project ID number)	**Project Area**	**Brief Project Description**	**Related Category 3 Outcome Measures**	**Estimated Incentive Amount (DSRIP)**
133339505.1.1 Center for Life Resources	1.11.1	Procure and build the infrastructure needed to pilot or bring to scale a successful pilot of the selected forms of service in underserved areas of the state	133339505.3.1 IT-9.2 ED Appropriate Utilization	$557,921
081771001.1.1 Central Counties Services	1.1.1	Establish More Primary Care Clinics	081771001.3.1 IT-10.1 Quality of Life	$2,616,584
081771001.1.2 Central Counties Services	1.11.2	Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers.	081771001.3.2 IT-6.2 Other Outcomes Improvement Target: Percent improvement over baseline of patient satisfaction scores	$4,004,924
081771001.1.3 Central Counties Services	1.12.2	Expand the number of community based settings where behavioral health services may be delivered in underserved areas	081771001.3.3 IT-10.1 Quality of Life	$2,692,588
081771001.1.4 (PASS 2) Central Counties Services	1.13.1	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	081771001.3.7 IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings	$7,423,208

Table 2-1. RHP CATEGORY 1 & 2 PROJECTS				
Project Title (include unique RHP project ID number)	**Project Area**	**Brief Project Description**	**Related Category 3 Outcome Measures**	**Estimated Incentive Amount (DSRIP)**
081771001.1.5 (PASS 2) Central Counties Services	1.10.2	Enhance improvement capacity through technology	081771001.3.8 IT-1.18 Follow-Up Hospitalization for Mental Illness – NQF 0576	$2,751,691
183086102.1.1 (PASS 2) Little River Healthcare	1.1.2	Expand existing primary care capacity	183086102.3.1 IT-9.2 ED Appropriate Utilization	$3,209,877
183086102.1.2 (PASS 2) Little River Healthcare	1.9.2	Improve Access to Specialty Care	183086102.3.2 - IT-12.1 Breast Cancer Screening 183086102.3.3 - IT-12.2 Cervical Cancer Screening 183086102.3.4 - IT-12.3 Colorectal Cancer Screening	$2,626,259
020957901.1.1 St. David's Round Rock	1.1.2	Expand existing primary care capacity	020957901.3.1 IT-9.2 ED Appropriate Utilization	$11,779,331
126936702.1.1 Williamson County and Cities Health District	1.1.2	Expand existing primary care capacity	126936702.3.1 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$3,940,497

Table 2-1. RHP CATEGORY 1 & 2 PROJECTS				
Project Title (include unique RHP project ID number)	**Project Area**	**Brief Project Description**	**Related Category 3 Outcome Measures**	**Estimated Incentive Amount (DSRIP)**
126936702.1.2 Williamson County and Cities Health District	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.	126936702.3.2 IT-9.2 Reduce Emergency Department visits for target conditions	$3,930,304
126936702.1.3 Williamson County and Cities Health District	1.5.3	Implement project to enhance collection, interpretation, and / or use of REAL data. Providers may select one or more of the following project components, as appropriate for the provider's starting point in collection and use of REAL data:	126936702.3.3 - IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap. 126936702.3.4 - IT-11.3 Improve utilization rates of clinical preventive services in target population with identified disparity. 126936702.3.5 - IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity.	$794,513
Category 2: Program Innovation and Redesign				
088334001.2.1 Bell County Public Health District	2.7.1	Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)	088334001.3.1 - IT-9.4 Other Evidence based outcome measure: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics. 088334001.3.2 - IT-9.4 Other Evidence based outcome measure: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics. 088334001.3.3 - IT-9.4 Other Evidence based outcome measure: Increase the number of clients retested for Syphilis 3-months after treatment for positive Syphilis in Bell County Public Health District clinics.	$760,576

Table 2-1. RHP CATEGORY 1 & 2 PROJECTS				
Project Title (include unique RHP project ID number)	**Project Area**	**Brief Project Description**	**Related Category 3 Outcome Measures**	**Estimated Incentive Amount (DSRIP)**
088334001.2.2 (PASS 2) Bell County Public Health District	2.7.1	Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)	088334001.3.4 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$866,738
126844305.2.1 Bluebonnet Trails	2.13.2	In an innovative manner not described above, implement other evidence-based project for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.	126844305.3.4 IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate	$1,856,400
126844305.2.2 Bluebonnet Trails	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	126844305.3.5 IT-9.2 ED Appropriate Utilization	$3,889,550
126844305.2.3 (PASS 2) Bluebonnet Trails	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	12684405.3.8 IT-9.2 ED Appropriate Utilization	$1,039,584
126844305.2.4 (PASS 2) Bluebonnet Trails	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	126844305.3.9 IT-9.1 Decrease in mental health admissions and readmissions to criminal justice setting such as jails or prisons	$906,288

Table 2-1. RHP CATEGORY 1 & 2 PROJECTS				
Project Title (include unique RHP project ID number)	**Project Area**	**Brief Project Description**	**Related Category 3 Outcome Measures**	**Estimated Incentive Amount (DSRIP)**
081771001.2.1 Central Counties Services	2.2.2	Apply evidence-based care management model to patients identified as having high-risk health care needs	081771001.3.4 IT-11.1 Improvement in Clinical Indicator in identified disparity group	$288,160
081771001.2.2 Central Counties Services	2.7.1	Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)	081771001.3.5 IT-11.1 Improvement in Clinical Indicator in identified disparity group	$288,160
081771001.2.3 Central Counties Services	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	081771001.3.6 IT-9.1 Decrease in mental health admissions and readmissions to criminal justice setting such as jails or prisons.	$1,580,190
133340307.2.1 Hill Country MHDD	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	133340307.3.1 IT-10.2 Activities of Daily Living	$221,202
133340307.2.2 Hill Country MHDD	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	133340307.3.2 IT-10.2 Activities of Daily Living	$362,716
133340307.2.3 Hill Country MHDD	2.16.1	Design, implement, and evaluate a program to provide remote psychiatric consultative services to all participating primary care providers delivering services to patients with mental illness or substance abuse disorders	133340307.3.3 IT-12.5 Other USPSTF endorsed screening (PHQ-A and BDI-PC) 133340307.3.4 IT-12.5 Other USPSTF endorsed screening (PHQ-9) 133340307.3.5 IT-12.5 Other USPSTF endorsed screening (CAGE and AUDIT)	$626,322

Table 2-1. RHP CATEGORY 1 & 2 PROJECTS				
Project Title (include unique RHP project ID number)	**Project Area**	**Brief Project Description**	**Related Category 3 Outcome Measures**	**Estimated Incentive Amount (DSRIP)**
133340307.2.4 (PASS 2) Hill Country MHDD	2.18.1	2.18.1 - Design, implement, and evaluate whole health peer support for individuals with mental health and /or substance use disorders.	133340307.3.6 IT-10.2 Activities of Daily Living	$820,126
133340307.2.5 (PASS 2) Hill Country MHDD	2.13.1	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.	133340307.3.7 IT-10.2 Activities of Daily Living	$617,463
220798701.2.1 Scott & White – Llano (formerly Llano Memorial Hospital)	2.8.1	Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.	220798701.3.1 IT-9.2 ED Appropriate Utilization	$741,418
220798701.2.2 (PASS 2) Scott & White – Llano (formerly Llano Memorial Hospital)	2.8.1	Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.	220798701.3.2 IT-9.2 ED Appropriate Utilization	$331,277
137249208.2.1 Scott & White Memorial Hospital	2.9.1	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized 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)	137249208.3.1 IT-2.11: Ambulatory Care Sensitive Conditional Admissions Rate 137249208.3.2 IT-9.2: ED appropriate utilization	$2,529,914

Table 2-1. RHP CATEGORY 1 & 2 PROJECTS				
Project Title (include unique RHP project ID number)	**Project Area**	**Brief Project Description**	**Related Category 3 Outcome Measures**	**Estimated Incentive Amount (DSRIP)**
094151004.2.1 (PASS 2) Seton Highland Lakes	2.9.1	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized 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)	094151004.3.1 IT-2.11 Ambulatory care sensitive conditions admissions	$4,013,512
126936702.2.1 Williamson County and Cities Health District	2.9.1	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized 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)	126936702.3.6 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$752,119
126936702.2.2 (PASS 2) Williamson County and Cities Health District	2.6.1	Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population.	126936702.3.7 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$1,162,124

Section III. Community Needs Assessment

The community needs assessment for RHP 8 aims to describe the health status of the region by presenting data and tables on demographics, insurance coverage, healthcare infrastructure, projected changes in the region and key health challenges. This information is important to the community, stakeholders, counties, hospitals, clinics, local mental health authorities, and public health districts to better understand the health concerns of RHP 8. This data is essential for developing broad, meaningful Delivery System Reform Incentive Payment (DSRIP) projects that will result in healthcare system transformation for RHP 8.

Community Needs Assessment Approach

RHP 8 approached the community needs assessment through a four-step process that occurred primarily during the early months of plan development. First, the anchor team compiled secondary data from multiple sources, including those suggested by the Health and Human Services Commission, for each county in the partnership. Any existing local assessment data was added to it. Second, the compiled assessment information was distributed to IGT entities and local stakeholders in each county, who were asked to review the data, to submit any additional data they may have, and to begin identifying priority areas. Third, the IGT entities were brought together to discuss priority areas; the premise was to indicate what type of transformational activities they would support if they were to put up IGT. Finally, the priority areas were summarized by county and at the regional level and disseminated to providers and other stakeholders for planning, who were also asked to submit additional information they may have relevant to the specific priorities. The collection of the community needs data strengthened the overall communication and collaboration between organizations in RHP 8 which will be critical over the five-year waiver.

Demographics

Population/Age

Demographic information for RHP 8 was compiled from the 2010 Census. The total population for RHP 8 in 2010 was 860,803 with Bell and Williamson Counties housing about 85% of the region's residents. The least populated county in RHP 8 is Mills County with 4,936 residents. RHP 8 is approximately 8,547 square miles with a population density of 100.73 residents per square mile which is slightly higher than Texas' population density of 95.92 residents per square mile. RHP 8 is expected to grow to 924,214 residents in 2020 and up to 1,120,992 by 2030 according to projects from the Texas Workforce Commission.[2]

Except for Bell and Williamson Counties, all the counties in RHP had a lower percent of their population under age 18 than Texas (27.3%). The majority of counties in RHP 8 have a greater proportion of older residents; 17% or more of their residents are older than 65 years with Llano

[2] Texas Workforce Commission County Narrative Profiles
http://www.texasindustryprofiles.com/apps/cnp/index.asp

County being the highest (31.1%), compared to Texas at 10.3% in this age group. Most of the counties in RHP 8 were close to the state's percentages for males and females, 49.6% and 50.4% respectively, except for San Saba County which is 54.9% male and 45.1% female.

Race/Ethnicity

The percentage of Texas residents that are non-Hispanic White is 45.3%, which is significantly lower than every county in RHP 8. The most rural counties in RHP 8 such as Blanco, Llano, and Mills, had higher percentages of residents that are non-Hispanic White and the lowest percentages of minority residents such as those who are Black or of Hispanic or Latino origin. Bell County had the highest percentages in RHP 8 of African Americans (21.5%) and residents who are two or more races (5.0%). Both of these percentages are significantly different from the rest of the counties in the region, all of which have a lower percentage of African Americans than Texas (11.8%)[4].

Income

In 2010, RHP 8 consisted of 292,958 households with median household incomes ranging from $31,895 in Mills County to $68,780 in Williamson County. Texas' median household income is $49,646, which is higher than every county in RHP 8 except for Williamson. The per capita income in Texas in 2010 was $24,870 which falls in the middle of the range of per capita income in RHP 8 with the lowest being in San Saba ($19,721) and the highest in Williamson ($29,663).[3]

In 2009, the Federal Poverty Level (FPL) was $10,830 for an individual and $22,050 for a family of four. In Texas, 17.1% of all residents were below the poverty line in 2009, which is a lower percentage than four of the counties in RHP 8. The highest levels of poverty in RHP 8 were found in counties that had the lowest per capita income, such as San Saba, Mills, and Milam counties. These counties, along with Lampasas County, had the highest percentages of persons younger than 18 years of age living in poverty across RHP 8, which were also higher than the state average of 14.3%[3].

Table 3-1 provides a summary of age, race/ethnicity, and income demographics for RHP 8.

[3] Texas Department of State Health Services – Health Currents www.dshs.state.tx.us/chs/healthcurrents

Table 3-1. RHP 8 POPULATION DATA (INCLUDING AGE, RACE/ETHINICITY, & INCOME)[4]									
	Bell	Blanco	Burnet	Lampasas	Llano	Milam	Mills	San Saba	Williamson
TOTAL COUNTY POPULATION (2010)	310,235	10,497	42,750	19,677	19,301	24,757	4,936	6,131	422,679
AGE									
% Less Than 18	28.4%	21.9%	23.2%	24.8%	15.9%	26.5%	24.3%	21.0%	28.7%
% Age 18-64	62.9%	59.9%	58.2%	59.4%	53.0%	56.1%	52.2%	59.8%	62.4%
% Age 65+	8.7%	18.2%	18.6%	15.8%	31.1%	17.4%	23.5%	19.2%	8.9%
GENDER									
% Male	49.5%	50.5%	49.1%	49.3%	48.3%	49.4%	49.5%	54.9%	49.2%
% Female	50.5%	49.5%	50.9%	50.7%	51.7%	50.6%	50.5%	45.1%	50.8%
RACE/ETHNICITY									
% White	61.4%	90.3%	88.5%	85.3%	94.9%	78.1%	90.0%	84.3%	78.1%
% Black	21.5%	0.7%	1.8%	3.2%	0.6%	10.0%	0.5%	3.3%	6.2%
% American Indian/Alaska Native	0.8%	0.7%	0.7%	0.9%	0.6%	0.7%	0.4%	0.8%	0.6%
% Asian	2.8%	0.5%	0.5%	1.0%	0.4%	0.4%	0.2%	0.2%	4.8%
% Native Hawaiian or Other Pacific Islander	0.8%	Z*	0.0%	0.2%	Z*	Z*	0.0%	Z*	0.1%
% Two or More Races	5.0%	1.9%	1.9%	3.2%	1.4%	1.8%	1.5%	1.5%	3.2%
% Hispanic or Latino Origin	21.6%	18.2%	20.2%	17.5%	8.0%	23.3%	16.6%	28.0%	23.2%
% White Not Hispanic	50.7%	79.4%	76.1%	75.4%	89.6%	65.5%	81.5%	67.4%	63.8%
INCOME									
Households (2010)	101,433	3,935	16,315	7,031	8,463	9,575	1,974	2,122	142,110
Per Capita Personal Income (2010)	$22,722	$27,010	$25,245	$22,943	$29,027	$21,509	$20,438	$19,721	$29,663
Median Household Income (2010)	$48,618	$46,128	$48,187	$46,378	$41,969	$39,305	$31,895	$36,308	$68,780
% Persons < 100% FPL (2009)	15.3%	12.2%	13.0%	17.9%	13.2%	18.0%	19.4%	21.5%	5.5%
% Persons <age 18 that are <100% FPL (2009)	20.7%	20.0%	22.1%	28.1%	26.6%	28.0%	30.6%	41.8%	8.7%
Average Monthly TANF (SFY 2009)[3]	151	-	3	2	1	29	2	2	127
Average Monthly SNAP (SFY 2009)	29,487	626	3,244	2,176	1,346	3,825	380	799	23,389

[4] United States Census (2010) http://quickfacts.census.gov

Education

Total public school enrollment in 2010 for RHP 8 counties is 187,868 with dropout rates varying by county from 1.0% in Burnet County to 7.7% in Bell County. The dropout rate in Texas for 2010 was 7.3%. Dropout rates for Llano, Mills and San Saba Counties were unable to be calculated due to incomplete data.[5] In RHP 8, every county had at least 77% of residents over age 25 holding a high school diploma with Williamson County being the highest at 91.6%. The range was larger in RHP 8 for the percentage of residents over age 25 that hold at least an associate's degree with the lowest in Milam County (13.5%) and the highest in Williamson County (37.3%).[6]

In RHP 8, there are a total of 37 school districts and 296 schools, including alternative, disciplinary, and charter schools.[7] During the 2010-2011 school year, 62.4% of Texas children participated in the Free and Reduced Lunch Program. Counties in RHP 8 ranged from 36% (Williamson County) to 77% (San Saba County) of children participating in the program.[5]

Table 3-2. RHP 8 EDUCATION DATA, 2010

	Bell	Blanco	Burnet	Lampasas	Llano	Milam	Mills	San Saba	Williamson
Total public school enrollment	64,906	1,677	7,423	3,724	1,910	4,587	885	961	101,795
High school dropout rate	7.7%	5.2%	1.0%	2.6%	N/A	3.9%	N/A	N/A	3.7%
Percent of population age 25+ with 12 or more years of education (2009)	88.6%	88.3%	83.5%	82.6%	88.0%	81.5%	77.2%	81.4%	91.6%
Percent of population age 25+ with a college degree (Associate's Degree or higher)	21.2%	25.4%	21.4%	17.3%	26.0%	13.5%	18.7%	18.1%	37.3%
Number of school districts (2012)	9	1	2	1	1	6	4	2	11
Number of schools (elementary, middle, high)	85	3	12	5	4	14	4	3	119
Elementary	52	1	8	3	2	6	2	1	77
Intermediate, Jr. High, Middle	21	1	2	1	1	5	1	1	23
High	12	1	2	1	1	3	1	1	19
Other (alternative, disciplinary, K-12, charter)	22	0	2	0	0	1	2	2	18
% students with Free and Reduced Lunch program	57.3%	51.1%	62.2%	61.1%	64.4%	70.1%	64.3%	77.0%	36.0%

*N/A indicates not enough data available to calculate percentage

[5] The Annie E. Casey Foundation Kids Count Data Center (2010) http://datacenter.kidscount.org/data/bystate/Default.aspx?state=TX
[6] United States Census (2010) http://quickfacts.census.gov
[7] Texas Education Agency http://ritter.tea.state.tx.us/cgi/sas/broker?_service=marykay&_program=adhoc.std_download_selected_report.sas&rpt_subject=geographic&ftype=html&fname=adgeo12&submit=Get+Report

Employment
In 2010, unemployment rates in RHP 8 ranged from 5.9% (Blanco County) to 10.5% (Milam County), with two counties exceeding the State rate of 8.2% (Milam and San Saba Counties).[8] Milam County's higher unemployment rate may be related to the closing of Alcoa, a large smelting operation, in early 2009.

There is a wide range of employers across RHP 8 in regards to type, size, and location. There were several employers in RHP 8 with over 1,000 employees which include the Veteran's Administration Hospital in Bell County, and Dell, Georgetown ISD, Sears Teleserv, and Williamson County Government in Williamson County. Types of companies/organizations that commonly employed the highest number of people in RHP 8 Counties are manufacturing, healthcare, food/restaurant supply, retail, city and county government, and education. Information is collected differently for each county, so while some counties included school districts and county employment, others did not. In addition, for employers in RHP 8, workforce boards provided employee numbers in ranges, exact numbers, or not at all for some counties. Additional information on the top employers in RHP 8 can be found in Addendum 1B.

Health Coverage

Over 102,000 people (aged and disabled) in RHP 8 were enrolled in Medicare in 2010.[9] In RHP 8, the total number of unduplicated Medicaid clients in 2009 was 113,095 with the range being from 1,023 in Milam County to 49,380 clients in Bell County. Williamson County also had 40,873 unduplicated Medicaid clients, and when combined with Bell County, the two represent 80% of RHP 8's total.

The rates of uninsured adults were high in RHP 8 with only Bell, Llano, and Williamson Counties being below Texas' rate of 26%[8]. The highest percentages of uninsured adults were in Mills and San Saba Counties with 30.5% and 34.5% uninsured, respectively. Although Williamson, Bell, and Llano counties fall below the statewide average rate of uninsured, each of these counties has a higher rate of uninsured than the national benchmark. Additionally, a Federally Qualified Health Center located in Williamson County, Lone Star Circle of Care, is a federally designated Health Professional Shortage Area in the areas of primary, dental and mental health care, and is the only clinic in the county treating uninsured patients. Thus, access to primary care for uninsured in Williamson County is an issue RHP 8 must address through DSRIP. In Texas, 19.5% of children 18 years and younger were without health insurance. Much like the rates for all adults, the highest rates of uninsured children were in Mills and San Saba Counties with the lowest rates occurring in Bell and Williamson Counties. In addition, the State CHIP enrollment in 2010 was 7.2%. Burnet, Llano, Mills, and San Saba Counties all had higher percentages of children participating in CHIP than the State of Texas, as seen in Table 3-3.

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[8] County Health Rankings (2010) www.countyhealthrankings.org
[9] Centers for Medicare and Medicaid Services - Medicare Enrollment Reports (2010) http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/County2010.pdf

Table 3-3. RHP 8 INSURANCE COVERAGE, 2010									
	Bell	Blanco	Burnet	Lampasas	Llano	Milam	Mills	San Saba	Williamson
Medicare[10]	32,062	2,382	9,576	3,864	5,033	4,719	1,119	1,155	42,398
Aged Only	25,424	2,184	8,606	3,283	4,501	4,017	1,006	1,040	36,800
Disabled Only	6,638	198	970	581	532	702	113	115	5,598
Unduplicated Medicaid	49,380	1,171	6,617	3,674	2,936	6,097	1,023	1,324	40,873
Adult Uninsured[11]	19.8%	26.7%	28.7%	27.4%	24.2%	27.0%	30.5%	34.5%	16.5%
Child Uninsured	12.6%	20.8%	21.8%	19.9%	18.6%	19.6%	23.0%	25.4%	10.7%
CHIP Enrollment (2009)	3.9%	5.5%	8.8%	6.5%	10.7%	6.6%	7.7%	10.6%	5.0%
Child Uninsured Data Source: US Census Small Area Health Insurance Estimates (2009),CHIP Enrollment Data Source: The Annie E. Casey Foundation Kids Count Data Center (2010)									

Healthcare Infrastructure and Environment

In RHP 8, there is a substantial range of providers by type and distribution among the counties. Bell and Williamson Counties had the highest total amounts of providers in 2010 with 6,520 and 5,718, respectively, due to high population and hospital density in these areas. The largest hospitals in RHP 8 are located in these two counties. Across RHP 8, Licensed Vocational Nurses and Registered Nurses are the most numerous out of all the types of providers. However, despite the high number of overall providers in Williamson County, the ratio of residents to primary care providers is still well above the national benchmark and the statewide average ratio. Thus, access to primary care in the urban areas of RHP 8 is also a problem, despite the hospitals located in those areas. Each county in RHP 8 has at least one of each type of provider except Blanco County, which did not have any physician assistants at the time the data was collected. The Texas Department of State Health Services reported that counties in RHP 8 had a total of 14,024 of the types of health providers shown in Table 3-4. RHP 8's 2010 population was 860,803 which, when divided by the total number of providers, equals about 61 residents per healthcare provider.

Table 3-4. RHP 8 PROVIDER DATA, 2010									
	Bell	Blanco	Burnet	Lampasas	Llano	Milam	Mills	San Saba	Williamson
Direct Care Physicians	608	4	63	1	19	12	4	1	595
Primary Care Physicians	253	4	35	9	13	9	4	1	333

[10] Centers for Medicare and Medicaid Services - Medicare Enrollment Reports (2010) http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/County2010.pdf

[11] U.S. Census Bureau Small Area Health Insurance Estimates (2009) http://www.census.gov/did/www/sahie/data/2009/tables.html

Table 3-4. RHP 8 PROVIDER DATA, 2010									
	Bell	Blanco	Burnet	Lampasas	Llano	Milam	Mills	San Saba	Williamson
Physician Assistants	118	-	8	4	5	4	1	1	77
Registered Nurses	2,810	17	174	76	83	88	16	16	1,961
Licensed Vocational Nurses	1,352	15	93	57	60	103	21	28	588
Nurse Practitioners	109	4	8	1	1	7	1	1	67
Dentists	137	4	22	4	8	4	1	2	244
Pharmacists	262	5	40	10	13	11	2	3	371
Chiropractors	41	3	11	4	2	4	1	2	126
EMS Personnel	66	7	19	9	5	11	3	2	140
TOTALS	6,520	104	674	244	255	315	73	121	5,718
Source: Texas Department of State Health Services Health Currents, 2010									

Hospital Sizes & Costs

There are a total of 1,435 beds in the hospitals located in RHP 8 in 2010,[12] ranging from 23 beds at Scott and White Hospital –Taylor, to 591 beds at Scott and White Memorial Hospital in Temple. Across the RHP 8, the average number of beds per hospital is 96. These hospitals serve the residents of counties located in RHP 8 as well as those residing in surrounding areas. Uncompensated Care charges totaled $445,414,516 in RHP 8, with nearly half that amount coming from Scott and White Memorial Hospital alone. Uncompensated Care compared to gross patient revenue as a percentage ranged from 1.2% at Reliant Rehabilitation Hospital to 17.3% at King's Daughters Hospital. Since the data collection, King's Daughters Hospital is now McLane's Children's Hospital. Table 3-5 provides a summary of the hospitals in RHP 8, as well as their annual charges, uncompensated care, and bad debt.

Potentially Preventable Hospitalizations

Potentially preventable hospitalizations are a burden on the healthcare system, especially in areas of limited resources. Chronic diseases such as Chronic Obstructive Pulmonary Disease (COPD) and Diabetes are found in this table and account for a large percentage of the total number of potentially preventable hospitalizations in each county. Preventable hospitalizations can be avoided by helping residents access appropriate quality care and services that will result in fewer trips to the Emergency Department. By developing DSRIP projects that aim to reduce Emergency Department visits, hospitals may be able to bring down their overall costs and use their staff and resources more efficiently.

Total cost of potentially preventable hospitalizations in RHP 8 counties was $738,375,609[13] for 2005-2010. The anchor compiled only hospitalization data from 2006-2010 in order to comply with HHSC requests for data no earlier than 5 years before the waiver. However, the cost-related data was unable to be separated by year so the amounts reflect costs during 2005-2010.

[12] 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals & Hospital Tracking Database - Texas http://www.dshs.state.tx.us/chs/hosp/hosp5/

Table 3-5. RHP 8 HOSPITAL DATA (SIZES & COSTS), 2010									
	City (County)	Ownership Type	Staffed Beds	Bad Debt Charges ($)	Charity Charges ($)	Total UC Care ($)	Net Patient Revenue ($)	Total Gross Pt. Revenue ($)	UC Care % of Gross Pt. Revenue
King's Daughters Hospital Scott & White	Temple (Bell)	NPR	29	$4,299,026	$4,640,587	$8,939,613	$21,634,642	$51,570,081	17.3%
Metroplex Hospital	Killeen (Bell)	NPR	154	$5,693,268	$36,000,363	$41,693,631	$110,687,711	$402,293,581	10.4%
Scott and White Continuing Care Hospital	Temple (Bell)	NPR	50	$242,145	$5,290,862	$5,533,007	$18,724,436	$53,044,848	10.4%
Scott and White Memorial Hospital	Temple (Bell)	NPR	591	$37,437,410	$162,794,591	$200,232,001	$743,713,961	$2,122,637,777	9.4%
Seton Highland Lakes	Burnet (Burnet)	NPR	25	$15,324,340	$4,404,059	$19,728,399	$51,053,380	$118,214,137	16.7%
Rollins Brook Community Hospital	Lampasas (Lampasas)	NPR	25	$1,467,457	$3,989,292	$5,456,749	$15,500,433	$40,753,108	13.4%
Llano Memorial Healthcare System	Llano (Llano)	FPR	26	$2,856,686	$204,256	$3,060,942	$27,299,928	$49,967,304	6.1%
Central Texas Hospital	Cameron (Milam)	FPR	34	$345,620	$235,841	$581,461	$6,311,420	$10,503,937	5.5%
Little River Healthcare	Rockdale (Milam)	FPR	21	$6,617,682	$1,080,000	$7,697,682	$26,522,084	$58,367,978	13.2%
Cedar Park Regional Medical Center	Cedar Park (Williamson)	FPR	77	$17,985,249	$3,703,062	$21,688,311	$71,569,689	$205,213,011	10.6%
Reliant Rehabilitation Hospital Central Texas	Round Rock (Williamson)	FPR	50	$134,301	$316,000	$450,301	$21,581,916	$37,156,602	1.2%
St. David's Round Rock Medical Center	Round Rock (Williamson)	NPR	131	$13,208,062	$44,498,116	$57,706,178	$140,217,918	$520,753,565	11.1%
Scott & White Hospital - Taylor	Taylor (Williamson)	NPR	23	$3,214,724	$295,503	$3,510,227	$15,652,991	$30,388,420	11.6%
Scott and White Hospital - Round Rock	Round Rock (Williamson)	NPR	76	$9,154,301	$7,335,043	$16,489,344	$113,538,476	$315,913,909	5.2%
Seton Medical Center Williamson	Round Rock (Williamson)	NPR	123	$17,763,880	$34,882,790	$52,646,670	$98,838,013	$388,967,331	13.5%

*St. David's Georgetown shares a provider number with St. David's Healthcare in Travis County which is in RHP 7 and is not reflected in this table.

Table 3-6 summarizes potentially preventable hospitalizations in RHP 8. For additional information on the healthcare infrastructure and environment in RHP 8, please see Addendum 1C.

Table 3-6. RHP 8 POTENTIALLY PREVENTABLE HOSPITALIZATIONS, 2006-2010[13]

	Bell	Blanco	Burnet	Lampasas	Llano	Milam	Mills	San Saba	Williamson
Angina	2,692	115	596	604	366	400	107	101	2,928
Asthma	441	0	125	370	73	129	0	24	474
Bacterial Pneumonia	1,341	60	464	271	204	423	49	38	1,901
Congestive Heart Failure	200	0	0	52	0	0	0	0	173
COPD	3,087	96	483	442	201	469	64	54	2,563
Dehydration	379	0	84	54	31	56	0	0	488
Diabetes Short-term Complications	845	0	126	119	49	113	0	0	785
Diabetes Long-term Complications	1,436	51	367	291	161	261	50	50	1,486
Hypertension	574	0	0	45	0	41	0	0	423
Urinary Tract Infection	902	0	172	122	53	109	0	0	857
TOTAL Hospitalizations	**11,897**	**365**	**2,412**	**2,370**	**1,133**	**1,996**	**264**	**258**	**12,078**
TOTAL Hospital Charges 2005-2010	**$241,806,737**	**$7,317,929**	**$48,489,685**	**$43,616,768**	**$20,010,951**	**$36,969,256**	**$6,676,657**	**$6,598,106**	**$326,889,520**

*Note: Annual hospitalizations less than 5 and hospitalizations less than 30 for 2005-2010 are reported as 0.

[13] DSHS Preventable Hospitalizations 2005-2010 www.dshs.state.tx.us/ph

Services & Systems

Seton Healthcare Family, St. David's Healthcare, Scott & White Healthcare, and Community Health Systems are hospital systems present in RHP 8. Seton has facilities in Burnet and Williamson Counties and Scott & White also has a large presence in RHP 8 with hospitals in Bell, Llano and Williamson Counties and numerous clinics across the region. Between all the hospitals in RHP 8, a full continuum of care is provided including health promotion, primary care, specialty care, chronic disease management, labor and delivery, general and specialty surgery, intensive care, behavioral healthcare services, rehabilitation, emergency care, among many others. The most comprehensive services are available through the hospital systems in Bell and Williamson Counties, while healthcare resources are less abundant in the more rural counties of RHP 8. Broad expansion and increased integration of the services offered in RHP 8 will be essential to maintain the capacity to serve the growing population in this area of Texas.

HPSA Designations

In RHP 8, all counties except Bell and Williamson are designated as a single county HPSA in at least one category, no counties have a partial county Health Professional Shortage Area (HPSA) designation (see Table 3.7)[14].

Table 3-7. RHP 8 HEALTH PROFESSIONAL SHORTAGE AREA DESIGNATIONS

	Bell	Blanco	Burnet	Lampasas	Llano	Milam	Mills	San Saba	Williamson
Primary Care	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Dental	No	No	Yes	No	No	No	No	Yes	Yes
Mental Health	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Current DHHS-funded Initiatives

In RHP 8, the following performing providers have identified Department of Health and Human Services (DHHS) funded initiatives being used (see Table 3.8).

Table 3-8. U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES (DHHS) FUNDED INITIATIVES

Entity	DHHS Funded Initiative	Brief Project Description
Bell County Public Health District	Women, Infants and Children (WIC)	Funding to conduct WIC activities in Bell County
Bluebonnet Trails Community Services	EHR Incentive Payments	Provided to assist in moving Medical Records to electronic format. No waiver projects propose doing this, but all use EHR.

[14] U.S. Department of Health and Human Services - Health Resources and Services Administration http://hpsafind.hrsa.gov/HPSASearch.aspx

Table 3-8. U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES (DHHS) FUNDED INITIATIVES		
Entity	**DHHS Funded Initiative**	**Brief Project Description**
Bluebonnet Trails Community Services	FQHC/ RHC/ School-based health center grants, including capital grants	HRSA Grant to build a Clinic in Seguin that will house an FQHC and Bluebonnet staff and services. This is capital investment and does not overlap services proposed in Seguin.
Bluebonnet Trails Community Services	Community Mental Health services block grant	Routine mental health services on an outpatient basis. We will provide outpatient services in Expansion project for Taylor, Texas clinic but those services are not for the same populations.
Bluebonnet Trails Community Services	Substance Abuse Prevention and Treatment Block Grant	Outreach, Screening, Assessment and Referral (OSAR) services to provide assessment and referral to persons seeking services for Substance Use Disorders. We are planning a Pass 2 project in RHP 8 to provide direct services not screening, assessment and referral services that comprise our OSAR contract.
Central Counties Services	Community Mental Health Services Block Grant	Central Counties Services annually receives $456,532 ($338,520 for adult mental health services and $118,012 for child mental health services) of Mental Health Block Grant funds dollars and is used for general services for both groups. No 1115 Waiver projects supplant how these funds are currently used by our Center.
Center for Life Resources	Community Mental Health services block grant	We received mental health services block grant which we use for general mental health services. 1115 Waiver funds will not be used for these services, nor will block grant funds be used for waiver programs.
Center for Life Resources	Substance Abuse Prevention and Treatment Block Grant	We receive block grants for Co-Occurring Psychiatric and Substance Abuse Disorders Services, Treatment Adult Services and Treatment Youth Services, which we use for general substance abuse services. 1115 Waiver funds will not be used for these services, nor will block grant funds be used for waiver programs.
Hill Country MHDD	Community Mental Health Services Block Grant	Hill Country, through Texas Department of State Health Services (DSHS) performance contract, receives a portion of the funds as Community Mental Health Services Block Grant which is utilized for services for individuals with Major Depression, Bipolar Disorder, and Schizophrenia.
Hill Country MHDD	Substance Abuse Prevention and Treatment Block Grant	Hill Country, through DSHS, receives a portion of funds for Substance Use Disorder Outpatient services in Kerr and Gillespie Counties.
Little River Healthcare	EHR incentive payments	Little River Healthcare is attesting to meaningful use this month; we are attesting to Stage one meaningful use and should be funded by January 2013. The EHR will be used to document services performed by provider, however, waiver 1115 funding will not be used for implementing and maintaining the EHR software.
Scott & White Llano	Accountable Care Organizations (ACOs)	Application submitted but not yet approved.

Table 3-8. U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES (DHHS) FUNDED INITIATIVES		
Entity	**DHHS Funded Initiative**	**Brief Project Description**
Scott & White Llano	Health Care Innovation Awards	[Clinic-based programs] Participating as a member site of High Value Healthcare Collaborative (HVHC) on a) initiatives to improve patient engagement for diabetes and Congestive Heart Failure management and b) improve shared decision making for preference sensitive surgical procedures.
Scott & White Memorial Hospital	Accountable Care Organizations (ACOs)	Application submitted but not yet approved.
Scott & White Memorial Hospital	Health Care Innovation Awards	[Clinic-based programs] Participating as a member site of High Value Healthcare Collaborative (HVHC) on a) initiatives to improve patient engagement for diabetes and Congestive Heart Failure management and b) improve shared decision making for preference sensitive surgical procedures.
Seton Highland Lakes Hospital	Pioneer ACO Model	Indirect affiliation via common parent company
Seton Highland Lakes Hospital	Bundled Payments for Care Improvement	Indirect affiliation via common parent company
Seton Highland Lakes Hospital	Partnership for Patients	Indirect benefit via common parent company
Seton Highland Lakes Hospital	EHR incentive payments	Current participant in hospital incentive program. Indirect affiliation in physician incentive program via common parent company.
St. David's Round Rock Medical Center	EHR Incentive Payments	Facilities have adopted EHRs, have met Meaningful Use Stage 1 requirements, and have been paid for Stage 1, Year 1 of the incentive program.
Williamson County & Cities Health Department	Maternal and child health grants	Subcontract for the provision of Title V Child Health Services that include screening and eligibility determination, direct clinical and/or dental services, laboratory services and appropriate referrals as necessary. Grant amount of $81,147. This grant only covers approximately 125 individuals. Waiver funding will be used to expand services to a larger population.
Williamson County & Cities Health Department	Women, Infants and Children (WIC)	Funding to conduct WIC activities in Williamson County.

Projected Changes during Waiver Period

RHP 8 is expected to continue growing in the coming years. The population of this region as reported in the 2010 Census is 860,803 and is expected to grow to 924,214 by 2020 (Texas Workforce Commission, 2010). This kind of population growth can be positive economically, but can also add to the burden carried by health service providers such as hospitals, clinics, local mental health authorities, and local health departments—especially when the current infrastructure is not sufficient to meet the current need. In August 2012, a preliminary agreement was made for a new acute care clinic to be built in Round Rock. The increase in demand for these and other health care services will likely result in increased healthcare facilities in the region. In addition, the growing retiree/older adult population and soldiers

returning home from foreign wars will each put unique physical and behavioral health demands on the healthcare system in RHP 8 (especially Bell County) over the course of the waiver.

RHP 8 will also be affected by political changes during the waiver period. Elected and appointed officials may change at the local, state, and national levels. The outcome of the 2012 presidential election may determine the path of the *Patient Protection and Affordable Care Act (ACA)*, which will create a pool of newly insured Americans eligible for healthcare services in 2014. To date, the State of Texas has resisted expanding Medicaid as well as establishing the state health insurance exchanges specified in the ACA. The presidential election and the upcoming Texas legislative session will provide the direction we can anticipate for the region. The outcomes will influence insurance coverage and access to care for residents of RHP 8.

The ACA and other economic drivers have caused many of the smaller, rural hospitals in Texas to be bought or merged with larger hospitals. Frequently, this has been the expansion of hospital systems into less metropolitan areas. This expansion creates stability for basic health care in those areas; however, specialty care is still limited. In addition, the most remote and sparse areas are still not adequately covered. Given that many of residents of these more rural counties are over the age of 65 (see "Demographics"), routine care for chronic conditions is needed. This population also has a need for timely and accessible specialty care.

Last but not least, the RHP 8 could be affected by a new medical school that is proposed to be built in RHP 7. The timing and scale of the project is at this point unclear; however, a new medical facility would certainly attract additional research and medical professionals. Depending on whether these professionals are drawn more from other institutions in the nation or move within the state will determine the significance of the change. For additional information, please refer to Addendum 1D.

Key Health Challenges

Much like the United States and the State of Texas, there are health challenges present in RHP 8 that can only be addressed successfully through broad system transformation and collaboration among healthcare providers and organizations. The challenges outlined for this region are closely related with the proposed DSRIP projects as well as the interests of RHP 8 hospitals, local mental health authorities, local health departments, and other stakeholders.

Poor access to primary care

As seen earlier in this section, there are fewer providers located in the more rural counties of RHP 8, particularly in Blanco, Mills and San Saba Counties. Except for nurses, these three counties have seven or fewer of all other healthcare professionals represented in Table 3-4. Expanding primary and specialty care services is an essential component of transforming and integrating the healthcare system in RHP 8.

Transportation is a common barrier to accessing care in RHP 8 that spans across all key health challenges. There is difficulty in supporting services in areas with low population density. However, RHP 8 is growing tremendously in population and needs such that healthcare

infrastructure and capacity will not be able to keep up without adequate programs and projects to expand in these areas. In many cases, successful outcomes are directly related to the amount of time required to access health care. Long distances between health care providers, much less specialty care, can inhibit positive outcomes.

In many cases, providers are just not available in some areas. In other cases, when they are available, they are not accessible due to clinic hours, scheduling processes, or full panels. In addition to the health provider shortage in several RHP 8 counties, access to care is also influenced by health coverage; as has been illustrated in this section, a significant proportion of RHP 8 residents are uninsured (see Table 3-3). A small number of these individuals in each county qualify for the county indigent healthcare program. Medically indigent is defined as county residents that are at or below 21% of the federal poverty limit (FPL). These residents use disproportionate amounts of resources from their local health care and social services providers and often lack access to care coordination and a medical home. In RHP 8, there is a need for additional support services such as patient education and transportation services to assist these residents in navigating the healthcare system and seeking care before there is an emergency. These types of services for indigent populations will allow for improved overall efficiency of healthcare services delivered in RHP 8.

Other service needs in RHP 8 within the primary care spectrum are preventive services, including routine preventive screenings and treatment related to women's health and reproductive health. Bell County is repeatedly among the highest Chlamydia and Gonorrhea rates in the state with each of these disease rates being approximately three times the rate in Texas in 2011[15].

- Gonorrhea – 362.4/100,000 (Texas = 117.8/100,000)
- Chlamydia – 1,325.7/100,000 (Texas = 473.0/100,000)

Bell County also reports over 586 clients were seen in STD clinics in 2011 and 618 in 2010. According to the CDC, the reported number of cases is often significantly lower than the actual number of cases because many infected people are often unaware of or do not seek treatment for their infections. In many clinical settings, routine testing is not practiced. Undetected and untreated sexually transmitted infections can result in health issues such as poor pregnancy outcomes, ectopic pregnancy, neonatal infections, and sterility.

Poor access to behavioral/mental health services

Although RHP 8 is served by four local mental health authorities, the behavioral health needs of the region exceed the capacity of these organizations to provide adequate care to many who may need services. This is not uncommon as mental and behavioral resources and services are often overburdened and lack the resources necessary to meet the needs. Persons experiencing symptoms of a mental health illness often are transported to Emergency Departments and then to psychiatric facilities or jail. Crisis stabilization and respite services would provide an opportunity for patients to received needed services in more appropriate settings, and allow law enforcement officers and emergency department personnel to focus on regular duties. Adults who have not been able to avoid psychiatric hospitalization or incarceration often need

[15] Texas Department of State Health Services – Texas STD Surveillance Report (2011) http://www.dshs.state.tx.us/hivstd/reports/

skills training on managing stress, medications, and daily life successfully. This may also include a transportation component to enable patients to see their healthcare providers or education on how to utilize the public transportation systems available in the area. Because transportation is often a huge issue in rural counties, telepsychiatry programs could be a useful resource in RHP 8 to overcome this barrier. In some cases, care coordination and integration of support services is essential in assisting individuals in managing their chronic or persistent mental illnesses.

Lack of coordinated care, especially for those with multiple needs

Chronic diseases are an acknowledged health challenge in RHP 8, much like the rest of the state and country. Many counties in the region had rates of chronic disease deaths that were similar or higher when compared to the rates for the State as a whole. As seen in Table 3-6, chronic diseases account for many preventable hospitalizations that use a considerable amount of time and resources that should be spent on other hospital functions. The effects of chronic diseases can be controlled, reduced, or eliminated by programs that encourage people to make healthier lifestyle choices and offer appropriate chronic disease management resources.

As these issues of poor access to services and uncoordinated care compound each other, the end result for RHP 8 is growing health disparities, particularly among those who are lower income, live in more rural areas of the region, have mental health issues or intellectual disabilities, or have multiple needs. This drives up health care costs by increasing inappropriate use of the emergency department and potentially preventable hospital admissions.

In 2010, there were 318,220 visits to Emergency Departments across RHP 8.[12] Non-trauma emergency room visits are one of the most costly ways to access the healthcare system and are often avoidable when residents have access to education about healthy living, adequate primary care, and prevention resources. Individuals with intellectual and developmental disabilities (IDD) often disproportionately use the emergency room to access care and may be in need of other wrap-around behavioral health and crisis intervention services. Appropriate identification of these individuals and tailoring services according to their needs will help to eliminate some of the burden on Emergency Departments.

In addition to inappropriate ED use, many conditions that could be managed through adequate primary care go untreated, resulting in avoidable hospitalization, costing RHP 8 upwards of $738,375,609 in the five-year period between 2005 and 2010 (See Table 3-6). A strengthened health care delivery system with improved access and coordination of a broad range of services would truly be transformative for the health outcomes and quality of life for residents in RHP 8.

Summary of Key Community Needs

Based on the broad themes of need presented in the Community Needs Assessment, we have organized our Community Needs table into themes with specific needs identified within each theme. Below is a table representing the community needs identified for RHP 8 that will be addressed in the five-year waiver plan. More detailed information for RHP 8 is available in Addendum 1E with links to additional data in Addendum 1.

Table 3-9. SUMMARY OF COMMUNITY NEEDS		
Identification Number	**Brief Description of Community Needs Addressed through RHP Plans**	**Data Source for Identified Need**
CN.1 Limited access to primary care		
CN.1.1	Limited access to the primary care within Milam County.	Table 3-4 – RHP 8 Provider Data
CN.1.2	Limited access to primary care for Williamson County residents under 200% FPL.	Table 3-1 – RHP 8 Population Data **Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **ICare 2.0 (2011 Vulnerable Population Report)** http://icc-centex.org/wp-content/uploads/2012/07/Vulnerable-Populations-2011_final.pdf
CN.1.3	Limited access to primary care for rural and uninsured Williamson County residents.	Table 3-3 – RHP 8 Insurance Coverage **Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **Central Texas Sustainability Indicators Project- 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf **ICare 2.0 (2011 Vulnerable Population Report)** http://icc-centex.org/wp-content/uploads/2012/07/Vulnerable-Populations-2011_final.pdf
CN.1.4	Limited access to primary health care for indigent and uninsured populations in Burnet County.	Table 3-3 – RHP 8 Insurance Coverage **Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **Central Texas Sustainability Indicators Project- 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf
CN.1.5	Limited access to emergent care and limited awareness of which levels of care are appropriate for different health needs places undue burden on the Emergency Department and Emergency Medical System in Llano County.	**2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals & Hospital Tracking Database** http://www.hhsc.state.tx.us/1115-docs/10ER-reportx.pdf

Table 3-9. SUMMARY OF COMMUNITY NEEDS		
Identification Number	**Brief Description of Community Needs Addressed through RHP Plans**	**Data Source for Identified Need**
CN.1.6	Limited access to primary care for preventive services with same day or next day appointments and extended hours.	**Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **Central Texas Sustainability Indicators Project- 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf **County Health Rankings (2010)** www.countyhealthrankings.org
CN.1.7	Limited access to preventive interventions for women of child bearing age and individuals with diagnosed chronic disease in Williamson County.	**Texas Department of State Health Services – Health Facts Profiles (2009)** http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles/ **FY 2010 Texas Medicaid Managed Care STAR Quality of Care Report:** http://www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf **County Health Rankings (2010)** www.countyhealthrankings.org **Community Health Profile of Williamson County Precincts (2011)** http://www.wcchd.org/statistics_and_reports/
CN.1.8	Limited access to preventive care (cancer screenings) in Milam County.	**Breast Cancer in Texas: A Closer Look:** http://www.cprit.state.tx.us/images/uploads/report_breastc_a_closer_look.pdf **Cervical Cancer in Texas 2010:** http://www.cprit.state.tx.us/images/uploads/cervical_cancer_in_texas_tcr_2010_low.pdf **Colorectal Cancer in Texas 2010:** http://www.cprit.state.tx.us/images/uploads/colorectal_cancer_in_texas_tcr_2010_low.pdf
CN.1.9	Increase access to testing and treatment sexually transmitted disease (STD) in Bell County.	**Texas Department of State Health Services – Health Facts Profiles (2009)** http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles/

Table 3-9. SUMMARY OF COMMUNITY NEEDS		
Identification Number	**Brief Description of Community Needs Addressed through RHP Plans**	**Data Source for Identified Need**
CN.1.10	Increase STD testing of females aged 14-45 to reduce potential complications of untreated STDs (i.e. Pelvic inflammatory disease).	**Texas Department of State Health Services – Health Facts Profiles (2009)** http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles/ **FY 2010 Texas Medicaid Managed Care STAR Quality of Care Report:** http://www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf **Texas 2011 STD Surveillance Report:** http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=34561&id=4962&terms=Texas+2011+STD+Surveillance+Report **Central Texas Sustainability Indicators Project- 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf
CN.2 Limited access to mental health/behavioral health services		
CN.2.1	Limited access to behavioral health services to rural, poor and under & un-uninsured populations (meds, case management, counseling, diagnoses) in Williamson County.	Table 3-3 – RHP 8 Insurance Coverage **US Department of Health and Human Services: Health Resources Services Administration Shortage Areas** http://datawarehouse.hrsa.gov/hpsadetail.aspx **US Census Bureau: 2009 Small Area Health Insurance Estimates** http://www.census.gov/did/www/sahie/ and http://www.census.gov/did/www/sahie/data/index.html **Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **FY 2010 Texas Medicaid Managed Care STAR Quality of Care Report:** http://www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf **Central Texas Sustainability Indicators Project- 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf

Table 3-9. SUMMARY OF COMMUNITY NEEDS		
Identification Number	**Brief Description of Community Needs Addressed through RHP Plans**	**Data Source for Identified Need**
CN.2.2	Limited access for serious mentally ill adults to crisis services in Williamson County	**Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **Central Texas Sustainability Indicators Project- 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf
CN.2.3	Limited access for youth with severe emotional disturbances to behavioral health community crisis services in Williamson and Burnet Counties.	**Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **FY 2010 Texas Medicaid Managed Care STAR Quality of Care Report:** http://www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf **Central Texas Sustainability Indicators Project- 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf
CN.2.4	Limited access for serious mentally ill adults to crisis services in Burnet County.	**Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **Central Texas Sustainability Indicators Project- 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf
CN.2.5	Limited access to behavioral health services, primarily substance abuse services for adults and youth who are poor and under & un-uninsured populations in need of outpatient and intensive outpatient care in Burnet and Williamson Counties.	**Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf
CN.2.6	Limited access to behavioral health services for rural populations in Mills and San Saba counties.	**HRSA Health Professional Shortage Areas** http://hpsafind.hrsa.gov/HPSASearch.aspx
CN.2.7	Lack of school-based behavioral health services in the Temple ISD.	See Addendum 1F
CN.2.8	Lack of access for adult behavioral health care in Bell, Lampasas and Milam Counties.	See Addendum 1G **HRSA Health Professional Shortage Areas** http://hpsafind.hrsa.gov/HPSASearch.aspx

Table 3-9. SUMMARY OF COMMUNITY NEEDS		
Identification Number	**Brief Description of Community Needs Addressed through RHP Plans**	**Data Source for Identified Need**
CN.2.9	Lack of social support services for high intellectual functioning Autism & Asperger's population (18 years & older) in Bell County.	See Addendum 1K **County Health Rankings (2010)** www.countyhealthrankings.org **State of Texas Dept. of Aging and Disability Services** Study on the Costs and Benefits of Initiating a Pilot Project to Provide Services to Adults with Autism Spectrum Disorders and Related Disabilities (2010) p.63 http://www.dads.state.tx.us/autism/publications/HB1574Report.pdf
CN.2.10	Limited access for serious mentally ill adults to crisis services in Bell, Lampasas and Milam Counties.	See Addendum 1G
CN.2.11	Improve behavioral health service access and capacity in Bell, Lampasas, and Milam Counties	See Addendum 1G
CN.2.12	Limited access in Williamson County to behavioral health services for adults with serious mental illnesses who are transitioning from inpatient care and crises into community living.	**Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **Central Texas Sustainability Indicators Project- 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf
CN.2.13	Limited access to adult behavioral health services in Williamson County.	**HRSA Health Professional Shortage Areas** http://hpsafind.hrsa.gov/HPSASearch.aspx

Table 3-9. SUMMARY OF COMMUNITY NEEDS		
Identification Number	**Brief Description of Community Needs Addressed through RHP Plans**	**Data Source for Identified Need**
CN.2.14	Limited access to behavioral health services and disparities in access to care and health outcomes for adults and youth who are intellectually and developmentally disabled in Williamson County.	See Addendum 1K **Williamson Burnet County Opportunities 2011 Community Needs Assessment:** http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf **FY 2010 Texas Medicaid Managed Care STAR Quality of Care Report:** http://www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf **Central Texas Sustainability Indicators Project - 2009 Data Report:** http://www.centex-indicators.org/annual_rept/ar2009.pdf **ICare 2.0 (2011 Vulnerable Population Report)** http://icc-centex.org/wp-content/uploads/2012/07/Vulnerable-Populations-2011_final.pdf **State of Texas Dept. of Aging and Disability Services** Study on the Costs and Benefits of Initiating a Pilot Project to Provide Services to Adults with Autism Spectrum Disorders and Related Disabilities (2010) p.63 http://www.dads.state.tx.us/autism/publications/HB1574Report.pdf
CN.2.15	Limited access to behavioral health services for adults and youth in Williamson and Burnet Counties who are involved in the adult and youth justice system.	See Addendum 1J **Capital Area Council on Governments - Statistical Overview of Criminal Justice Relative Activities** http://www.capcog.org/documents/criminal_justice/FY_2011_Statistical_Overview_Williamson.pdf **Texas Criminal Justice Coalition - Williamson County Juvenile Justice Data Sheet** http://tcjc.redglue.com/sites/default/files/youth_county_data_sheets/Williamson%20County%20Data%20Sheet%20(Sep%202012).pdf
CN.2.16	Lack of behavioral health professionals in Llano and Blanco counties.	Table 3-4 – RHP 8 Provider Data **HRSA Health Professional Shortage Areas** http://hpsafind.hrsa.gov/HPSASearch.aspx
CN.2.17	Lack of community support services for persons with severe and persistent mental health diagnoses in Bell County.	See Addenda 1H & 1I **Bell County Health Assessment (2010) – p.142** http://www.co.bell.tx.us/2010%20Needs%20Assessment.pdf

Table 3-9. SUMMARY OF COMMUNITY NEEDS		
Identification Number	**Brief Description of Community Needs Addressed through RHP Plans**	**Data Source for Identified Need**
CN.2.18	Limited access to behavioral health crisis services and delayed responses to early signs of behavioral health issues in Llano County.	**HRSA Health Professional Shortage Areas** http://hpsafind.hrsa.gov/HPSASearch.aspx
CN.2.19	Limited access to behavioral health services for individuals who have suffered trauma in Blanco and Llano counties.	**HRSA Health Professional Shortage Areas** http://hpsafind.hrsa.gov/HPSASearch.aspx
CN.2.20	Limited access to behavioral health services for individuals with both psychiatric issues and substance use disorders in Blanco and Llano counties.	**HRSA Health Professional Shortage Areas** http://hpsafind.hrsa.gov/HPSASearch.aspx
CN.2.21	Limited access to Behavioral Health services for Veterans in Blanco and Llano counties.	**HRSA Health Professional Shortage Areas** http://hpsafind.hrsa.gov/HPSASearch.aspx
CN.2.22	Limited access to whole health peer behavioral health services for individuals in Llano and Blanco counties.	**HRSA Health Professional Shortage Areas** http://hpsafind.hrsa.gov/HPSASearch.aspx
CN.3 Lack of coordinated care for those with multiple needs		
CN.3.1	Limited coordinated care exists in Bell County for disparity groups having co-occurring behavior health needs and chronic physical conditions resulting from prolonged use of psychotropic medications.	See Addendum 1G **Bell County Health Assessment (2010) – p.118-119** http://www.co.bell.tx.us/2010%20Needs%20Assessment.pdf
CN.3.2	Limited coordinated care exists in Bell County for disparity groups having co-occurring behavioral health needs and sexually transmitted diseases.	**Texas Department of State Health Services – Health Facts Profiles (2009**) http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles/
CN.3.3	Inconsistency in data collection which identifies health disparities and populations at risk.	**Williamson County Epidemiology Report (2011)** http://www.wcchd.org/statistics_and_reports/docs/2011_Epidemiology_Report.pdf
CN.3.4	Fragmented system in navigating access to appropriate level of care for uninsured Williamson County residents.	**Community Health Profile of Williamson County Precincts (2011)** http://www.wcchd.org/statistics_and_reports/
CN.3.5	Discontinuity of care and limited awareness of available resources and services among indigent, uninsured and Medicaid populations in Bell County leads to potentially avoidable ED and hospital utilization.	Table 3-4 – RHP 8 Provider Data **Bell County Health Assessment (2010) – p.77-79** http://www.co.bell.tx.us/2010%20Needs%20Assessment.pdf

Section IV. Stakeholder Engagement

RHP Participants Engagement

RHP 8 has engendered broad stakeholder engagement from the beginning of the process through the rapid dissemination of information, use of a variety of media for communication, and through public meetings. As new information became available from HHSC, the anchor team focused on interpreting those materials and putting accessible, meaningful information in the hands of stakeholders in our region as quickly as possible—typically the same day or the following day. To reach as many people as possible, RHP 8 established a website in May 2012, http://www.tamhsc.edu/1115-waiver/rhp8.html, that is updated frequently, sometimes daily, with new information, as well as a master email list consisting of anyone who has indicated an interest in receiving RHP updates (whether participating or not). The first list consisted of contact information compiled for every eligible IGT entity and performing provider in the region, and additional representatives and stakeholders were added from there. Finally, throughout the process, RHP 8 has met in public meetings (face-to-face, conference calls and webinars), that were posted on the website in advance and information disseminated through the listserv; when appropriate, these meetings were also posted by public entities participating (i.e., counties) in the waiver.

RHP 8 Organization

During the formation of RHPs, RHP 8 was originally formed as a very large region, drawn at first as up to 30 counties covering much of rural Central Texas. Early conversations split the region into 8 East and 8 West, dividing the 16 western counties from those surrounding the Brazos Valley, which ultimately became RHP 17. The remaining 16 counties that then comprised RHP 8 struggled to find consensus regarding their anchor institution. Several RHP 8 meetings were held with all 16 counties early on, and then the meetings were put on hold until the region and HHSC resolved the anchor issue in early June. Ultimately, RHP 8 and RHP 16 were formed, splitting the 16-county region into 9 and 7 counties respectively.

As stated in the Roles and Responsibilities Document released by HHSC, it is the role of the Anchor to serve as a point of contact for the RHP with HHSC, facilitate RHP meetings and communicate the purpose and function of the RHP to regional stakeholders. This includes providing opportunities for public engagement as part of development of RHP plan and prior to submission of final plan. In addition to coordinating activities and developing partnerships across the region, the anchor also is tasked with providing technical assistance to participating entities.

RHP 8 Approach to Stakeholder Engagement

Clear communication throughout the RHP is essential to ensuring broad participation and developing partnerships for regional system transformation. RHP 8 used a multi-pronged approach to communication knowing that our region was rather large and the Anchor was not centrally located. This approach included formal meetings, informal meetings, webinars, conference calls, listserv, individual emails and a routinely updated website. Formal meetings took place where potential IGT entities and providers met at the Anchor's location. In many other instances, the Anchor would travel to another county to meet with their interested

parties. Table 4-1 at the end of this section provides a summary of formal meetings coordinated in RHP 8 to communicate changes to waiver requirements, answer questions, and provide helpful materials to eligible and participating entities. TAMHSC created an email distribution list early in the RHP development process in order to communicate broadly with the region. All meeting attendees were added to the distribution list as well as any regional stakeholder who requested to be included. TAMHSC used the email distribution list, webinars, and the website, to ensure all who wanted to be informed of waiver changes and compromises would be. Communication with the RHP is ongoing via email, phone, and the RHP 8 website.

As projects were formed and HHSC guidelines became formalized, individualized communication with each performing provider or IGT entity proved more efficient than large meetings with the entire RHP. Additional meeting information is located in Addendum 2A.

Engagement During the Planning Processes

Once the counties included in RHP 8 were finalized, a dialogue about regional priorities could begin and performing providers could begin to craft plans that could meet those priorities. In June 2012, TAMHSC emailed a short form to the RHP to gather this information and to start talking with performing providers about their project ideas and securing the appropriate IGT. Upon request, TAMHSC met individually with performing providers in the region to explain the waiver requirements, talk about DSRIP projects, and discuss the IGT process. On July 9th, the first list of potential projects was released to the region. This lead to a meeting on July 19th, where performing providers with proposed projects that would cross county lines could talk to those IGTing entities at one time. These projects were posted to the Anchor website.

As the waiver continued to develop and project areas changed, TAMHSC emailed interested providers a revised template in late July 2012 to obtain more detail about challenges, expected outcomes, valuation and overall goals of potential DSRIP projects in the region. These documents were promptly posted to TAMHSC's waiver website so the region would be able to see other proposed projects that could be an opportunity for collaboration (see Addendum 2B for an example). This process encouraged the performing providers and IGT entities to communicate with each other and continue revising DSRIP projects to be as robust as possible, while continuing to refine their projects remaining within HHSC guidelines put forth in the Program Funding and Mechanics Protocol and the RHP Planning Protocol. In August, some of the RHP entities requested webinars to keep apprised of the numerous changes that were occurring. TAMHSC held several webinars, posting the presentations to the web. The last formal meeting occurred on September 20, 2012. At this point, the RHP 8 anchor team provided technical assistance to individual performing providers. We also keep the rest of the region appraised of the RHP status and timelines through emails and the RHP 8 website.

On December 12th, the RHP scheduled a meeting to sign and certify the full RHP 8 Plan, with the intent to submit the plan to HHSC on December 14th.

RHP Engagement Beyond Plan Submission

Once the full RHP 8 plan is submitted, RHP 8 will meet in January with the region to discuss and plan for DY3 and discuss any general feedback we have received from HHSC. RHP 8 has

established a plan for the entire RHP to meet at least semi-annually to share information, review progress, and address any issues that may arise. In addition, the anchor team will continue to update the website regularly, and will use the email listserv to disseminate information between meetings. The RHP anticipates DY3 will provide an opportunity to include new activities, since certain IGT entities and providers elected to wait until DY3 to participate for a variety of reasons. The anchor will ensure these entities will have an opportunity to participate in DY3 planning. At the direction of the region, the anchor will organize additional planning meetings specific to the DY3 plan in addition to the regular communication of the RHP. Less formal means of technical assistance is available daily to waiver stakeholders and participants in RHP 8 via phone or email.

Public Engagement

Prior to the creation of the official RHP 8, Williamson County spearheaded the effort to promote education of waiver and show both IGT entities and providers the value of the waiver. After RHP 8 was officially formed and the anchor named, TAMHSC began providing the RHP with an overview of the waiver, a review of community health status and needs data, and a forum to determine community priorities related to the selection of DSRIP projects. Most of these meetings were formally posted at the respective county courthouse, and the meeting schedule was forwarded via the RHP listserv to all RHP participants. These meetings were attended by local elected officials, health care providers, community organizations, supportive health and social services organizations, and other key community leaders. In these meetings, the anchor team reviewed assessment data from recent community health assessments as well as other secondary data that was gathered from the U.S. Census Bureau, the Department of State Health Services, the Robert Wood Johnson Foundation County Health Rankings, and other sources, as posted on the RHP 8 website, http://www.tamhsc.edu/1115-waiver/rhp8.html. Then, the anchor team had the region determine priority project areas. On a fairly expedited schedule, the priority ranking of needs were released to the region and providers were encouraged to create summary projects they could share with interested IGT entities. All meeting materials were posted to the RHP 8 website. All meeting attendees were notified of the RHP listserv and the opportunity to be added the listserv in order to receive meeting notices as well as updates on RHP 8 and state waiver activities. Additionally, the RHP website link was posted on all planning agendas and announced during each community meeting as a timely informational resource for community members.

All subsequent meetings of the RHP were posted prior to each meeting with related meeting materials posted to the website immediately following each meeting. Each RHP meeting was open to the public to attend, being held in Round Rock or various County facilities. In addition, several webinars were conducted to allow the region to participate without traveling and attendance records can be found in Addendum 2C. All meeting materials, contact information, critical HHSC documents, summaries of HHSC documents, timelines, pieces of the RHP 8 Plan, and ultimately the full RHP 8 Plan have been published in a timely manner to the RHP 8 website (http://www.tamhsc.edu/1115-waiver/rhp8.html). This website link is included in our email signatures as well as other materials distributed to the region during meetings. TAMHSC emails general information to anyone in the RHP that has indicated a desire to receive these communications. Specific information is targeted to the audience it most suits.

When requested, representatives from TAMHSC attended public Commissioners' Court and Hospital District Board Meetings to answer questions, provide feedback, give updates, and provide information regarding how the waiver works and the positive effects it could have in their county. These sessions were posted on Commissioners' Court agendas and on the web and thus, open to the public. Beginning August 7, 2012 in Williamson County, a standing weekly agenda item was publicly posted to allow for any discussion necessary about the 1115 Waiver. In addition, TAMHSC contacted all the County Judges in RHP 8 to inform them of the waiver and to offer additional information, should it be desired.

During the course of the waiver process, a short article was printed in the 2012-2013 Community Health Impact Report Healthcare Directory on page 7 which provided a brief summary on waiver activities at the time and informed the community of Williamson County's intent to participate in the program (Addendum 2D).

Public Comment on RHP Plan

Once Pass 1 of the RHP Plan was drafted, it was posted for public comment between November 8 and November 14, 2012. To ensure broad notification of the availability of the plan for public comment, several counties posted a notice through their existing mechanisms (i.e., website and paper posting at the courthouse). Other entities were given a copy of the posting in case they also had public notice mechanisms they regularly used, and the anchor issued a media advisory in case any local media outlets wanted to pick up the story, as several had provided coverage during the planning process. The notices of availability of the plan for public comment were issued as press releases (Addendum 2E) and also posted on TAMHSC's public website for RHP 8 as well as several county websites (Addendum 2F) indicated the URL where the plan could be found, as well as how to submit public comments. A public comment form was also posted on the website and could be submitted electronically or by mail. Because of the size of the document, it was primarily available electronically on the RHP 8 website for review but could be requested in hard copy if needed. Only one public comment form was submitted to RHP 8 for the Pass 1 version of the RHP Plan. The commenter requested the addition of several sentences to Section III, the Community Needs Assessment. Although HHSC had previously said this section would be final once submitted on October 31, 2012, the changes elaborated on the uninsured population and the ratio of providers to residents in Williamson County. HHSC approved the change (see Addendum 2G for both the public comment and the approval). This new text was included in the November 16, 2012 submission of Pass 1. This form was used for both public comment periods.

Since RHP 8 elected to submit Pass 1 and Pass 2 separately, the final plan including Pass 2 projects was reposted for public comment from December 3-7, 2012. The final plan followed a public comment process similar to the one described for the November 16, 2012 submission. No public comment forms were received on the final draft of the RHP Plan.

TAMHSC also sought to engage the County Medical Societies in the waiver and RHP 8 and sent informational letters to each society in RHP 8. TAMHSC followed up with a request for support of the waiver by the societies. Copies of these communications and the letter of support are included in Addenda 2H-2J.

Table 4-1. Summary of RHP 8 Regional and Public 1115 Waiver Communication		
Date	**Description of Meeting/Communication with RHP 8**	**Type**
2/16/12	Waiver Webinar	Public
2/23/12	Waiver Webinar	Public
3/12/12	Commissioner to Burnet County Courthouse for Burnet County Commissioners Waiver Working Group meeting	Public
3/20/12	Waco public meeting	Public
4/18/12	Public meeting in Belton	Public
4/20/12	Region 8 conference call	Public
5/23/12	HHSC Webinar	Public
6/05/12	Proposed Process and Timeline for Plan Submission emailed to the region	RHP
6/12/12	Potential Region 8 IGT entities and stakeholders submit requested DSRIP Project Area priority list to TAMHSC	RHP
6/14/12	TAMHSC hosts meeting for Region 8 to discuss process for DSRIP projects	RHP
6/26/12	TAMHSC meets with Williamson County Commissioners Court to provide an update on 1115 Waiver activities	Public
7/02/12	Bell County holds workshop session for update and discussion of the waiver	Public
7/09/12	Preliminary DSRIP proposals shared with region via email and publicly via TAMHSC RHP 8 website	Public
7/12/12	Little River Healthcare Meeting	RHP
7/19/12	Proposal Review Meeting for Proposed Projects Covering Multiple Counties in Region 8 at Williamson County Annex in Round Rock, TX	RHP
7/24/12	TAMHSC meets with Bell County Commissioners Court to provide an update on 1115 Waiver activities	Public
7/26/12	TAMHSC attends a work shop meeting with Williamson County Commissioners Court to answer question on 1115 Waiver activities	Public
8/02/12	TAMHSC attends Rockdale Hospital District Board Meeting	Public
8/03/12	TAMHSC collects second submission of DSRIP project draft proposals with most updated metrics and posted to RHP 8 website	Public
8/06/12	TAMHSC meets with San Saba County Commissioners Court to provide an update on 1115 Waiver activities	Public
8/15/12	TAMHSC led webinar discussion with RHP 8 regarding waiver updates	RHP
8/20/12	RHP 8 Meeting with Williamson County providers for waiver update	RHP
8/22/12	TAMHSC led webinar discussion with RHP 8	RHP
9/20/12	RHP Meeting to discuss waiver updates and changes and revised timeline	RHP
9/20/12-12/11/12	Conference calls with providers and IGT entities to provide technical assistance	RHP
12/12/12	RHP 8 meets to certify the RHP 8 Plan	

Section V. DSRIP Projects

RHP Plan Development

RHP 8 Requirements

RHP 8 is a Tier 4 region, which carries a minimum requirement of four projects from Categories 1 and 2 with at least two from Category 2. The plan includes 17 projects from Category 1 and 20 projects from Category 2; 23 of these projects were selected in Pass 1 and 14 in Pass 2. Table 2-1 shows all the projects that are included in the Section V of the plan. Addendum 4 describes projects that were considered in the earlier stages of plan and were not included in the plan. Projects were not included primarily because they did not have IGT and did not meet the final planning protocol requirements.

Pass 1 / Pass 2

As a smaller region, RHP 8 used a relatively simple process for Pass 1 and Pass 2 project selection. As mentioned in Section III, each IGT entity was provided with the local and regional assessment data and asked to determine its priorities early in the process. These priorities were communicated in public meetings, and were summarized and disseminated to eligible performing providers to inform them what IGT entities would be willing to fund. Based on the then-current list of project areas and options, the anchor created a form, and the performing providers were asked to submit 2-page concept proposals for the IGT entities to review. The anchor compiled the concept proposals and facilitated meetings with the IGT entities and performing providers to discuss their ideas. This allowed providers and IGT entities to begin to negotiate. As the planning protocol evolved, so did the projects.

Once the final planning protocol was approved, most of the performing providers and IGT entities had agreements in place as to what funds were available for which projects; the amount of DSRIP for the region did not approach the regional DSRIP cap. Based on this, RHP 8 proceeded through Pass 1 focused on meeting the Pass 1 requirements and ensuring that eligible Pass 1 providers were able to include projects that would enable them to participate in Pass 2. RHP 8 has only one major safety net hospital and no public hospitals. The process utilized the performing providers' Pass 1 workbooks for information to ensure the following:

1) RHP 8 met the minimum number of projects from Categories 1 and 2;
2) The major safety net hospital's DSRIP projects were included in Pass 1;
3) The private and non-profit hospital providers' DSRIP projects met the 5 percent allocation guideline for broad participation;
4) The local mental health centers were each represented in Pass 1 so that they could participate in Pass 2; and
5) The local health departments were represented in Pass 1 so that they could participate in Pass 2.

In this process, we were able to include everything in Pass 1 except for what the entities with smaller percent allocations had in excess of those allocations—the community mental health centers, the local health departments, and the academic health science center. Since the academic health science center did not have direct care providers in RHP 8 outside of other

participating performing providers, it elected to give away its allocation so that all of the community mental health centers and local health departments could be represented in Pass 1 with meaningful size projects and be able to include all of their projects through Pass 2. Pass 2 then consisted of projects that would not fit under the Pass 1 allocations, as well as those from providers not eligible under Pass 1.

RHP 8 Goals

Based on our community needs assessment (see Section III), RHP 8 has developed the overarching goal to transform the local and regional health care delivery systems to improve access, efficiency, and effectiveness. We aim to achieve this by reaching four primary goals:

1) **Improve access to timely, high quality care for residents, including those with multiple needs;**
   Providers in RHP 8 will achieve this goal by expanding the availability and capacity of primary care in the region, as well as what services are available through primary care providers. In addition to new primary care sites and expanded clinic hours, providers will be enhancing urgent medical advice, establishing community paramedicine, targeting disparities groups with evidence based health promotion, providing disease prevention and screening, managing chronic care, and increasing behavioral health extended through telehealth and primary care providers. Many of these new services aim to improve patient satisfaction, an indicator of quality of care, since patients could be seen sooner and have more choice. Others aim to reduce potentially preventable admissions and readmissions to both hospitals and jails and also reduce inappropriate ED use.

2) **Increase the proportion of residents with a regular source of care;**
   The expansion of primary care capacity in the region will provide opportunities for residents to establish a regular source of care. In addition to availability, enhancing the convenient and urgent medical advice will promote patients' seeking out a medical home. New patient navigation programs will help residents who are currently without a regular source of care to be referred to available and appropriate primary care providers.

3) **Increase coordination of prevention and care for residents, including those with behavioral or mental health needs; and**
   As mentioned, new patient navigation programs will increase the coordination of services for residents, including those with mental health needs. Some of these services will be offered using technology (telehealth, among others), while others are available in a traditional setting through expanded number of clinics, clinic hours or provider time. As part of enhancing the services available, evidence based health promotion and disease prevention will be expanded, particularly for higher risk populations or those groups with documented disparities in targeted health outcomes. Specific to those with behavioral or mental health needs, RHP 8 will develop crisis stabilization services for residents in some of the more rural areas, as well as providing virtual psychiatric consults to participating primary care providers. RHP 8 also will integrate behavioral health services and services for individuals with developmental disabilities.

4) **Reduce inappropriate utilization of services.**
Given the largely rural nature of RHP 8, inappropriate utilization of services is a critical issue as many needed services simply are not available locally. All of the activities described under Goals 1, 2 and 3 above, RHP 8 believes will reduce inappropriate utilization of the Emergency Department and Emergency Medical Services. The expansion of primary care availability and accessibility, care coordination through patient navigation, targeted behavioral health services, providing cancer screening in rural areas, and evidence-based health promotion/disease prevention targeting high risk and disparities populations all serve to get people into the right care at the right time. Specific outcomes of interest include appropriate utilization of the ED, state psychiatric hospitals, and jails and reducing the ambulatory care sensitive admission rate.

Process for Project Evaluation and Selection

The Program Funding and Mechanics Protocol (PFM) established the requirements for project selection, requiring that projects address a specific regional need identified in the community needs assessment (see Section III) that is supported by data. The PFM also identified criteria for RHP and provider participation, including RHP and provider allocations.

In RHP 8, the initial allocations were outlined for the region as a whole, and then Pass 1 allocations were given by the Health and Human Services Commission (HHSC) for each hospital that had previously participated in the Disproportionate Share Hospital or Upper Payment Limit programs. The designated percentages of the regional allocation were also calculated for named categories of providers: academic health science centers, community mental health centers, and public health departments. Given these allocations, RHP 8 went through the steps described above in the "Pass 1 / Pass 2" Section:

1) Prioritization of community need within each community and as a region;
2) Solicitation of project concepts based on identified priorities and the then-current DSRIP menu;
3) Presentation of project concepts by providers to Intergovernmental Transfer (IGT) entities;
4) Revision of project concepts with the new and final DSRIP Planning Protocol;
5) Review of proposed projects by anchor entity to highlight any potential issues related to the fit with the Planning Protocol;
6) Review of the proposed projects by IGT entities to determine fit with local needs and priorities, as well as the scope and potential impact of each project;
7) Selection of projects to support by IGT entities; and
8) Negotiation of project specifics and amount of IGT available to support each project.

Once the IGT entities committed support to the projects they selected, the anchor conducted a cursory review to ensure that the requirements were met, which was subsequently verified through the provider and anchor workbooks. The final RHP 8 plan includes all proposed projects that met HHSC requirements, addressed an appropriate community need, and had secured IGT. No project that met these requirements was excluded from the plan.

Category 4 Exemptions

No performing providers in RHP 8 are exempt from Category 4 reporting.

U.S. Department of Health & Human Services (DHHS) Funding
RHP 8 providers indicated DHHS funding they received in Table 3.8. In addition, each provider addressed DHHS funding in their narratives in Section V of this Plan.

Project Valuation
RHP 8 adopted a general five-step approach to guide project valuation across the RHP, with each provider able to determine the ultimate valuation of each project with its related IGT entity. Once each provider had determined the content of the project, including tasks, timelines, milestones, and metrics, it was asked to consider the following steps:

1) **Determine how much the project, including the Category 1 or 2 portion, the Category 3 portion, and where applicable the Category 4 portion, will cost to implement.**
   It is critical that each provider understands the actual cost to their organization of implementing a project, to ensure feasibility of implementation, long-term sustainability, and that the valuation at least covers these costs. When determining the actual implementation costs, several factors influence variations in costs across seemingly similar projects, including:
   - Size of the organization (existing infrastructure, resources, administrative costs);
   - Complexity of the project and project implementation;
   - Size and scope of the project;
   - Size of the target area (geography) if the project is in multiple locations or including transportation as a supporting service;
   - Size and characteristics of the target population; and
   - Resource needs for implementation and long-term sustainability.

   The initial estimated project costs were suggested to include all implementation costs, including personnel, equipment/supplies, travel, training, expert consultants, subcontracts, and any administrative support costs. This bottom line for the project gives providers a starting point for valuing their project.

2) **Calculate any cost savings or costs avoided, both short- and long-term.**
   Substantial variability arises from this step, as each project focuses on different target outcomes, where the cost-savings or costs avoided may be calculated in a variety of ways. For each project, providers were encouraged to estimate additional value of the project in consideration of the following:
   - Collaboration of resources or services with other providers that reduces the costs of service delivery;
   - Cost-savings for potentially preventable admissions, readmissions, and complications;
   - Costs potentially avoided that had historically been incurred through:
     - Transportation of patients to services;
     - Inappropriate emergency department utilization;
     - Poor prevention or chronic care management that leads to the need for acute care;
     - Disability and long-term care needs resulting from lack of care;
     - Unnecessary criminal justice institutionalization; and
     - State mental health hospital utilization.

As a final step in estimating value, providers were asked to consider other sources of value to patients, to the health care system, and to the community—particularly those sources that are more difficult to put dollar amounts to but can be significantly impacted in the long-term. These include:

- Overall patient and community quality of life;
- Increased stability for patients and their families;
- Reduced missed workdays and/or increased productivity;
- Better overall health outcomes for patients and their families; and
- Other community factors—better quality of life allows for stronger economic development, which contributes to having more resources for health and human services.

3) **Determine how much IGT is available for the project.**
Once the provider had an estimated amount for the entire project, including both cost and value, they were recommended to work with their IGT entities to determine how much IGT would be available for the project by year. This was also influenced by each provider's DSRIP allocation in Pass 1 and Pass 2 that determined maximum amounts for projects they could propose. There is variability among seemingly similar projects based on IGT availability, given IGT entities' available resources and their willingness to commit them to specific projects.

4) **Scale the project appropriately based on the support available.**
With an understanding of the IGT available and how much incentive that may generate for a provider, given that they are able to meet their metrics, providers were encouraged to use their cost and value estimates to determine the feasible and sustainable scale of the project. In many cases, limited IGT forced providers to reduce the scope of their projects and to select specific target areas or target populations, or limit the number of clients they could see each year. Thus, much variability is a result of limited IGT in this RHP.

5) **Once a total value determined for each project, those values divided between Category 1 or 2, Category 3, and Category 4 (if a hospital performing provider).**
The final step in the process was for the provider to take the entire project valuation and divide it appropriately among the project component categories (1 or 2, 3, and if a hospital, 4), at the minimum meeting the required percentages for each category but with discretion left to the provider to determine what was appropriate for their project.

Within this valuation framework, each performing provider has the flexibility to consider factors unique to its project. Thus, there is variability among seemingly similar projects based on aspects of the organizations, project complexity, investment needed to implement and sustain activities, target population, scope of the project, and available IGT.

Category 1 Infrastructure Development - Narratives & Tables

- **Bluebonnet Trails Community Services**
  - 126844305.1.1
  - 126844305.1.2
  - 126844305.1.3
  - 126844305.1.4 (Pass 2)
  - 126844305.1.5 (Pass 2)

- **Center for Life Resources**
  - 133339505.1.1

- **Central Counties Services**
  - 081771001.1.1
  - 081771001.1.2
  - 081771001.1.3
  - 081771001.1.4 (Pass 2)
  - 081771001.1.5 (Pass 2)

- **Little River Healthcare**
  - 183086102.1.1 (Pass 2)
  - 183086102.1.2 (Pass 2)

- **St. David's Round Rock Medical Center**
  - 02095790.1.1

- **Williamson County and Cities Health District**
  - 126936702.1.1
  - 126936702.1.2
  - 126936702.1.3

Category 1 Project Narrative
Bluebonnet Trails Community Services – 126844305.1.1

Project Area, Option and Title: 1.12.2 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas
RHP Project Identification Number: 126844305.1.1

Performing Provider Name: 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 Burnet and Williamson Counties in RHP 8 and six adjacent Counties in three other RHPs. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS provides behavioral health, intellectual and developmental disabilities and early childhood services to over 10,000 poor, under and uninsured individuals in multiple locations throughout these two counties.
- **Intervention:** BTCS proposes to provide outpatient behavioral health services to a low income and rural area in eastern Williamson County; and to provide services to a group of patients that are currently ineligible for services. BTCS will provide services to all behavioral health diagnostic groups and including substance use disorders.
- **Project Status:** This is a new project opening during DY2 in a new location and in an area of Williamson County that does not have a clinic for behavioral health services.
- **Project Need:** This project addresses RHP 8 Community Needs Assessment needs: CN.2.1 - Limited access to behavioral health services to rural, poor and under and uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; and CN.2.13 – Limited access to adult behavioral health services in Williamson County.
- **Target Population:** The target population is all diagnostic categories of behavioral health disorders in this rural area. We anticipate serving 1,000 new patients. Of those served by BTCS in FY 2012, an average of 43% of the adults were Medicaid-eligible; 76% of youth were eligible for CHIP or Medicaid and 73% of BTCS clients are below the federal poverty level. We estimate that approximately 70% of those benefitting from this project will be poor, under or uninsured.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project will seek to serve 1,500 adults and youth in DY4 and 2,000 in DY5 and to do so in or closer to their home communities. We expect his location will reduce barriers to access and improve adherence to appointments and satisfaction with access.
- **Category 3 Outcomes:** IT-6.2: Although this measure is of satisfaction, it is specific within the ECHO^{tm} instrument to measurement of satisfaction related to timely care and appointments, adequacy of information provided at appointments, provider communication and self-assessment of the patient's overall health status and functional status. As noted in the Category 3 Narrative, ECHO^{tm} is a CAHPS registered instrument

that is specifically used with behavioral health interventions and therefore we feel it meets the stand alone requirements stated in this measure. We feel that these are detailed, specific and therefore a very strong improvement target. These domains are related to the goals for this clinic, i.e., improving access to care, improving quality of care and improving overall health and functioning of the patients treated. These domains are also reflective of one of the triple aims, to improve the patient experience of health care. Our goal is to improve patient satisfaction with access, provider communication and overall health status by a percentage TBD based on the baseline established in DYs 2 and 3.

- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. BTCS and community leaders in eastern Williamson County consider this to be a transformative project because there are no behavioral health services in this area and in this community. The residents have lower incomes and higher Medicaid percentages than the western part of the County but currently have no access.

Project Description:

Expansion of Services

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. BTCS proposes to expand outpatient behavioral health services to a low income and rural area in eastern Williamson County; and to expand services to a larger group of patients than are currently eligible for BTCS services. The East Williamson County Clinic (EWCC) will provide a behavioral health team including psychiatrists, Advanced Practice Nurses (APNs), Case Managers (CMs), Substance Abuse Counselors, Behavioral Analysts (to support care for Autistic and other IDD patients), Peer Support Specialists, Registered Nurse and business support staff. The team will be responsible for diagnosis and medication management, counseling, psychosocial rehabilitation, case management and benefits assistance provided to adults and youth seeking treatment. This team will be located in a clinic in Taylor, Texas established and renovated through a grant from the St. David's Foundation.

This behavioral health team has the potential to serve an additional 1,000 people a year and will provide a full range of behavioral health services based on a philosophy of wellness and recovery and supported with a certified Peer Support Specialist on the team to help with personal recovery efforts. The location of the clinic addresses transportation and socio-economic limitations and challenges by establishing a full service behavioral health clinic in the city of Taylor. It addresses eligibility limitations by providing care to all persons, regardless of diagnosis and by adopting the practice of open access for intake and scheduling. For persons requiring higher levels of medical expertise, and to ensure easy access to medical services, the clinic will be linked by telemedicine to our locations with additional physicians.

"Mental disorders are common in the United States, and in a given year approximately one quarter of adults are diagnosable for one or more disorders."[16] Only 36% of those with a disorder are receiving treatment and only 13% of them are receiving minimally adequate treatment (NIMH Statistics; http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml). [17] BTCS contracts with the Department of State Health Services (DSHS) to provide specialty behavioral health services to adults with Serious Mental Illnesses (SMI) and children with Severe Emotional Disturbance (SED), which DSHS identifies as the "priority population". The DSHS contract with BTCS restricts the use of general revenue for ongoing services to individuals within limited diagnostic groups. The contract does not restrict BTCS from using non-general revenue sources of funds (such as those available through this waiver) to serve other individuals. However, these contract restrictions, effectively limit our ability to care for all those in need in our communities. DSRIP allows us to broaden our scope of service beyond the restrictive "priority population"—without violating our ability to perform under the contract with the State of Texas. These individuals who do not qualify for services funded through the DSHS contract are referred out. Unfortunately, those in poverty and those who are uninsured or underinsured cannot access care despite being referred to it, especially since all care is outside their local area. We will expand access to care by establishing this behavioral health clinic in a low income, rural area and opening access to all. The team is committed to providing care to this area and to the broader population of persons with behavioral health needs.

We propose to serve the area around Taylor, Texas and to open the clinic to all behavioral health diagnoses. According to 2010 Census data, eastern Williamson County has a poverty rate of 19.5%, higher than the state average of 16.5%. By contrast western Williamson County, the Round Rock and Georgetown area have poverty rates of only 5.5%. Services have tended to be aligned around the more affluent part of the County. This full service clinic with a responsive team integrated into the community will address this disparity.

Goals and Relationship to Regional Goals:

The goal of the expansion is to add a new clinic location in an underserved area of Williamson County, Taylor, Texas and to offer services to a broader population than the one served under contract with DSHS. With this expansion we expect to improve behavioral health outcomes for persons in this area who now have limited access to behavioral health services. The challenges facing individuals in the more rural area of Williamson County are that there are no behavioral health practitioners in the area. To receive services people must travel into Round Rock or into Austin and Travis County. For those who are poor and uninsured, the dilemma is exacerbated because there is no public transportation and even if transportation can be acquired and paid for, they could be treated only if they are eligible for DSHS services. Substance abuse treatment is limited and frequently unavailable even though the disorder is prevalent among those requesting services. This project allows us to open access to persons outside the narrow scope of eligible youth and adults through a clinic easily accessible to these individuals.

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[16] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005 Jun;62(6):617-27.

[17] Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve month use of mental health services in the United States. Archives of General Psychiatry. 2005 Jun;62(6):629-640.

Project Goals:
(1) Establish a behavioral health clinic in eastern Williamson County; (2) develop a robust behavioral health team on site and supported by telemedicine; (3) provide behavioral health care that is multi-disciplinary, recovery oriented and comprehensive; and (4) provide behavioral health care to all those in need regardless of income, insurance status or diagnosis.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs; and
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

The EWCC will offer a solution focused, multi-faceted approach to care to include wraparound services and transition planning for effective functioning in their home communities and care that is local. We expect the variety of services available, responsiveness of the design, staffing and location to improve behavioral health functioning outcomes and significantly improve satisfaction through timely access, clear communication with providers and culturally competent providers. This project builds on the expertise and resources of BTCS related services for the SMI patients. Patients in the Eastern Williamson County Clinic will also have access to crisis intervention and respite if needed as well as housing and employment supports.

Challenges:
The primary challenge for this project is to establish a location that serves all persons in need of behavioral health services rather than just those in the priority population and for BTCS to be accepted in that role by the community and referring providers. Currently BTCS is known as the provider of care for those with SMI diagnoses and we have not accepted patients with other diagnoses. As a result many people in need routinely access other providers as a first option when seeking behavioral health assessment and treatment. We can be successful with a comprehensive range of services for youth and adults with a behavioral health team that is accessible, responsive and integrated into the community.

5-Year Expected Outcome for Provider and Patients:
BTCS expects to see a greater number of people served in Williamson County with a broader range diagnoses and conditions. We expect to see a growing level of satisfaction related to accessing care quickly, improved communication with clinicians, information provided to patients on treatment and self-help resources, increased cultural competency and perceived improvement in functioning. The expected outcomes are a result of and related to project goals stated above, including the ability to serve an additional 1,000 persons more per year.

Starting Point/Baseline:
Currently no clinic exists in eastern Williamson County and services are not provided outside the DSHS guidelines for priority population at any BTCS location. Therefore, the baseline for the number of patients at that location and the number of patients not in the priority population is 0 in DY2. From December 2011 through August 2012, we served approximately 175 persons from eastern Williamson County at the BTCS location in Round Rock. All of those

served had diagnoses within the priority population guidelines and all others were precluded from service and referred elsewhere.

Rationale:

Community Need Addressed:

- Community Need Area: CN.2 - Limited access to primary care
- Specific Community Need:
  - CN.2.1 - Limited access to behavioral health services to rural, poor and under & un-uninsured populations (meds, case management, counseling, diagnoses) in Williamson County.
  - CN.2.13 – Limited access to adult behavioral health services in Williamson County.

A project to expand the capacity to provide behavioral health services to adults with SMI and children/youth with SED in this rural underserved area as well as to individuals with diagnoses outside the priority population of DSHS is vital to improved behavioral health outcomes in Williamson County. A full service behavioral health clinic integrated into this rural community will provide a wide range of care and serve as a hub for community involvement undertaken by an accessible and responsive team of professionals. The team who will provide physician and physician extender diagnosis, assessment and treatment; medication services; brief, solution focused counseling services; outpatient substance abuse services; and community education and provider consultation.

As stated above, BTCS does not currently provide behavioral health care to all persons, only to those in the priority population. We also do not provide substance abuse treatment as part of the behavioral health service array. Both of these are identified needs in this area. One critical disparity identified for RHP 8 is scarcity of behavioral health services throughout the region and especially in rural areas. As stated in the RHP Planning Protocol document, 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. Additionally, 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. 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 residents are unable to access either routine services or needed care in a timely manner because they lack transportation, are in poverty, lack insurance coverage or because they are unable to schedule an appointment due to work scheduling conflicts.

BTCS assessed the patient data in its Anasazi EHR and found that 175 people accessed services by traveling to the BTCS clinic in Round Rock. This is far lower than prevalence statistics indicate individuals in the area have a need for services. Community leaders in Taylor identified this as a need and assisted BTCS to apply for a grant to plan and initiate such a clinic. This clinic increases capacity and access to these specialty services. We expect to decrease the number of cancellations and no shows as compared to our current operations in other clinics. In DY5, we expect to demonstrate improved satisfaction with access as a result of this local, integrated

service. With the assistance of Peer Support Specialists, we expect to improve functional status by assisting individuals use transitional housing and employment supports which are currently only available in the larger urban areas or metropolitan area of Round Rock and Georgetown. Certified Peer Support Specialists will provide the training and supports in coordination with Qualified Mental Health Professionals. We expect to create an expanded model of care that goes beyond the DSHS priority population and meets the comprehensive needs of individuals in their own communities.

Core Project Components:

Although 1.12.2 does not have required core components listed with it, it is in the same Project Option as 1.12.1 and those required core components were used as a guide for our own components. We have reviewed the components, modified them and will address them as below:

a) *Evaluate existing locations of behavioral health clinics and to identify barriers to access including, transportation, operating hours, admission criteria and acceptable payment. If any of these barriers is a significant issue in care access, develop and implement improvements.* Patients currently accessing care at the Round Rock clinic in west Williamson County will be offered the opportunity to use the Eastern Williamson County Clinic in Taylor. Persons requesting services from BTCS but who are not in the priority population established by DSHS will be offered services at the Taylor clinic regardless of residency or home address. Operating hours outside the usual business hours will be available at the EWCC.

b) *Review the interventions impact on access to behavioral health services and identify "lessons learned," opportunities to scale all or part of the interventions to a broader patient population, and identify key challenges associated with expansion of the interventions, including special considerations for safety-net populations.* We will establish a Plan, Do, Study, Act (PDSA) cycle improvement process through the Quality Management department of BTCS to collect and analyze data related to these interventions. That data will include ECHO™ Satisfaction Survey results and Electronic Health Record (EHR) data related to functioning scales and frequency in the use of higher levels of care such as Emergency Departments (EDs) and inpatient psychiatric care. We will assess the results, make improvements in the operation of this Clinic, and develop plans to expand services to "non-priority population" patients. We will hold community planning meetings with providers, patient advocates and community leaders in a number of communities to assess expansion opportunities.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: BTCS uses the mental health block grant for routine mental health services on an outpatient basis. We will provide outpatient services in this expansion project for Taylor, Texas clinic but those services are not for the same populations.

Related Category 3 Outcome Measure:

- OD-6 Patient Satisfaction
  - IT- 6.2 Other Outcome Improvement Target: Percent improvement over baseline of patient satisfaction scores for:
    - getting timely care, appointments, and information;

- how well their doctors communicate; and
- patient's overall health status/functional status.

Reasons/rationale for selecting the outcome measure:
We plan to use the Experience of Care and Health Outcomes (ECHO™) survey, Version 3.0 which is designed to collect consumer's ratings of their behavioral health treatment. A version was adopted by NCQA for inclusion in HEDIS. It is also a registered CAHPS (ECHO™ Survey Homepage, http://www.hcp.med.harvard.edu/echo/). We selected this measure because our informal surveys of persons in eastern Williamson County indicates that without any options, the individuals are unable to form a judgment concerning the necessity for or advantages to services in their home community. We selected this instrument because it is specific to use for behavioral health, it contains domains to measure the specific areas of interest, i.e., measurement of satisfaction related to timely care and appointments, adequacy of information provided at appointments, provider communication and self-assessment of the patient's overall health status and functional status. Additionally, ECHO™ is a CAHPS registered instrument and because of all of the reasons for selection, we feel it meets the stand alone requirements stated in this measure. We want to assess the impact of timely appointments, access to a stable provider in the community, involvement with that provider and improvement in behavioral health status. We believe there will be marked improvement in satisfaction with the health care experience when care is local, accessible and committed to the community; and that this satisfaction will lead to superior health status for the entire community.

Relationship to Other Projects:
This enhances additional projects that BTCS is pursuing including: related to Crisis Respite for Persons in Behavioral Health Crisis (#126844305.1.2); and Emergency Services Diversion (#126844305.2.2); in that it provides access to care following those emergency interventions. We expect the other projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. It also supports the Transitional Housing Guided by Peer Support (#126844305.2.1), by supporting peer specialists in this rural area and therefore offering the option of housing within the home community.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improve and adjust the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care. The Williamson County Mental Health Task Force will be the primary conduit for our planning discussions.

Project Valuation:
We expect to serve 1,500 adults and youth in DY4 and 2,000 patients in DY5 and to do so in or closer to their home communities. 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).

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available online.

Bluebonnet Trails 126844305.1.1 (Project 1.12.2) Category 1 Milestones and Metrics			
126844305.1.1	**1.12.2**		**Expand the number of community based settings where behavioral health services may be delivered in underserved areas**
Bluebonnet Trails MHMR			**126844305**
Related Category 3 Outcome Measure (s):	**126844305.3.1**	**IT-6.2**	**Other Outcome Improvement Target: Percent improvement over baseline of patient satisfaction scores**

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)
Milestone 1 [P-3]: Develop administrative protocols and clinical guidelines for projects **Metric 1** [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines. **Baseline/Goal:** Develop needed operational manuals, policies and procedures. **Data Source:** Administrative protocols; Clinical guidelines **Milestone 1 Estimated Incentive Payment: $78,731** **Milestone 2** [P-4]: Hire and train staff to operate and manage projects selected. **Metric 1** [P-4.1]: Number of staff secured and trained.	**Milestone 3:** [P-7]: Evaluate and continuously improve services. **Metric 1** [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/Goal:** Establish QM plan for PDSA cycle, display data collected and convene stakeholder meetings. **Data Source:** Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement **Milestone 3 Estimated Incentive Payment: $518,106**	**Milestone 4** [I-X]: Increase the utilization of behavioral health care in east Williamson County **Metric 1** [I-X.1]: Increase the number served for community behavioral healthcare services a. Measurement of the Metric is a count of those receiving community behavioral health services in Williamson County in this Clinic **Baseline/Goal:** Baseline - There was no clinic in this underserved area prior to DY2 therefore the baseline is 0 for persons served. Goal - Serve 1,500 people in DY4 in the new location in the underserved area **Data Source**: EHR and Intake/admission records **Milestone 4 Estimated Incentive Payment: $394,417**	**Milestone 5** [I-X]: Increase the utilization of behavioral health care in east Williamson County **Metric 1** [I-X.1]: Increase the number served for community behavioral healthcare services a. Measurement of the Metric is a count of those receiving community behavioral health services in Williamson County in this Clinic **Baseline/Goal:** Baseline - There was no clinic in this underserved area prior to D2 therefore the baseline is 0 for persons served. Goal - Serve 2,000 people in DY5 in the new location in the underserved area **Data Source**: EHR and Intake/admission records **Milestone 5 Estimated Incentive Payment: $276,452**

Baseline/Goal: Hire and train critical team staff to include, APN, Counselors, Peer Support Specialist. **Data Source:** Project records; Training curricula **Milestone 2 Estimated Incentive Payment: $78,732**			
Year 2 Milestone Bundle Amount: $157,463	**Year 3 Estimated Milestone Bundle Amount: $518,106**	**Year 4 Estimated Milestone Bundle Amount: $394,417**	**Year 5 Estimated Milestone Bundle Amount: $276,452**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,346,438			

Category 1 Project Narrative
Bluebonnet Trails Community Services - 126844305.1.2

Project Area, Option and Title: 1.13.1 – Develop and implement crisis stabilization services to address the identified gaps in the current crisis system
RHP Project Identification Number: 126844305.1.2

Performing Provider Name: 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 Local Mental Health Authority for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is the public provider of behavioral health services for the poor under and uninsured in Williamson County.
- **Intervention:** BTCS proposes to create, certify and provide for an involuntary emergency detention unit for the purpose of providing crisis stabilization. A 48-Hour Observation Unit will be established in Georgetown, Texas to provide for emergency and crisis stabilization services in a secure and protected, clinically staffed, psychiatrically supervised treatment environment. This 48-Hour Observation Unit will provide assessment and active intensive treatment for adults.
- **Project Status:** This is a new project, no facility or service now exists in any of the Counties served by BTCS that accepts and evaluates adults on emergency detention orders. We expect to serve about 300 people a year when the project matures.
- **Project Need:** No 48 Hour Observation Unit exists in BTCS's area. This addresses RHP 8 Community Needs Assessment needs: CN.2.1 - Limited access to behavioral health services to rural, poor and under & uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; CN.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson County; and CN.2.13—Limited access to adult behavioral health services in Williamson County.
- **Target Population:** The target population is adults presenting a significant threat to the safety of self or others and exhibiting behaviors consistent with acute psychiatric disorder. Of adults served by BTCS in FY 2012, an average of 43% were Medicaid-eligible; 73% of BTCS clients are below the federal poverty level. We estimate approximately 70% of those benefitting from this project will be poor, under or uninsured. We expect to serve 250 people in DY4 and 300 in DY5.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project helps patients by providing access to care locally and proactively so that they are not taken out of County and hospitalized. Quick local assessment supports local stabilization and reduces the number of short inpatient stays which result from using the hospital as an assessment location. The project seeks to provide assessment and stabilization services to 250 people

in DY4 and 300 people in DY5. **Category 3 Outcomes:** IT-3.8: Our goal is to reduce the behavioral health 30 day readmission rate to hospital by a percentage TBD based on baseline established DY3. What the achievement of this goal means is **to provide services to the target population of people who have been hospitalized or experienced a crisis event and/or have been in the Crisis Respite facility and to assist them to regain functioning and self-manage their wellness**. Improvement in functioning and self-management of symptoms and wellness are critical patient outcomes. When the goals are achieved, then program participants should experience a reduction in symptoms and a reduction in crisis events. We expect to serve 250 people in this community based crisis alternative in DY4 and 300 people in DY5. Our goal is to serve people in the community. This not only represents a substantial savings over using hospital and ED, but more importantly improves the lives of those who otherwise would have go to hospital out of County or spend wasted time in inappropriate ED settings. Currently hospital and EDs are the only options.

- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. This project is transformative in that it creates an alternative for those in behavioral health crisis that is local, reduces hospital admissions and use of EMS and EDs. There are no community based crisis stabilization alternatives except hospitals and EDs.

Project Description:

Crisis Stabilization for Persons in Behavioral Health Crisis

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. BTCS proposes to create, certify and provide for an involuntary emergency detention unit for the purpose of providing crisis stabilization. To do so, a 48-Hour Observation Unit will be created to provide for emergency and crisis stabilization services provided to individuals in a secure and protected, clinically staffed, psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. This 48-Hour Observation Unit will provide active intensive treatment for adults in need of acute inpatient psychiatric service; with suicidal indication; persons presenting a significant threat to the safety of self or others; and persons exhibiting behaviors consistent with acute psychiatric disorder which may include significant mental status changes.

The 48-Hour Observation Unit will be fully compliant with all regulations and health and safety standards. This option will be accomplished by modifying our current voluntary Crisis Respite facility in Georgetown. A physical separation will be created between an area comprising two rooms and the remainder of the sixteen bed facility in order to establish a locked unit that is suitable for patients in crisis to be securely and safely detained for up to 48 hours. During the 48 hours, the individual in crisis will be assessed; will receive medication and intensive psychiatric treatment meeting their needs; and will be provided short term care, step down

respite care and assisted transition into outpatient services and community resources. The facility will provide access to emergency care at all times and will safely and appropriately manage individuals with the most severe psychiatric symptoms. It is designed to provide a safe and secure environment for short-term stabilization of behavioral health symptoms that may or may not require a continued stay in an acute care facility. Extended observation and treatment can take place for up to 48 hours. Individuals who cannot be stabilized within that timeframe would be linked to the appropriate level of care (inpatient hospital unit).

This involuntary behavioral health facility has the potential to serve an additional 300 people a year. The proposal builds on the current crisis system established by the LMHA and the relationships with local law enforcement agencies. To accomplish this we propose to make necessary building modifications, increase professional staff for the facility to meet standards requiring 24 hour nursing coverage, MD assessment within one hour and transfer capability to another inpatient facility if appropriate. Establishing the capacity to accept persons who are under Emergency Detention and hold them for assessment and short term stabilization will reduce the unnecessary utilization of Emergency Departments (EDs), psychiatric inpatient facilities and jail. This project reduces preventable readmissions to hospital by providing a community alternative for rapid stabilization and referral to appropriate residential options. Since the service is located in the same building as voluntary Crisis Respite, those who can achieve sufficient stability can transfer to the voluntary program to complete treatment. For persons requiring higher levels of medical expertise, and to ensure easy access to medical services, the clinic will be linked by telemedicine to our locations with additional physicians.

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. In meetings with stakeholders in Williamson County, we learned that those admissions are being taken directly to the hospital by law enforcement officers because they have no local crisis alternative and have been requested to take individuals from ED's or have taken them upon their own screening and assessment. They transport for direct admission to the State Hospital when in their judgment the individual needs an involuntary facility even for a short period of time. No such facility exists in Williamson County or any other County served by BTCS. 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 crisis stabilization. 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 95% of those were from Williamson County. Of those admissions, 13% were from EDs and local Hospitals; 8% were from the State Hospital; and 13% were from jail. Clearly, all of these individuals were candidates for crisis stabilization as a first option rather than hospitalization—expending valuable time and resources in the wrong setting. This project directly addresses the problem of inappropriate admission by creating the 2 beds for the 48-Hour Observation Unit as an option for law enforcement in lieu of jail, ED or State Hospital. We will ensure that qualified assessment staff will be available at all times so that when an individual is brought to the facility he/she can be assessed and disposition made as quickly as possible, thereby allowing the law

enforcement officer to return to regular duties. Social Service staff will provide for follow up to refer the individual to other levels of care upon stabilization or to prepare and process legal mental health commitment as needed.

Goals and Relationship to Regional Goals:

Project Goals:

- Establish an involuntary crisis stabilization service in Williamson County through a 48-Hour Observation Unit.
- Develop a professional team on site and supported by telemedicine.
- Provide this crisis service in a safe and secure environment that allows for those in custody and under detention order to be detained and assessed
- Reduce or eliminate the inappropriate utilization by the mentally ill of ED's, jails, private hospitals and the State Hospital for short stays.

This Project meets the following Regional Goals:

- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.
- Reducing inappropriate utilization of services.

We are proposing this project in Williamson County because it is the largest county in the BTCS catchment area, with 55% of the population. Additionally, data above indicates that 95% of the admissions for crisis residential services came from Williamson County. Williamson County also has a well-developed mental health deputy program and provides the opportunity for expansion and refinement of that program. This location is a good strategic choice because the County shares a border with 3 of the other 8 Counties we serve. As the program matures, the number of beds can be expanded easily to serve half of the catchment area if needed.

Challenges:

The primary challenge for this project is to achieve widespread use of the 48-Hour Observation Unit as a first option by law enforcement. There are established law enforcement patterns of detention and disposition for mental health cases in Williamson County—as well as Burnet County. Just providing a new option will not automatically lead to acceptance and utilization. We plan to communicate to law enforcement leadership in the county and to the front line officers. We currently provide training and have routine communication with the major law enforcement agencies, Williamson County Sheriff's Office, Burnet County Sheriff's Office, and the police departments of Round Rock, Georgetown, Burnet and Marble Falls. We plan to continue these activities and add additional communication and education meetings for the first year of the project to foster acceptance and use of the services.

5-Year Expected Outcome for Provider and Patients:

Over the next 5 years, we expect the outcomes to include reduction of hospitalizations for persons who are currently admitted for very short stays, reduction of ED utilization by law enforcement that have behavioral health clients in custody, and reduction in incarceration of the mentally ill.

Starting Point/Baseline:
Currently, no involuntary crisis stabilization service exists in Williamson County; therefore, the baseline is 0 in DY2. We do not have the data to estimate the number of people who were admitted to jail inappropriately, who were admitted to private psychiatric facilities in adjacent Counties or who were detained in EDs. A major effort is needed during DY2 to identify the extent of the resources needed and ensure that the intervention is appropriate and adequate. We will use the number of admissions into the State Hospital System and Psychiatric Inpatient Units during SFY2012 as our baseline for the performance indicators.

Rationale:
Community Need Addressed:

- Community Need Area: CN.2 – Limited access to primary care
- Specific Community Need:
  - CN.2.1 – Limited access to behavioral health services to rural, poor and under & un-uninsured populations (meds, case management, counseling, diagnoses) in Williamson County
  - CN.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson County
  - CN.2.13 – Limited access to adult behavioral health services in Williamson County

A secure and safe community based crisis stabilization alternative will give law enforcement officers and crisis responders new opportunities to help people. Someone experiencing a mental health crisis is assessed to determine if he/she is 'a danger to self or others'. It is that standard in the law that must be met in order to detain someone, transport them to a safe place, conduct a thorough evaluation and determine the most appropriate course of action to assist the individual. A law enforcement officer, who has someone in custody under this circumstance, has little recourse other than to transport the person to the nearest safe and secure facility for evaluation. Jail, EDs and psychiatric hospitals are secure options and generally safe options. But as referenced in the RHP Planning Protocol – Category 1, page 141, *Behavioral Health News* Vol. 7 Issue 3 reported that "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." A project to improve stabilization services and add a missing part of the continuum of care, the capacity to assess and treat people who are on emergency detention orders, is needed in Williamson County. BTCS participates in the Mental Health Task force for Williamson County and this group of leaders and health care professionals report that mentally ill people are taken inappropriately to EDs, jail and the State Hospital. Other than the data reported above related to admissions to the voluntary Crisis Respite facility, the community need being expressed is, to a certain extent, anecdotal. However it is clear that we need to begin offering a community based crisis stabilization option even as we address the core components of this Project Option.

Project Components:

This project to provide involuntary Crisis Respite services for adults 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.* We will work with health care and law enforcement stakeholders to identify gaps that lead to inappropriate admission to jail, EDs and short term stays in psychiatric hospitals. We will convene community stakeholders during the remainder of FY 2013 to identify information needed to assess the gap in crisis services and assess root cause.

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 law enforcement is transporting to and from EDs in their own community and in Austin and one cause is limited crisis response services and/or concern for the safety and security of the patient and the community. We will identify tools and agreements needed to access and analyze to determine 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 BTCS staff to assess admissions and dispositions to voluntary Crisis Respite and to all psychiatric facilities in the area. We will focus on those detained and transported during 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 to determine if it is sufficient in bed capacity and scope of evaluation and treatment options available. We will use that information to recommend next steps for RHP 8.

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.* We will review the impact of involuntary Crisis Respite and identify lessons learned and adjust the model with respect to area, 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.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project provides crisis services to enhance the initiatives currently funded by the U.S. Department of Health and Human Services (DHHS). BTCS receives funds to operate substance abuse Outreach Screening and Referral services in Williamson and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services in this project; however, this project enhances and extends the care currently provided with Federal funds by a providing a local option to address crisis needs. We believe this crisis service will improve the healthcare outcomes for entire community, relieve pressure on law enforcement and ED's and promote stable community tenure for our patients.

Related Category 3 Outcome Measure:

- OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)
    - IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate

Reasons/rationale for selecting the outcome measure:
Readmissions to psychiatric facilities are driven by a number of circumstances surrounding the initial hospital stay. Those include inaccurate assessment of acuity and early release, poor or hurried discharge planning, inadequate knowledge of community resources, inadequate resources to accommodate a sound community placement. Creating the option to provide involuntary detention and evaluation in the community provides the opportunity to address several of these drivers. We can provide timely evaluations and quick stabilization linked to community follow up. We know the community resources including housing and treatment options. It also gives us the chance to intervene with those who otherwise would be readmitted rather than getting community help. Admissions to inpatient settings should be more appropriate and readmissions reduced.

Relationship to Other Projects:
This enhances additional projects that BTCS is pursuing related to Child Crisis Respite (#126844305.1.2) and Emergency Services Diversion (#126844305.2.2) in that it provides access to care following those emergency interventions. We expect the other projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. It both supports and relies on the Transitional Housing (#126844305.2.1) projects which provide a place for people to continue recovery in the community after stabilization is achieved. This option supports substance abuse treatment as a back-up for relapse and crisis events. Routine outpatient care is enhanced by the safety net of short term crisis resolution.

This project also supports the intensive outpatient crisis services (#126844305.1.4) project (to be implemented by the LMHA in Burnet County, in RHP 8. By providing the involuntary crisis stabilization service in Williamson County, the providers in Burnet County (25-45 minutes from the proposed 48-Hour Observation Unit) will be supported by a resource previously unavailable for persons in crisis.

Relationship to Other Performing Provider Projects and Plan for Learning Collaborative:
BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. The exchange of ideas through both developing and existing relationships will keep the line of communication open and will help us adjust and refine our programs and approaches to behavioral health care.

Project Valuation:
We expect to serve 250 people in this community based crisis alternative in DY4 and 300 people in DY5. Serving people in the community is a substantial savings over using hospital and ED, which are now the only options. 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).

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 online.

Bluebonnet Trails 126844305.1.2 (Project 1.13.1) Category 1 Milestones and Metrics				
126844305.1.2	**1.13.1**	**1.13.1.a – 1.13.1.e**	**Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system**	
Bluebonnet Trails MHMR				**126844305**
Related Category 3 Outcome Measure (s):	**126844305.3.2**	**IT-3.8**	**Behavioral Health/Substance Abuse 30 day readmission rate**	
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)**	
Milestone 1 [P-3]: Develop implementation plans for needed crisis services. **Metric 1** [P-3.1]: Produce data-driven written action plan for development of involuntary Crisis Respite for adults based on gap analysis and assessment of needs. **Baseline/Goal:** Document a plan that includes all of the elements above and is specific to implementation of Crisis Respite Adults. **Data Source:** Written plan **Milestone 1 Estimated Incentive Payment: $474,954** **Milestone 2** [P-4]: Hire and train staff to implement Crisis Respite service in accordance with Standards.	**Milestone 4** [P-7]: 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. **Metric 1** [P-7.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. **Baseline/Goal:** Participate in meetings as scheduled and disseminate information to stakeholders **Data Source:** Minutes, agendas,	**Milestone 5** [I-X]: Increase the utilization of appropriate crisis alternatives **Metric 1** [I-X.1]: Target population reached; number served in this community based crisis alternative. Measurement of the Metric is a count of those receiving crisis services in this location **Baseline/Goal:** Baseline - There were no crisis alternatives in Williamson County in DY 2 therefore the baseline is 0 for persons served. Goal - Serve 250 people in DY4. **Data Source:** EHR and program records. **Milestone 5 Estimated Incentive Payment: $1,575,183**	**Milestone 6** [I-X]: Increase the utilization of appropriate crisis alternatives **Metric 1** [I-X.1]: Target population reached; number served in this community based crisis alternative. Measurement of the Metric is a count of those receiving crisis services in this location. **Baseline/Goal:** Baseline - There were no crisis alternatives in Williamson County in DY 2 therefore the baseline is 0 for persons served. Goal - Serve 300 people in DY5. **Data Source:** EHR and program records. **Milestone 6 Estimated Incentive Payment: $1,279,908**	

Metric 1 [P-4.1]: Number of staff hired and trained. **Baseline/Goal:** Hire all staff required by standards prior to operation. **Data Source:** Staff rosters and training records and training curricula, DFPS licensure reports **Milestone 2 Estimated Incentive Payment: $474,955** **Milestone 3** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services. **Metric 1** [P-5.1]: Completion of policies and procedures. **Baseline/Goal:** Complete all policies and procedures to achieve certification and to begin operation. **Data Source:** Manuals, internal record and certification reports. **Milestone 3 Estimated Incentive Payment: $474,955**	attendance rosters, public communication. **Milestone 4 Estimated Incentive Payment: $1,574,746**		
Year 2 Milestone Bundle Amount: $1,424,864	**Year 3 Estimated Milestone Bundle Amount: $1,574,746**	**Year 4 Estimated Milestone Bundle Amount: $1,575,183**	**Year 5 Estimated Milestone Bundle Amount: $1,279,908**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $5,854,701			

Category 1 Project Narrative
Bluebonnet Trails Community Services - 126844305.1.3

Project Area, Option and Title: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.
RHP Project Identification Number: 126844305.1.3

Performing Provider Name: 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 Local Mental Health Authority (LMHA) for Burnet and Williamson Counties located within RHP 8 and for 6 other counties in adjacent Regions. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is the sole public behavioral health provider for all the counties it serves including those for youth.
- **Intervention:** BTCS will develop specialized Therapeutic Foster Care (TFC) to intervene with youth in crisis, diverting them from admission to hospitals or juvenile justice facilities. Our TFC Child Respite project will foster children in need of intensive short-term behavioral health services, but not in need of protection. Children receiving or eligible for Department of Family and Protective Services (DFPS) Foster Care are not in the target population for this project and, therefore, DFPS funding is not available for use for this project. No funding is available for children who are not in the CPS system but in need of crisis respite due to behavioral health crisis. We will establish foster homes in Williamson County and provide services to youth and families to stabilize the crisis and initiating ongoing services.
- **Project Status:** This is a new project. Not only are there not any TFC facilities, there are not any psychiatric stabilization facilities for youth in this region.
- **Project Need:** This project addresses RHP 8 Community Needs Assessment: CN. 2.3 - Limited access for youth with severe emotional disturbances to behavioral health community crisis services in Williamson and Burnet Counties; and CN. 2.15 - limited access to behavioral health services for adults and youth in Williamson and Burnet Counties who are involved in the adult and youth justice system.
- **Target Population:** The target population is high risk youth in behavioral health crisis the majority of them involved in Juvenile Justice; however, no incarcerated children will be admitted to the program. 39% of those admitted to Williamson County Juvenile Probation were diagnosed with behavioral health disorders. We will provide crisis respite for 30 youth annually based on the number of homes. 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.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide 730 crisis respite bed days in DY4 serving 16 youth; and to provide 1,460 crisis respite bed

days in DY5 serving 30 youth. Our improvement measure is increasing the utilization of appropriate crisis alternatives and the metric is Target Population Reached; that will be 16 youth in DY4 and 30 youth in DY5. Local care that promotes family preservation is clearly a benefit to youth and families. The most appropriate crisis services are those that are local and responsive. Creating this option allows us to reduce out of county placement into residential and inpatient care in order to promote family participation and return to home for the youth. Improvement Milestone I-12.1, increasing the utilization of appropriate crisis alternatives creates the opportunity to provide these patient benefits.

- **Category 3 Outcomes:** IT-9.1: Our goal is to decrease in mental health admissions and readmissions to criminal justice settings; residential treatment out of County and detention services operated by Williamson County Juvenile Probation by a percentage TBD based on baseline established in DY3.
- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. We consider this project to be transformative because it will create a local system of services that supports youth who experience behavioral health crises to stay connected to community and family. Currently the only option is for youth to be removed from their home region and any proximity to their families. This crisis option will allow families to work on therapeutic issues while the youth is safe and working on those issues as well. It promotes family preservation.

Project Description:

Child Crisis Respite through Therapeutic Foster Care

BTCS is the LMHA for Burnet and Williamson Counties located within RHP 8 and for 6 other counties in adjacent Regions. As the LMHA, we contract with the Department of State Health Services (DSHS) to provide specialty behavioral health services to children and adolescents with Serious Emotional Disturbance (SED) that DSHS identifies as the "priority population". The Federal Definition for youth diagnosed with SED can be found at: http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc. Youth diagnosed with SED are generally having adjustment or functioning difficulties in more than one life domain and therefore experience crisis episodes that disrupt schools and families alike. BTCS proposes to develop a specialized Therapeutic Foster Care (TFC, also called Treatment Foster Care) project that will be used to intervene with youth in crisis and divert them from admission to a psychiatric hospital or juvenile justice facility.

The *Texas Criminal Justice Coalition - Williamson County Juvenile Justice Data Sheet*, reveals that of the 869 youth between the ages of 10 and 17 who were referred to Texas Juvenile Justice Department, 39% or 335 of them were diagnosed with mental illness. http://tcjc.redglue.com/sites/default/files/youth_county_data_sheets/Williamson%20County%20Data%20Sheet%20(Sep%202012).pdf. The conclusion is that "Reducing the number of youth

adjudicated to residential facilities can only be achieved if stakeholders strongly invest in 'a consistent, county-based continuum of effective interventions, supports, and services'". BTCS and leadership in the County agree that a part of the continuum that is missing is a community based alternative for crisis stabilization for these youth. The foster homes in this project will be used to provide safe environments to begin reintegration and family reunification as an alternative to detention or hospitalization at the point of crisis, thereby diverting the youth from those higher levels of care. The foster homes will also be available for transition care upon discharge from hospital or residential facility, thereby shortening lengths of stay. TFC 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 TFC, the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. TFC 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. BTCS is a member of the Mental Health Task Forces for Williamson County and they have identified a need for crisis services for youth from this area. Currently there are no behavioral health crisis options available in Williamson County.

Goals and Relationship to Regional Goals:
The goal of this proposal is to use TFC to provide crisis respite for youth in lieu of referral to a juvenile justice detention facility or a psychiatric hospital and to provide services that allow families and youth to remain together once the crisis is resolved. This community based respite alternative will be the foundation to successfully reintegrate youth with emotional and/or behavioral needs into their families—families who are trained to have the skills to meet those needs—and their communities.

Project Goals:

- Establish the Therapeutic Foster Care Program including identifying facilities and foster parents;
- Improve Clinical Resources to support services for families and youth
- Develop protocols to use to divert from residential care and to reunify after residential care.

The Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

The TFC 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. Supporting 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 are committed to preserving families and 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.

Challenges:
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. Another major challenge is the identification of suitable homes or facilities, suitable candidates for foster parents and enhanced clinical expertise at the local clinic to carry out needed supports. We can address the challenge related to regulation and infrastructure 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 homes for several years. We will address the philosophy of care challenge by using resources related to the variety of evidenced based practices (EBP) that have been implemented in TFC settings, as noted in *Evidenced Based Practices in Treatment Foster Care- A Resource Guide* produced by the Foster Family Based Treatment Association (http://www.ffta.org/). Using the excellent reputation of BTCS we will initiate a strategy to provide enhanced community education and communication to recruit families and additional homes. We will provide specialized clinical training for foster parents as specified in the licensure standards and will add licensed and certified clinical staff at the local BTCS clinics to provide professional support. The Community Needs Assessment for RHP 8 identifies poor access to mental/behavioral health services as a key health challenge for the region (see Section II of this Plan). We will need to make extra effort to resolve the provider shortage issues. We will use the innovative nature of this program as an inducement to recruit providers. We are confident that qualified professionals will want to participate in such a project.

5-Year Expected Outcome for Provider and Patients:
Over the next 5 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. Our improvement measure is increasing the utilization of appropriate crisis alternatives and the Metric is Target Population Reached; that will be 16 youth in DY4 and 30 youth in DY5. Local care that promotes family preservation is clearly a benefit to youth and families.

Starting Point/Baseline:
Currently no Child Crisis Respite program exists in Burnet of Williamson County; therefore, the baseline is 0 in DY2. We have some data related to the number of youth referred to juvenile justice and hospitalized in State Hospitals, but do not have comprehensive data on ED episodes, private hospital admissions. We will undertake to identify resources and methods to capture and share information across these various child serving agencies.

Rationale:

Community Need Addressed:

- Community Need Area: CN.2 - Limited access to primary care
- Specific Community Need:
  - CN.2.3 - Limited access for youth with severe emotional disturbances to behavioral health community crisis services in Williamson and Burnet Counties; and
  - CN.2.15 - Limited access to behavioral health services for adults and youth in Williamson and Burnet Counties who are involved in the adult and youth justice system.

The TFC model involves placement of children experiencing emotional or behavioral disorders with specially trained foster families. BTCS will develop sites in Williamson County and consider establishing sites in later years in Burnet County. All homes will have trained foster parents recruited from within the communities and professional support provided by licensed and certified staff currently working for BTCS outpatient sites in those counties. As mentioned earlier, TFC is not a part of the foster care program administered by the Department of Family and Protective Services. Our project is not designed for children in protective care and therefore, not eligible for DFPS foster care funding. Our target populations are frequently placed in residential care through juvenile probation but almost never placed in therapeutic home settings. We are proposing to use specially trained foster parents who are willing and able to work with youth who have intense behavioral health needs, and to wrap additional services around those youth using staff and resources available from our current operations. There is no foster care funding for this use of foster care. The foster family provides a stable environment and safe, secure supervision. The foster family and the professional service providers work together as a team with both youth and family. This team 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. We selected this Project Area and Project Option because our goal is to implement a crisis response for youth that addresses identified community need. Caregivers and agencies involved with these children and adolescents have heretofore been left with few options other than to assess and transport to Austin or even farther outside of RHP 8 for admission to a hospital or secure residential facility for stabilization.

Project Components:

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 Austin 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 adjacent counties or to increase capacity in Region 8.

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.

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.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project significantly enhances delivery system reform by enhancing the holistic health care approach of BTCS and its partners in Williamson and Burnet Counties. BTCS currently receives funds from U.S. Department of Health and Human Services (DHHS) to operate substance abuse Outreach Screening and Referral services in Williamson and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services; however, this project enhances and extends the care currently provided with Federal funds by a new and innovative approach 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.

Related Category 3 Outcome Measure:

- 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

Reason/Rationale for selecting the Outcome Measure:
Achieving the goal to establish a crisis stabilization alternative in the community will reduce the number of youth who are removed at the point of crisis due to having no other options. Although the Improvement Target references criminal justice it is understood that most youth are not admitted to criminal justice settings but to the various levels of the juvenile justice system to include residential treatment in a secure facility. Youth in crisis cause damage and are disruptive; frequently they are referred to juvenile justice for safety even though the problem is a mental health problem. Crisis stabilization available in the community will reduce those referrals and achieve this Outcome.

Relationship to Other Projects:
This enhances the Emergency Services Diversion project (#126844305.2.2) that BTCS is proposing. That project is focused on diversion of persons with behavioral health issues from EDs and inpatient care. This project adds a community resource which can be used as a tool by those persons involved in ED diversion. BTCS is also proposing to provide an expanded clinic in East Williamson County (#126844305.1.1) and this project will act as a crisis alternative when needed for those patients. We also anticipate that some high functioning individuals with Intellectual and Developmental Disabilities, especially youth with Autism, might require and access crisis respite services. Our IDD Assertive Community Treatment project (#126844305.2.3) is proposed in Pass 2 along with services to adults and youth in justice system and outpatient substance abuse services for adults and youth. These all fit together to continue building a continuum of care for youth with behavioral health needs in RHP 8.

Relationship to Other Performing Provider Projects and Plan for Learning Collaborative:
BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care.

Project Valuation:
The project seeks to provide crisis respite to 16 youth in DY4 and to provide crisis respite to 30 youth in DY5. These are very high intensity youth who otherwise would be removed from home and placed in a psychiatric hospital or residential treatment facility. 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.

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails 126844305.1.3 (Project 1.13.1) Category 1 Milestones and Metrics			
126844305.1.3	**1.13.1**	**1.13.1.a – 1.13.1.e**	**Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system**
Bluebonnet Trails MHMR			**126844305**
Related Category 3 Outcome Measure (s):	**126844305.3.3**	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons**

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)
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 **Metric 1** [P-1.1]: Number of meetings and participants. **Baseline/Goal:** Goal - Hold meetings that are attended by a representative of all of the key groups identified above. **Data Source:** Attendance lists, agendas and minutes **Milestone 1 Estimated Incentive Payment: $136,563** **Milestone 2** [P-3]: Develop	**Milestone 3** [P-4]: Hire and train staff to implement Crisis Respite through TFC. **Metric 1** [P-4.1]: Number of staff hired and trained. **Baseline/Goal:** Goal - Hire 1 licensed staff and recruit and certify 1 foster parent, certify 1 foster home. **Data Source:** Staff rosters and training records and training curricula, DFPS licensure reports **Milestone 3 Estimated Incentive Payment: $348,750**	**Milestone 4** [I-X]: Increase the utilization of appropriate crisis alternatives. **Metric 1** [I-X.1]: Target population reached; number served in this community based crisis alternative. Measurement of the Metric is a count of those receiving crisis services in this location. **Baseline/Goal:** There were no crisis alternatives for youth in Williamson County in DY2; therefore the baseline is 0 for persons served. Goal - Serve 16 youth DY4. **Data Source:** Claims, encounter, and clinical record data. **Milestone 4 Estimated Incentive Payment: $348,750**	**Milestone 5** [I-X]: Increase the utilization of appropriate crisis alternatives. **Metric 1** [I-X.1]: Target population reached; number served in this community based crisis alternative. Measurement of the Metric is a count of those receiving crisis services in this location. **Baseline/Goal:** There were no crisis alternatives for youth in Williamson County in DY2 therefore the baseline is 0 for persons served. Goal - Serve 30 youth DY5. **Data Source:** Claims, encounter, and clinical record data. **Milestone 5 Estimated Incentive Payment: $310,000**

implementation plans for needed crisis services. **<u>Metric 1</u>** [P-3.1]: Produce data-driven written action plan for development of Crisis Respite through TFC based on gap analysis and assessment of needs. **Baseline/Goal:** Goal - Document a plan that includes all of the elements above and is specific to implementation of therapeutic foster care. **Data Source:** Written plan **Milestone 2 Estimated Incentive Payment: $136,562**			
Year 2 Milestone Bundle Amount: $273,125	**Year 3 Estimated Milestone Bundle Amount: $348,750**	**Year 4 Estimated Milestone Bundle Amount: $348,750**	**Year 5 Estimated Milestone Bundle Amount: $310,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,280,625			

Category 1 Project Narrative – Pass 2
Bluebonnet Trails Community Services – 126844305.1.4

Project Area, Option and Title: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current crisis system
RHP Project Identification Number: 126844305.1.4

Performing Provider Name: 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 Local Mental Health Authority (LMHA) for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is the sole public behavioral health provider in these Counties.
- **Intervention:** BTCS proposes to collaborate with Burnet County Sheriff's Department and Seton Highland Lakes Medical Center to provide crisis assessment, referral and short-term stabilization in Burnet County. To establish this service, a space near the Emergency Department (ED) of the Seton Highland Lakes Medical Center in Burnet, Texas will be renovated so that is suitable for walk-in patients and for law enforcement to bring persons in need of assessment and stabilization. The service will be available 24 hours a day 7 days a week.
- **Project Status:** This is a new project, no facility or service now exists in any of the Counties served by BTCS that accepts and evaluates adults on emergency detention orders.
- **Project Need:** There is no facility in the counties served by BTCS that accepts persons on Emergency Detention for assessment and stabilization and people have to be transported to hospitals in Austin, Texas. This project addresses RHP 8 Community Need CN.2.4 – Limited access for serious mentally ill adults to crisis services in Burnet County.
- **Target Population:** The target population is adults presenting a significant threat to the safety of self or others and exhibiting behaviors consistent with acute psychiatric disorder. Of those served by BTCS in FY 2012, an average of 43% of adults were Medicaid-eligible; 73% of BTCS clients are below the federal poverty level. We estimate that approximately 70% of those benefitting from this project will be poor, uninsured or underinsured. We expect to serve 200 people in DY4 and 300 in DY5.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project provides access to behavioral health crisis services that are local and specific to these disorders. That access results in fewer hospitalizations for patients, quicker recovery and stability in community living. Both the health and quality of life that patients experience is improved when they can remain in the community and return quickly to productive community life. This directly addresses Improvement Milestone I-12.1 utilization of appropriate crisis alternatives, even though the baseline for the number used to calculate the percentage

increase is TBD in DY3. The project seeks to provide assessment and stabilization services to 200 people in DY4 and 300 people in DY5.

- **Category 3 Outcomes:** IT-3.8: Our goal is to reduce the behavioral health 30 day readmission rate to hospital by a percentage TBD based on baseline established DY3. What the achievement of this goal means is **to provide services to the target population of people who have experienced a crisis event and assist them in accessing community based crisis services as opposed to utilizing inpatient psychiatric facilities out of County or inappropriate EDs.** Community based alternatives provide immediate intervention and symptom management, thereby providing improvement in functioning that is critical patient outcomes. When the goals are achieved then program participants should experience a reduction in symptoms and a reduction in crisis events. We expect to serve 200 people in this community based crisis alternative in DY4 and 300 people in DY5. Our goal is to serve people in the community. This not only represents a substantial savings over using hospital and ED, but more importantly improves the lives of those who otherwise would have go to hospital out of County or spend wasted time in inappropriate ED settings. Currently hospital and EDs are the only options and re-hospitalization occurs because care is remote, not timely and discharge and referral is difficult and often inadequate.
- **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

Project Description:

Crisis Assessment for Persons in Behavioral Health Crisis – Burnet County

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. BTCS proposes to collaborate with Burnet County Sheriff's Department and Seton Highland Lakes Medical Center (Medical Center) to provide crisis assessment, referral and short term stabilization in Burnet County. To establish this service, a space near the Emergency Department (ED) of the Medical Center in Burnet, Texas will be renovated so that is suitable for walk-in patients and for law enforcement. Frequently, law enforcement will use it for persons who are being held under Emergency Detention and require evaluation to determine the best options for treatment and stabilization. The unit will be staffed by caseworkers, nursing and licensed professionals linked to psychiatric services via telemedicine. The project includes adding two Sherriff's Deputies to serve as part of Mobile Crisis Outreach Team working with the behavioral health professionals for BTCS and the and health care staff of the Medical Center. The secure unit will operate as an urgent care crisis clinic, clinically staffed and psychiatrically supervised for immediate access to urgent or emergent medical evaluation and treatment 24 hours a day 7 days a week. Individuals in crisis will be assessed and may receive medication and intensive and short-term care, step-down respite care and assisted transition into outpatient services and community resources. An advantage to locating this crisis assessment unit in the Medical Center is that it provides access to emergency care at all times and improves the capacity to safely and appropriately manage individuals with the serious psychiatric symptoms. Another advantage to the location is that it provides the opportunity to provide urgent care interventions for those who have come to the ED due to a behavioral health crisis but do not need the services of an ED. The space for the unit will be to provide a safe and secure environment for assessment of those in the custody of law enforcement and those who have come to the facility voluntarily or with family members or friends.

The proposal builds on the current crisis system established by BTCS and on the relationships with the Sherriff's Department and the Medical Center. Over the last several years, BTCS has developed a crisis response system that includes: a 24 hour crisis line, crisis screening and assessment in every county and a 16 bed voluntary crisis respite facility in Georgetown. We have proposed DSRIP projects that add to that continuum including 48-hour involuntary crisis observation unit in Georgetown, transitional housing guided by peer support in Round Rock and Crisis Respite for youth. The current and proposed elements of the continuum will be available for those assessed in this Crisis Assessment unit. Having the options will reduce the shorten lengths of stay in EDs and reduce utilization of psychiatric inpatient facilities and reduce the number of mentally ill who are taken to jail. This project reduces preventable readmissions to hospital by providing a community alternative for assessment and referral to appropriate residential options. This behavioral assessment unit should be capable of addressing the needs of around 5 to 7 people at a time. That number will need to be assessed based on practice, number of step-down alternatives and acuity of the individuals being assessed. The total number to be served will depend on the rate of crisis referrals and assessment request from the Medical Center ED.

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. The Sheriff's Department in Burnet County reports that they spend a great deal of time transporting individuals out of County for assessment and disposition. Also based on the electronic health record (EHR) for BTCS, there were 211 crisis screenings at the ED at the Medical Center. At times, the Deputies have no alternative but to transport for direct admission to the Austin State Hospital when in their judgment the individual needs further detention and thorough assessment. No suitable facility exists in Burnet County, therefore the ED is being used, but it puts undue burden on that facility. Further 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 crisis assessment and referral. 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. Of those admissions, 13% were from EDs and local Hospitals; 8% were from the State Hospital; and 13% were from jail. Clearly, all of these individuals were candidates for thorough crisis assessment to determine the best referral option rather than expending valuable time and resources in the wrong setting. This project creates a local crisis assessment option that directly addresses the problems of wasted time for laws enforcement to drive out of county for crisis assessment, long stays in the ED for those with behavioral health diagnoses and inappropriate referral and admission. It creates an option for law enforcement in lieu of jail, ED or State Hospital.

Goals and Relationship to Regional Goals:
The goals of this project are to improve the current crisis response system for behavioral health by developing crisis assessment and referral unit to improve access to behavioral health care in

the most appropriate and cost-effective setting and reduce unnecessary inpatient admissions, costly law enforcement trips and inappropriate incarceration or use of EDs.

Project Goals:

- Establish a crisis assessment and referral unit in Burnet County in partnership with the Sherriff's Department and the Medical Center.
- Develop a professional team and a mobile team including mental health deputies to provide assessment and disposition.
- Provide this crisis service in a safe and secure environment that allows for individuals in custody and under detention order to be detained and assessed.
- Reduce or eliminate the inappropriate utilization by the mentally ill of ED's, jails, private hospitals and the State Hospital for short stays.

This Project meets the following Regional Goals:

- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.
- Reducing inappropriate utilization of services.

We are proposing this project in Burnet County because there is no specially designated and trained mental health Deputies in this County and over 50% of the crisis screenings are now done at the ED. There is sufficient volume of crisis events in Burnet County for the Sheriff to request a specially trained officer to respond and transport. This project is an important part of the crisis services continuum in RHP 8, for BTCS and especially for the people of Burnet County.

Challenges:

The primary challenge for this project will be to create a seamless system of communication and collaboration among the partner entities: BTCS, Burnet County Sheriff's Department and Seton Highland Lakes Medical Center. Each entity has its own set of rules and guidelines to work within, but each will need to find ways to meet current requirements and to achieve the objective of safely and efficiently assessing, referring and finding adequate placement for those in crisis or diverted from the ED. We will address this challenge by jointly designing the processes and protocols for the unit and then holding operational meetings very frequently at first, to identify and eliminate problems with the processes. A second challenge is to engage other local law enforcement agencies especially in the Cities of Burnet and Marble Falls and other health care providers so that they are informed and comfortable referring or bringing people in crisis to this unit. We plan to continue current community outreach and education and add additional communication and education meetings for the first year of the project to foster acceptance and use of the services.

5-Year Expected Outcome for Provider and Patients:

Over the next 5 years, we expect the outcomes to include reduction of hospitalizations for persons who are currently admitted for very short stays, reduction of the length of stay in the ED for those presenting with a primary or secondary behavioral health diagnosis (including substance abuse diagnoses) and reduction in inappropriate incarceration of the mentally ill.

Starting Point/Baseline:
Currently, no crisis assessment unit exists in Burnet County; therefore, the baseline is 0 in DY2. We do not have the data to estimate the number of people who were admitted to jail inappropriately and who were admitted to private psychiatric facilities in adjacent Counties. We do know the number assessed in EDs but do not have length of stay or wait time data. A major effort is needed during DY2 to identify the extent of the resources needed and ensure that the intervention is appropriate and adequate. We will use the number of admissions into the State Hospital System and Psychiatric Inpatient Units during SFY2012, screenings at the ED and length of stay in the Medical Center ED as our baseline for the performance indicators.

Rationale:
Community Need Addressed:
- Community Need Area: CN.2 – Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.4 – Limited access for serious mentally ill adults to crisis services in Burnet County

A secure and safe community based crisis assessment alternative will give law enforcement officers and crisis responders new tools to provide a thorough assessment and resolve issues locally. It also supports better assessment and diversion of individuals from the ED thereby decongesting and improving access to emergency care for those who truly need that service. Internal reports from the BTCS medical record, Anasazi, indicates that there were 418 crisis screenings performed in Burnet County over the last 12 months. Over half of those, 211, were performed at an ED. The second largest number of screenings, 77, was performed at the jail. This indicates the need to locate a robust crisis screening and assessment unit in this County. BTCS participates in the Mental Health Task force for Williamson County and this group of leaders and health care professionals report that mentally ill people are taken inappropriately to EDs, jail and the State Hospital. Other than the data reported above related to admissions to the voluntary Crisis Respite facility, the community need being expressed is, to a certain extent, anecdotal. However, it is clear that we need to begin offering a community based crisis stabilization option even as we address the core components of this Project Option.

Project Components:
This project to provide involuntary Crisis Respite services for adults 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.* We will work in cooperation with Burnet County Sheriff's Department and the Medical Center staff to convene other health care and law enforcement stakeholders to identify gaps that lead to inappropriate admission to jail, EDs and short term stays in psychiatric hospitals. We will convene these community stakeholders during the remainder of FY 2013 to identify information needed to assess the gap in crisis services and assess root causes of inappropriate resource utilization.

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 will work closely with the Burnet County Sheriff's

Department to review and analyze records from the prior year concerning law enforcement transports to and from EDs in their own community and in Austin. In partnership with the Department and the Medical Center we will engage other health care, law enforcement and emergency responders to assess the elements of the current crisis system.

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 BTCS staff to assess admissions and dispositions to voluntary Crisis Respite and to all psychiatric facilities in the area. We will focus on those detained and transported during the last year.

d) *Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* Using the information gathered concerning client needs current crisis response patterns, we will redesign the communication and transport flow with the Sherriff's Department and the Medical Center. We will then identify tools and agreements needed to expand the use of the unit by all stakeholders in the County. We will use that information to recommend next steps for RHP 8.

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.* We will review the impact of the Crisis Assessment unit in relation to the other elements of the crisis response continuum and identify lessons learned and adjust the model with respect to area, 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.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project provides crisis assessment services to enhance the initiatives currently funded by the U.S. Department of Health and Human Services (DHHS). BTCS receives funds to operate substance abuse Outreach Screening and Referral services in Burnet and Williamson Counties and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services in this project; however, this project enhances and extends the care currently provided with Federal funds by a providing a local option to address crisis needs. We believe this crisis service will improve the healthcare outcomes for entire community, relieve pressure on law enforcement and ED's and promote stable community tenure for our patients.

Related Category 3 Outcome Measure:

- OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)

- IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate

Reasons/rationale for selecting the outcome measure: Readmissions to psychiatric facilities are driven by a number of circumstances surrounding the initial hospital stay. Those include the accuracy of the assessment of acuity, early release, poor or hurried discharge planning, inadequate knowledge of community resources and inadequate resources to accommodate a sound community placement. Creating the option to provide a thorough screening and evaluation in the community provides the opportunity to address several of these drivers. We can provide timely evaluations and quick stabilization linked to community follow up. We know the community resources including housing and treatment options. It also gives us the chance to intervene with those who otherwise would be readmitted rather than getting community help. Admissions to inpatient settings should be more appropriate and readmissions reduced.

Relationship to Other Projects:
This enhances additional projects that BTCS is pursuing related to Child Crisis Respite (#126844305.1.2) and Emergency Services Diversion (#126844305.2.2) in that it provides a site for thorough screening and assessment. We expect the other projects will demonstrate improved outcomes due to availability of crisis screening provided in the communities in which people live. It both supports and relies on Crisis Stabilization (#126844305.1.2) and the Transitional Housing (#126844305.2.1) projects which provide a place for people to stabilize and/or continue recovery in the community after stabilization is achieved. This option relies on expansion of Substance Abuse Services Adult and Youth in Williamson and especially Burnet County (#126844305.1.5) since some will need referral for that service.

Relationship to Other Performing Provider Projects and Plan for Learning Collaborative:
This project is somewhat related to Central Counties crisis respite project (#081771001.1.4), Hill Country MHDD's Co-occurring Psychiatric and Substance Abuse Disorder project (#133340307.2.1) and Trauma Informed Care (#1333403007.2.2).

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. The exchange of ideas through both developing and existing relationships will keep the line of communication open and will help us adjust and refine our programs and approaches to behavioral health care.

Project Valuation:
We expect to serve 200 people in this community based crisis alternative in DY4 and 300 people in DY5. Our goal is to increase utilization by 10% in DY4 and 15% in DY5. Serving people in the community is a substantial savings over using hospital and ED, which are now the only options. It also clearly provides patient benefit by timely access to care to help individuals achieve symptom relief and improved functioning. 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).

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails 126844305.1.4 (Project 1.13.1 – Pass 2) Category 1 Milestones and Metrics				
126844305.1.4	**1.13.1**	**1.13.1.a -- 1.13.1.e**	**Development of behavioral health crisis stabilization services as alternatives to hospitalization.**	
Bluebonnet Trails MHMR				**126844305**
Related Category 3 Outcome Measure (s):	**126844305.3.6**	**IT-3.8**	**Behavioral Health/Substance Abuse 30 Day Readmission Rate**	
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)**	
Milestone 1 [P-3]: Develop implementation plans for needed crisis services. **Metric 1** [P-3.1]: Produce data-driven written action plan for development of involuntary Crisis Assessment in Burnet based on gap analysis and assessment of needs. **Baseline/Goal:** Document a plan that includes all of the elements above and is specific to implementation of Crisis Assessment. **Data Source:** Written plan **Milestone 1 Estimated Incentive Payment: $341,612** **Milestone 2** [P-4]: Hire and train staff to implement Crisis Assessment service in accordance with Standards.	**Milestone 4** [P-7]: 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. **Metric 1** [P-7.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. **Baseline/Goal**: Participate in meetings as scheduled and disseminate information to stakeholders **Data Source:** Minutes, agendas,	**Milestone 5**[I-X]: Number of patient interventions **Metric 1** [I-X.1]: Number of patient in target population served by this emergency diversion service. **Baseline/Goal:** Baseline - 0 since no such service currently exists in the RHP; Goal - Serve 200 people in DY4. **Data Source:** EHR and program records. **Milestone 5 Estimated Incentive Payment: $1,089,000**	**Milestone 6** [I-X]: Number of patient interventions **Metric 1** [I-X.1]: Number of patient in target population served by this emergency diversion service. **Baseline/Goal:** Baseline - 0 since no such service currently exists in the RHP; Goal - Serve 300 people in DY5. **Data Source:** EHR and program records. **Milestone 6 Estimated Incentive Payment: $1,000,000**	

Metric 1 [P-4.1]: Number of staff hired and trained. **Baseline/Goal:** Hire all staff required by standards prior to operation. **Data Source:** Staff rosters and training records and training curricula, DFPS licensure reports **Milestone 2 Estimated Incentive Payment: $341,612** **Milestone 3** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services. **Metric 1** [P-5.1]: Completion of policies and procedures. **Baseline/Goal:** Complete all policies and procedures to achieve certification and to begin operation. **Data Source:** Manuals, internal record and certification reports. **Milestone 3 Estimated Incentive Payment: $341,612**	attendance rosters, public communication. **Milestone 4 Estimated Incentive Payment: $990,000**		
Year 2 Milestone Bundle Amount: $1,024,836	**Year 3 Estimated Milestone Bundle Amount: $990,000**	**Year 4 Estimated Milestone Bundle Amount: $1,089,000**	**Year 5 Estimated Milestone Bundle Amount: $1,000,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $4,103,836			

Category 1 Project Narrative – Pass 2
Bluebonnet Trails Community Services – 126844305.1.5

Project Area, Option and Title: 1.12.2 Expand the number of community based settings where behavioral health services may be delivered in underserved areas
RHP Project Identification Number: 126844305.1.5

Performing Provider Name: 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 Local Mental Health Authority (LMHA) for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is responsible for an array of public behavioral health services as well as for behavioral health planning and coordination throughout our local service area.
- **Intervention:** BTCS will establish outpatient substance abuse treatment sites in Georgetown and Marble Falls to meet the needs of a growing population, especially the poor, under or uninsured. The sites will be in our current facilities and will be licensed for supportive outpatient and intensive outpatient services.
- **Project Status:** BTCS currently does not provide direct substance abuse treatment services, only assessment and referral. There are no intensive outpatient substance abuse programs in Williamson and Burnet County.
- **Project Need:** This project addresses RHP 8 Community Need CN. 2.5: Limited access to behavioral health services, primarily substance abuse services for adults and youth who are poor and under and uninsured populations in need of outpatient and intensive outpatient care in Burnet and Williamson Counties. Those without resources cannot travel into Austin for services to achieve and maintain sobriety.
- **Target Population:** Target population is community referrals, and those referred from ED's in need of outpatient substance abuse services. BTCS served over 7,769 with behavioral health disorders in FY 2012. An average of 43% of adults were Medicaid-eligible; 76% of youth were eligible for CHIP or Medicaid and 73% of BTCS clients are below the federal poverty level. Approximately 70% of those benefitting from this project will be poor, under or uninsured. We expect to serve 700 a year by DY5.
- **Category 1 or 2 Expected Project Benefit for Patients:** 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 ED. The project seeks to provide services to 350 people in DY4 and 700 in DY5 at these new sites in Williamson and Burnet Counties. Providing services locally reduces ED utilization by reducing crises that stem from service gaps. Local services also improve treatment adherence and therefore satisfaction with access. Improvement Milestone I-X is the number of patient interventions in these new community based settings.

- **Category 3 Outcomes:** IT-10.1: The goal of this project is to help people with substance use disorders to transition to stable living in the community by providing access to community outpatient services. This is clearly a patient benefit and a community benefit. 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 achieving a sustained long term recovery improves quality of life and leads to this outcome. 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, community life and Quality of Life. The patient experience of health is one of the triple aims and measured here through report of improvement in the quality of the patients' lives.
- **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

Project Description:

Outpatient Substance Addiction Services for Adult and Youth

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. 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. BTCS proposes to establish outpatient substance abuse treatment sites in Georgetown and Marble Falls to meet the needs of a growing population, especially the poor, uninsured and/or underinsured. The services will be located in our current facilities in those cities and both sites will be licensed for both supportive outpatient counseling and intensive outpatient services. To accomplish this expansion of services we will renovate the spaces to prepare them for Facility Licensure, recruit and hire licensed counselors and prepare policies procedures and treatment protocols.

The goal of this project is to allow people who have limited resources to access intensive outpatient and supportive counseling substance abuse services in their home county. Many of these individuals will need this access following a detoxification stay in Travis County or after an Emergency Department (ED) visit in their home county or Travis County. Access to outpatient treatment following detoxification is essential to recovery. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies, "Admissions to detoxification treatment represent a special category of admissions. They are generally initiated because of an acute need for medical care. Detoxification is ideally followed by a transfer to outpatient or rehabilitation/residential treatment" (SAMHSA, Office of Applied Studies. *Treatment Episode Data Set (TEDS): 1997-2007. National Admissions to Substance Abuse Treatment Services*, DASIS Series: S-47, DHHS Publication No. (SMA) 09-4379, Rockville, MD, 2009). The relapse rate for those in treatment for substance use disorder is 40% to 60% and the variation in rate depends largely on the length of time sobriety is maintained following detoxification. The intensive outpatient substance abuse program and the supportive counseling services are well known in the industry and follow specific licensure and curriculum requirements. Intensive outpatient program will be provided four to six hours a day five days a week in group settings. Supportive outpatient services will be provided in group and individual sessions based on the stage of recovery and needs of the clients. We will provide psycho-education, peer support groups, solution focused and multi-faceted approach to care to include motivational interviewing, co-occurring psychiatric and substance use disorder services.

We expect the variety of services available, responsiveness of the design, staffing and locations to improve behavioral health functioning outcomes and significantly improve satisfaction. This project builds on the expertise and resources of BTCS related to services for the individuals with substance use disorders. When these sites are fully operational, they will serve a total of 700 a year. Individual progress and treatment outcomes will be documented in the electronic health record, Anasazi, and available for summary reporting as required.

Goals and Relationship to Regional Goals:
The goal of the expansion is to add intensive and supportive outpatient substance abuse services in Burnet and Williamson County. With this expansion we expect to improve health outcomes for persons in this area who now have limited access to behavioral health services. The challenges facing individuals in Williamson and Burnet County are that there are no intensive outpatient substance abuse programs in the area. To receive services people must travel into Travis County. For those who are poor and uninsured, the dilemma is exacerbated because there is no public transportation and even if transportation can be acquired and paid for, they could be treated only if they are eligible for Department of State Health Services (DSHS) programs. Substance abuse treatment is limited and frequently unavailable even though the disorder is prevalent among those requesting services.

Project Goals:

- Establish intensive outpatient and supportive outpatient substance abuse services in Williamson and Burnet County.
- Provide behavioral health care that is multi-disciplinary, recovery oriented and comprehensive.
- Provide behavioral health care, specific to substance use disorders, to all those in need regardless of income, insurance status or diagnosis.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs; and
- Increasing coordination of substance abuse and mental health care for residents.

Challenges:
The primary challenge for this project is to gain community acceptance as a provider of comprehensive substance abuse treatment services and to receive referrals from a broad range of community sources. Currently BTCS is known as the authority for substance abuse services and provides referrals for state-funded treatment. BTCS must become accepted as a comprehensive treatment provider by the community and by referring providers. The 'Treatment Episode Data Set' cited above indicates that nationally 37% of the referrals to treatment are from criminal justice agencies and 33% are self-referrals. We can license and offer a comprehensive range of services for adults and youth and a behavioral health team that is accessible, responsive and integrated into the community. This program will be successful only if referrals are forthcoming. We believe that establishing the services in our current locations will help with acceptance. Also we have excellent relationships with justice entities and use those relationships to achieve referrals. We will continue to participate in community task forces and forums to promote treatment and recovery and promote the success of treatment to the public.

5-Year Expected Outcome for Provider and Patients:
BTCS' goal is to establish outpatient substance abuse treatment sites in the two Counties and for a greater diversity of people with substance use disorders to be served in Williamson and Burnet County. We expect the outcome to be a greater acceptance of treatment as the sites are established in the community. We expect to see a growing level of satisfaction related to getting care quickly; integrated behavioral health care, cultural competency and perceived improvement in functioning. We believe that a successful program will reduce disparity in treatment for the poor and uninsured/underinsured and lead to a healthier more productive community. Over the next five years we expect the increase in the number of people accessing outpatient substance use disorder treatment to reach a capacity of 700 people served a year for Williamson and Burnet County residents. 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 the outcomes. The outcome expected is an increase in the quality of life for citizens of these Counties who access services.

Starting Point/Baseline:
This is a new project for BTCS in Burnet and Williamson County. There is no program for substance abuse treatment that targets the poor and uninsured in Williamson or Burnet County and therefore the baseline for DY2 is 0. We do not have current data to identify those from Burnet and Williamson 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 means of gathering and tracking that data. We are also aware that we must secure licensure for intensive outpatient substance abuse services.

Rationale:
Community Need Addressed:

- Community Need Area: CN.2 -Limited Access to Mental Health/Behavioral Health Services
- Specific Community Need: CN.2.5 - Limited access to behavioral health services, primarily substance abuse services for adults and youth who are poor and under & un-uninsured populations in need of outpatient and intensive outpatient care in Burnet and Williamson Counties.

The primary intent of this project is to establish a new substance abuse service location in an underserved area. There are no substance abuse providers in Williamson or Burnet County that focus on providing services to the poor and uninsured. Locating a service locally will increase utilization, eliminating the barrier of travel into Travis County that prevents the economically disadvantaged from accessing care. Through meetings with community stakeholders and participation in the Williamson county Mental Health Task Force and the Burnet County Mental Health Task Force, BTCS has identified that there is a lack of access to behavioral health care services in those Counties resulting in part from provider shortages and lack of insurance coverage. One of the most pressing deficiencies identified is lack of access to outpatient substance abuse treatment especially for the poor and uninsured or underinsured. By establishing intensive outpatient and supportive outpatient substance abuse treatment services in Williamson and Burnet County we will provide access for persons who have been diagnosed with and require treatment for substance use disorders.

According to the Williamson and Burnet County Community Needs Assessment, http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf

Williamson County is one of the fastest growing counties in the state. It grew by 69% from 2000 to 2010. Both Bell and Williamson Counties have a gap between segments of the population that leads to health care disparity. Areas of Williamson County have a population percentage below poverty of only 5.5% while other areas have a rate of 19.5% which is above the state average of 16.5%. Burnet County only grew by 22.5% during the same period but is picking up pace now. That county also shows a disparity in income, with the percentage below poverty being around 8% but in the segment of the population, female heads of household with children, it is 15% slightly below the state average. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health, 23.5 million persons aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009 (9.3% of persons aged 12 or older); of these, only 2.6 million—11.2% of those who needed treatment—received it at a specialty facility (http://www.drugabuse.gov/publications/drugfacts/treatment-statistics).

When access is problematic, the difficult decision to seek treatment is deferred or the problem denied. As stated above, BTCS does not currently provide behavioral health care to all persons, only to those in the priority population. We also do not provide substance abuse treatment as part of the behavioral health service array. Both of these are identified needs in this area. One critical disparity identified for RHP 8 is scarcity of behavioral health services throughout the region and especially in rural areas. As stated in the RHP Planning Protocol document, 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 Medicaid-eligible have no guarantee of access to needed services and may face extended waiting periods. Additionally, 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. However, many residents are unable to access either routine services or needed care in a timely manner because they lack transportation, are in poverty, lack insurance coverage or because they are unable to schedule an appointment due to work scheduling conflicts.

Core Project Components:

Although 1.12.2 does not have required core components listed with it, it is in the same Project Option as 1.12.1 and those required core components were used as a guide for our own components. We have reviewed the components, modified them and will address them as below:

a) *Evaluate existing locations of behavioral health clinics and to identify barriers to access including, transportation, operating hours, admission criteria and acceptable payment. If any of these barriers is a significant issue in care access, develop and implement improvements.* We know that our current locations do not offer substance abuse services and that there are none in these counties for the poor and uninsured/underinsured. As we open for services we will use satisfaction surveys and information from patients and families to determine how to eliminate barriers to service access.

b) *Review the interventions impact on access to behavioral health services and identify "lessons learned," opportunities to scale all or part of the interventions to a broader patient population, and identify key challenges associated with expansion of the interventions, including special considerations for safety-net populations.* We will establish a Plan, Do, Study, Act (PDSA) cycle improvement process through the Quality Management department of BTCS to collect and analyze data related to these interventions. That data will include ECHO™ Satisfaction Survey results and Electronic Health Record (EHR) data related to functioning scales and frequency in

the use of higher levels of care such as EDs and inpatient psychiatric care. We will assess the results; make improvements in the operation of this intensive outpatient service option as well as the supportive counseling service. We will hold community planning meetings with providers, patient advocates and community leaders in a number of communities to assess expansion opportunities.

We choose Milestones and Metrics for DY2 and 3 that represent the developmental nature of this new service. We will measure and report the development of policies and procedures, hiring staff and establishing the service. We know that achieving referrals and community acceptance is important to be able to serve the target population, so we selected he milestone concerning satisfaction with access for the Milestone and Metric for DY4. Once the service is established and the referral base secure, we will measure reduction in use of ED and detoxification facilities as the Milestone and Metric for DY5.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: BTCS receives funds from U.S. Department of Health and Human Services (DHHS) including Substance Abuse Prevention and Treatment Block Grant used to operate substance abuse Outreach Screening and Referral services in Williamson, Burnet and several other counties; and Community Mental Health services block grant used for outpatient mental health services. These DHHS funds will not be used for direct services in this project; however, participants could be referred and treated in those other programs ongoing or upon discharge. This project enhances and extends those services in the community. Many persons with a mental health diagnosis also have a co-occurring substance use disorder and as indicated there are no substance abuse services that are primarily for the poor and uninsured/underinsured. This project would continue the current direction of BTCS and provide integrated care; and to improve access in rural areas, for low income individuals and for everyone who requests and needs services.

Related Category 3 Outcome Measure:

- OD- 10 Quality Of Life/ Functional Status
  - IT-10.1 Quality of Life

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 with substance use disorders 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 achieving a sustained long term recovery improves quality of life and lead\s to this outcome. 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:
This enhances additional projects that BTCS is pursuing including: related to Crisis Stabilization for Persons in Behavioral Health Crisis (#126844305.1.2); and Emergency Services Diversion (#126844305.2.2); in that it provides access to care following those emergency interventions. We expect the other projects will demonstrate improved outcomes due to availability of outpatient and

aftercare services in the communities in which people live. It also supports the Transitional Housing Guided by Peer Support (#126844305.2.1), by offering the option of housing within the home community if needed.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
While this project shares a number of things in common with other LMHA's, the project Hill Country MHDD is planning regarding Co-occurring Psychiatric and Substance Use Disorders (#133340307.2.1) is the most similar.

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care. In an effort to ensure the exchange of ideas, the Williamson County Mental Health Task Force will be the primary conduit for our planning discussions.

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 ED. The project seeks to provide services to 350 people in DY4 and 700 in DY5 at these new sites in Williamson Counties. 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

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails 126844305.1.5 (Project 1.12.2 – Pass 2) Category 1 Milestones and Metrics			
126844305.1.5	**1.12.2**		**Expand the number of community based settings where behavioral health services may be delivered in underserved areas**
Bluebonnet Trails MHMR			**126844305**
Related Category 3 Outcome Measure (s):	**126844305.3.7**	**IT-10.1**	**Quality of Life**

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)
Milestone 1 [P-3]: Develop administrative protocols and clinical guidelines for projects selected **<u>Metric 1</u>** [P-3]: Manual of operations for the project detailing administrative protocols and clinical guidelines **Baseline/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: $522,840**	**Milestone 2** [P-4]: Hire and train staff to operate and manage projects selected. **<u>Metric 1</u>** [P-4.1]: Number of staff secured and trained **Baseline/Goal:** Develop curricula and hire licensed staff sufficient to begin providing outpatient services. **Data Source**: Project records; Training curricula as develop in DY2 **Milestone 2 Estimated Incentive Payment: $256,851** **Milestone 3** [P-6]: Establish behavioral health services in new community-based settings in underserved areas. **<u>Metric 1</u>** [P-6.1]: Number of new community-based settings where behavioral health	**Milestone 4** [I-X]: Number of patient interventions. **<u>Metric 1</u>** [I-X.1]: Number of patient in target population served at these 2 new sites. **Baseline/Goal:** Baseline – 0, since no such sites operated by provider are now located in RHP; Goal - serve a total of 350 in DY4. **Data Source: EHR** **Milestone 4 Estimated Incentive Payment: $517,052**	**Milestone 5** [I-X]: Number of patient interventions. **<u>Metric 1</u>** [I-X.1]: Number of patient in target population served at these 2 new sites. **Baseline/Goal:** Baseline – 0, since no such sites operated by provider are now located in RHP; Goal – serve a total of 700 in DY5. **Data Source: EHR** **Milestone 5 Estimated Incentive Payment: $466,063**

	services are delivered **Baseline/Goal:** Baseline – No current sites operated by provider for substance abuse services in RHP. Goal - Establish 2 sites **Data Source:** Site licensure records; Electronic Health Records demonstrating services at those sites. **Milestone 3 Estimated Incentive Payment: $256,850**		
Year 2 Milestone Bundle Amount: $522,840	**Year 3 Estimated Milestone Bundle Amount: $513,701**	**Year 4 Estimated Milestone Bundle Amount: $517,052**	**Year 5 Estimated Milestone Bundle Amount: $446,063**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,019,656			

Category 1 Project Narrative
Center for Life Resources – 133339505.1.1

Project Area, Option and Title: 1.11.1 Procure and build the infrastructure needed to pilot or bring to scale a successful pilot of the selected forms of service in underserved areas of the state
RHP Project Identification Number: 133339505.1.1

Performing Provider Name: Center for Life Resources
Performing Provider TPI #: 133339505

Project Summary:

- **Provider Description:** Center for Life Resources (CFLR) is a local mental health authority (LMHA) serving: Brown, Coleman, McCulloch, San Saba, Mills, Comanche, and Eastland Counties. CFLR serves a variable number of clients based on Department of State Health Services (DSHS)/Department of Aging and Disabled Services (DADS) contractual agreements. Currently, (FY2013) we are serving approximately 1,250 clients in a 7,074 square mile area with a population of approximately 102,497.
- **Intervention:** Through the implementation of a telemedicine model we will provide clinically appropriate treatment as indicated by a psychiatrist or other qualified provider throughout this expansive area. Thus reducing unnecessary emergency department (ED) and service use and improve consumer satisfaction/access were previously limited or unavailable.
- **Project Status:** This is a new project for this region (RHP 8 Counties of Mills and San Saba Counties). We will determine a baseline in DY2 that will serve as a foundation for future progress and monitoring. We expect to see a progressive increase in those served through DY5.
- **Project Need:** There currently is very limited to no access to psychiatric or other mental health care providers in this region (CN2.6). This fact has led to the federal distinction of mental health professional shortage area http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm. This limited availability often lends itself to utilization of unnecessary or inappropriate ED use. Further, as highlighted through the mental health professional shortage area map; there are inadequate numbers of providers willing to relocate to rural and frontier regions. We believe innovative solutions, such as telemedicine, must be considered and attempted to address the stated community need (CN 2.6).
- **Target Population:** The to be determined target populations we intend to serve are individuals residing in Mills and San Saba Counties suffering from serious mental illness. These primarily include but are not limited to individuals who either are Medicaid-eligible or are indigent. Our estimation based on current calculations and past billing is that no less than 50% of our clients currently meet this distinction. This would imply that at least half of those we serve in this new capacity through telemedicine would be Medicaid-eligible or indigent.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide 72 telemedicine encounters in DY4 and 84 in DY5. Through the implementation and subsequent provision of telemedicine services this project seeks to provide a satisfying, individually tailored service that also works to reduce unnecessary ED usage. Customer satisfaction will be measured using evidenced based satisfaction tools in DY4 and DY5. These two years will be

compared and steps to ensure continued satisfaction will be based on the subsequent data. Frequency of unnecessary ED usage will be accounted for through internal tracking in our electronic health records.

- **Category 3 Outcomes:** IT-9.2: ED appropriate Utilization (Standalone measure). Our goal is to reduce ED visits for the target conditions of behavioral health/substance abuse with baseline to be determined in DY2.
- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. Through the TAMHSC allocation, CFLR is now better able to plan and afford increased clinician time and directly impact the number and frequency of available appointments in this mental health professional shortage area. This increase in available clinician time is believed to have the ability to significantly impact those we intend to serve by increasing access where there was limited to none previously.

Project Description:

Telemedicine in Mills and San Saba Counties

According to the Health Resources and Services Administration (HRSA) as presented through the Department of State Health Services, both Mills and San Saba Counties meet the federally designated status of mental health professional shortage areas http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm. Mills and San Saba Counties have very limited to no access to local psychiatric service providers. Further, the distances traveled for potential treatment require travel outside of county. This creates increased hardship for individuals and families who have limited or no funds to travel to areas with psychiatric availability. Despite the limited access to care, consumer need has not been diminished and is often provided by non-mental health agencies. Both Mills and San Saba counties currently send individuals to an emergency department (ED) in one of three other counties (Brown, Lampasas, and Llano). This has significant costs to all counties as accounted through the possible unnecessary use of law enforcement, incarceration, ambulance services, and emergency department use.

Due to the difficult nature of obtaining and keeping psychiatric services in rural areas it is necessary to develop and implement other strategies to provide the needed services. Our project will address the issue of developing a community strategy by procuring and building the infrastructure needed to pilot or bring to scale a successful pilot of the selected form(s) of service in the proposed underserved areas (Mills and San Saba Counties) which will be combined with the following plan of action.

CFLR proposes that we can better address the psychiatric need in these rural community settings through the implementation of a telemedicine system.

Core Project Components:

a. *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.* CFLR or agent thereof, will identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in (Mills and San Saba) Counties as defined as a mental health professional shortage area.
b. *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.* This will be accomplished by assessing 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.
c. *Assess applicable models for deployment of telemedicine, telehealth, and telemonitoring equipment.* Further, we will assess the applicable models of deployment of telemedicine, telehealth, and telemonitoring equipment. This will be accomplished as we evaluate previously successful models also adopted in rural settings that might be successful in ours. This process will be done to determine feasibility and likely highlight the offsetting of costs associated with unnecessary ED services. Simply, we propose the use of a telemedicine system that will give greater access of care to citizens and reduce any unnecessary costs.

Due to our agency placing high priority on the right care, in the right place, at the right time, our regional project focuses on RHP Milestone I-15: Satisfaction with telemental services. We believe that satisfaction is an integral milestone when focusing on the right care, in the right place, and right setting. As telemedicine systems have not been indicated currently in this region other outside resources must be examined for efficacy. It is commonly accepted in private sector management that customer satisfaction is an important factor in determining utilization. It is believed that data will begin to demonstrate this belief after implementation in DY3. Our intention in the implementing of this project will be to show an increase in the number of those who would not normally be able to receive these services having greater access and greater satisfaction as a result.

Goals and Relationship to Regional Goals:

Project Goals:

Our goal is directly related to: OD-9 Right Care, Right Setting - IT-9.2 ED appropriate utilization: Reduce ED visits for target conditions for Behavioral Health/Substance Abuse.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs; and
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

Challenges:

The challenges that we foresee are those seen with adopting any new system into a community where there was not one previously. This implementation is likely to have “growing pains” and adjustments will be made regarding being new as well as adjusting to customer desire/needs.

5- Year Expected Outcome for Provider and Patients:
It is believed that each consequential year will see an increase in the number of people using this system. During DY2 we will use data sources (Anasazi systems, emergency room, and law enforcement) to determine a baseline need for services. Also during this time we will utilize surveys to monitor satisfaction of services provided. After a baseline is determined the CFLR will adopt and begin implementing standardized approaches to help reduce emergency room visits as well as patient satisfaction. It is estimated that there will be an increase in use in DYs 3 and 4 as people begin to see the benefits of this program. Further, with continued education and implementation of proven techniques we expect to produce the foundation for a vibrant and growing program that adapts to customer need while reducing unnecessary emergency department use. For patients we expect to reduce the need for excessive or unnecessary driving while providing high quality services that were not previously available in their area.

Starting Point/Baseline:
Baseline will be determined over the course of DY2 and implemented in DY3. This will be found through data collection sources such as local hospitals, law enforcement, and other sources as indicated.

Rationale:
Community Need Addressed:
- Community Need Area: CN.2 – Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.6 – Limited access to behavioral health services for rural populations in Mills and San Saba counties.

CFLR will meet all of the core project requirements (see Project Description). CFLR or agent thereof, will identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in (Mills and San Saba) Counties as defined as a mental health professional shortage area. This will be accomplished by assessing 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. Further, we will assess the applicable models of deployment of telemedicine, telehealth, and telemonitoring equipment. This process will be done to determine first feasibility and then determine if the project would be capable of offsetting the costs associated with unnecessary emergency department services. Some of the possible cost deferments are listed below although are not limited to these specific examples.

According to txpricepoint.org, the average cost accounted for just one possibly preventable condition such as psychosis at Brownwood Regional Medical Center (BRMC) is $6,030 a day with a median charge of $14,472. Another example of a possibly preventable condition is an acute adjustment & psychosocial dysfunction. BRMC has an average charge per day of $7,699 with a median charge of $16,939. Further research shows the average cost to transport an individual to a local hospital by local EMS services is $655. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, were an officer is on hand, can range from 1 to 3 hours. A law enforcement deputy's average pay can range from $12.50 to $15 per hour, so in an average situation this would be an additional $30-$45 cost. When multiplied by the average number of preventable situations per year, 24, the total

costs for EMS transport and law enforcement time is around $16,620 per year. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services. The given $16,620 is solely an average and our best estimation based on prior experience.

Even though these financial costs are significant, the human cost is much harder to measure can be even more significant. It is believed that early intervention in appropriate settings could reduce unnecessary utilization of community resources and emergency departments as well as improve individual care.

Our proposed project will address both of these issues by utilizing a tested application of technology through the use of telemedicine to address Community Need Area 2 and Specific Community Need 2.6. It is reasonably believed that the introduction of hi-speed internet in many of the rural areas greatly increases the viability of telemedicine. Given the need for the right care at the right time in the right place and addressing local needs, telemedicine provides great promise.

Continuous Quality Improvement: CFLR 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.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: We do not currently receive any U.S. Department of Health and Human Services funding that will be directly used for the implementation of telemedicine services.

Related Category 3 Outcome Measure(s):

- OD- 9 Right Care, Right Setting
  - IT-9.2 ED appropriate utilization: Reduce Emergency Department visits for target conditions for Behavioral Health/Substance Abuse.

CFLR has met with and spoken to several judges, law enforcement officials and county commissioners and has determined that there is a significant need for telemedicine services in their respective counties as telemedicine will assist in lowering costs for their departments while expanding and enhancing behavioral health services in these counties. Additionally, it will allow for the right care to be provided at the right place and the right time. We will develop a system to track the behavioral health clients served by this project through our internal database, Anasazi.

Relationship to Other Projects:

We are proposing to implement/enhance telemedicine services in seven counties covering RHP 8 (#133339505.1.1), RHP 11 (#133339505.1.1 & #133339505.1.2), and RHP13 (#133339505.1.1). Each of these projects will work to in tandem with the intended purpose of greatly increasing the likelihood of right care, at the right time, in the right setting.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Two other providers are proposing telemedicine projects, Central Counties Services (#081771001.1.2) and Hill Country (#133340307.2.3) but each covers counties different that those covered by CFLR. Collaboration is greatly encouraged and will be a part of our overall implementation and success. Further, as part of DY2 or DY3 as appropriate, CFLR will contact other similar providers to discuss the planning necessary for a learning collaborative and implementation.

Project Valuation:
This project seeks to provide 72 telemedicine encounters in DY4 and 84 in DY5. We plan to do this where no known similar services are being provided currently. Due to the nature of these locations and their distinction as mental health professional shortage areas, it is often difficult or even prohibitive for individuals to receive appropriate services in the right setting. Our valuation places priority on patient and community benefit through our pursuit of providing the right care at the right time in the right place. We have attempted to demonstrate the current cost of providing these services and the advantages of providing them locally through our proposed telemedicine project. The data will clearly demonstrating the need to attempt telemedicine services in this area.

Given the data provided above from txpricepoint.org and independent local research found in the rationale section, costs were determined to be roughly $16,620 per event. The stated per event cost multiplied by the number of individuals we plan to serve is significant and offers tremendous value through telemedicine. For instance, providing the same 72 encounters we intend to provide in DY4 in the current system would cost over 1.1 million dollars (72 * 16,620 =1,196,640). When adding in the additional services in DY5 the costs of provision for just those two years in the current system would be over 2.5 million dollars (84 * 16,620 = 1,396,080 + 1,196,640 = 2,592,720). Given the total four-year incentive payment of $557,921 the cost savings and value of providing right care in the right setting is a fraction of the cost (21%). It is our belief that our commitment to right care, at the right time, in the right setting offers an alternative option that would greatly improve patient and community care through local access at a comparatively lower cost. We do not believe that the value is limited to just cost savings.

Similar to other projects in our region we also looked at cost utility analysis and quality of adjusted life year (QALY) with respect to the varying level these were valued. Data provided by the Agency of Health Care Research and Quality (AHRQ) gave a range from $50,000 to $200,000 per (QALY) in the United States (http://www.ahrq.gov/research/iomqrdrreport/futureqrdrapf1.htm).

Our project looked at the value to community as a whole providing the funds, but also the value to the individuals receiving the services. Through the provision of quality local services in underserved areas, we would be afforded the unique opportunity to help those individuals who do not have the means to seek more expensive options outside of their area. We believe this availability has the direct effect of improving the quality of life for those suffering significant mental illness.

Center for Life Resources 133339505.1.1 (Project 1.11.1) Category 1 Milestones and Metrics			
133339505.1.1	**1.11.1**	**1.11.1.a – 1.11.1.c**	**Procure and build the infrastructure needed to pilot or bring to scale a successful pilot of the selected forms of service in underserved areas of the state (this must be combined with one of the two interventions below).**
Center for Life Resources			**133339505**
Related Category 3 Outcome Measure (s):	**133339505.3.1**	**IT-9.2**	**ED Appropriate Utilization**

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)
Milestone 1 [P-1]: Identify Texas Counties having availability of high speed broadband communication lines. **Metric 1** [P-1.1]: Documentation of assessment of counties that identifies areas of state that have or lack capacity for high speed broadband connections capable of supporting telemedicine, telehealth, telemonitoring. **Baseline/Goal:** Baseline - Results of the assessment rationale/evidence; Goal - Implement telemedicine in underserved area to improve access and provide right care, right setting service. **Data Source:** Filed record of research.	**Milestone 2** [P-7]: Hiring of tele-presenters, as needed, for remote site equipment operation. **Metric 1** [P-7.1]: Number of staff hired and trained. **Baseline/Goal:** Hire one licensed staff and one peer support specialist. **Data Source:** Interviews with staff, review of hiring or payroll records, appropriate licensure records. **Milestone 2 Estimated Incentive Payment: $121,310**	**Milestone 3** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service. **Metric 1** [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles. a. Project reports including 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). Project reports also include output measures which describe the number and type of telemental transactions which occur. **Baseline/Goal:** After implementation we will use real-time	**Milestone 5**[I-15]: Satisfaction with telemental services. **Metric 1** [1.15.1]: XX% of consumer, peer and provider surveys indicate satisfaction with telemental services. a. Numerator: TBD Number of patients, peers and providers reporting satisfaction b. Denominator: TBD Number of patients, peers and providers surveyed **Baseline/Goals:** We set as our goal for 63 of the 84 (75%) encounters we plan to provide to be classified as satisfying to the individual by the end of DY5. Depending on the actual encounter numbers, should they vary, we maintain a goal that 75% of encounters will be classified as satisfying to the individual. **Data Source:** Use of evidenced based satisfaction tools used in appropriate

Milestone 1 Estimated Incentive Payment: $186,681		data analysis of our Anasazi database system. Specifically, telemedicine will have its own tracking code through which we can run real-time monitoring. **Data Source:** Standards will be set and routinely monitored through Anasazi **Milestone 3 Estimated Incentive Payment: $62,156** **Milestone 4** [I-X]: Provide telemedicine services. **Metric 1** [I-X.1]: Provide documentation of telemedicine encounters. **Baseline/Goal:** Provide 72 telemedicine encounters over baseline. **Data Source:** Standards will be set and routinely monitored through Anasazi our electronic health record system **Milestone 4 Estimated Incentive Payment: $62,157**	format. **Milestone 5 Estimated Incentive Payment: $62,809** **Milestone 6** [I-X]: Provide telemedicine services. **Metric 1** [I-X.1]: Provide documentation of telemedicine encounters. **Baseline/Goal:** Provide 84 telemedicine encounters over baseline. **Data Source:** Standards will be set and routinely monitored through Anasazi our electronic health record system. **Milestone 6 Estimated Incentive Payment: $62,809**
Year 2 Milestone Bundle Amount: $186,681	**Year 3 Estimated Milestone Bundle Amount: $121,310**	**Year 4 Estimated Milestone Bundle Amount: $124,313**	**Year 5 Estimated Milestone Bundle Amount: $125,618**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $557,921			

Category 1 Project Narrative
Central Counties Services – 081771001.1.1

Project Area, Option and Title: 1.1.1. Establish more primary care clinics
RHP Project Identification Number: 081771001.1.1

Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations (MUP).
- **Intervention:** This project will provide school-based mental health services for children ages 5-9 (K-3rd grade) who have difficulty adjusting to the classroom environment due to emotional/behavioral problems. Counseling services may include the child's family. Services will be provided in the Temple Independent School District's (TISD) elementary schools.
- **Project Status:** This is a new project.
- **Project Need:** In FY2012, TISD had a grade retention rate for children K-3 that was 5.23%, almost twice the state average retention rate (2.95%). The TISD staff identified 163 children in K-3 (excluding special education children) who were poorly adapted to the classroom setting due to emotional/behavioral problems (see Addendum 1F). See also CN2.7: Lack of school-based behavioral health services in Temple.
- **Target Population:** 163 children were identified in school year 2011-2012 as needing this service. The number of children to be served under this project are estimated to be 120 in DY3, 140 in DY4, and 160 in DY5 – most children's services will be quite complex and will include family counseling as well as individual and group counseling. The exact number of children who have Medicaid in this new project is unknown. Kids Counts from 2010 indicated that 24.2% of Bell County children were Medicaid clients in 2010. In addition, 80% of the children in K-3 at TISD participate in the subsidized/free meals program. We anticipate the children we serve will be at least similar to the Kids Counts figures, if not higher.
- **Category 1 or 2 Expected Project Benefit for Patients:** This project provides mental health services to approximately 150 K-3 children per year. Services will help children address their emotional/behavioral problems experienced in the classroom with the goal of moving children from being poorly-adjusted to being evaluated as moderately or well-adjusted to the classroom setting. The target for demonstrating this improvement will be

60 children in DY3, 84 children in DY4, and 112 children in DY5. Patient satisfaction with school-based mental health services is expected to improve each year the service is offered (see Improvement Milestone I-11.1). The goal will equate to a satisfaction survey that is scored on a 100 point scale with the score of 1-35 = poorly satisfied; 36-70 = moderately satisfied; & 71-100 = highly satisfied. The Center would expect the number of children to score in the moderate to high satisfaction range will increase from DY3-DY5 (50%, 60%, and 70% respectively), with satisfied children meaning there is positive value in the services.)

- **Category 3 Outcomes:** IT-10.1: Improve quality of life functioning/level of adaptation to their school learning environment – DY4 to be 15% improvement above the baseline, and DY5 to be 25% above that baseline scores. The impact of behavioral change for at least 210 children 5-9 years old that will make a quality of life, social and vocational difference in the 70 plus years for each child (14,700 person-years) that follow these effective interventions and skill development activities.
- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. This new service for our region will be truly transformational for these children in that those children served will have increased academic achievement and vocational achievement for 70+ years for each child whose school-setting adjustment improves in these first years of school. We intend to document this new service in a manner that it can be duplicated in other schools in our area, and throughout the state.

Project Description:

School-based behavioral health services

The Center will work with Temple Independent School System (TISD) to develop a behavioral health adjustment evaluation tool based on each child's behavior, attendance, and academic performance. This tool will then be applied to all kindergarten through third grade students (total of 2,897 children last school year) in the TISD system and will reflect a) those students who are well adjusted to scholastic achievement, b) those students who are moderately well adjusted to scholastic achievement, and c) those students who are poorly adjusted to scholastic achievement (163 K-3rd grade children identified as such in school year 2010-2011).

For this project the Center will employ 6 properly trained and credentialed clinical staff who will be housed within the different elementary schools of TISD to work with the TISD children identified as poorly adjusted to the scholastic environment/scholastic achievement goals. They will connect with our Center's electronic health record system which will document each child's assessment, improvement plans and progress towards their individual improvement goals. The children will be referred to this in-school clinic by TISD staff and will be jointly staffed with the assigned school counselor, the child's teacher, and the attendance officer of that school (child's guidance team). The Center staff will observe the children in his/her classroom setting and

meet with the parent(s) to discuss the child's adaptation difficulties. The child's quality of life inventory will be completed by the appropriate parties to establish a base-line measure by which to measure improvement in the child's quality of life. This will give the clinical staff another perspective on the child's adaptive skills and deficits and will serve as a core element in shaping the clinical/social interventions chosen for each child. An individualized improvement plan will be developed and reviewed with the above referenced team, the child's parent(s), and the child. The improvement plan will include such elements as: individual/group skill building activities to improve coping skills, attention to tasks, etc., role playing, social situation rehearsing, focused interventions to extinguish certain behaviors, while teaching alternate, more appropriate behaviors, family counseling, parent education, and other efforts to improve, when possible, the child's support in his/her home environment as well, etc. This child's parent(s) and teacher will be advised of the child's improvement plan content and goals and will be advised how they can support the child's improvement efforts in the classroom and at home. Each child's progress towards improving his/her quality of life will be assessed after 6 months of services and every 90 days thereafter. It is expected that each child served by this project will steadily improve his/her level of school adjustment/functioning each time that it is measured (See Category 3 Outcomes section below) with an age-appropriate quality of life inventory. These assessments will be shared with the child's guidance team and the child's personal improvement plan will be adjusted accordingly to guide the child's continued improvement.

These school-based behavioral health services will be designed to work with the children identified by the TISD staff as poorly adjusted to scholastic achievement, with the goal of moving 20% of the children evaluated as poorly adjusted up to the moderately adjusted category during the first full school year (2013-2014). It is expected that those children with the poorest personal adjustment to the school setting/scholastic learning environment will stay enrolled in these services until their score moves them to the moderately well-adjusted group of children. This project should also have an impact of reducing the number of children held back in their grade due to behavioral/mental adjustment-related problems (TISD held back 5.23% of its K-3rd grade students in the 2010-2011 school year compared to the state average of 2.95% being held back for these same grades). The 6 credentialed behavioral health staff who are trained in child mental health and behavioral counseling would work with the children identified as poorly adjusted scholastically to improve each identified.

This project will also seek frequent satisfaction feedback from the students, family and other third party stakeholders regarding ways to improve the service engagement of the child and his/her family. Initial resistance to these services is seen as a potential challenge/barrier to children using these services, and this "plan, do, study, act" rapid assessment and process improvement efforts.

Goals and Relationship to Regional Goals:

Project Goals:

Expand the capacity of/access to behavioral health services for children K-grade 3 in the Temple Independent School District setting who are poorly adjusted to scholastic achievement due to personal or familial behavioral health problems in order to assist these children to improve their ability to successfully function in the school environment. Provide early intervention for

behavioral health problems of young children which is often more successful than a later intervention, and is accomplished at less personal quality of life costs for the patient, as well as less financial cost to successfully intervene/reduce/resolve the behavioral health problem.

This Project meets the following Regional Goals:

- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Improving access to timely, high quality care for residents, including those with multiple needs.

Challenges:
We may see some initial resistance on the part of parent(s) to allow their child to participate in these services, and some reluctance on the part of the parent(s) to participate in these services due to the stigma associated with behavioral health problems/services. We plan to put together a simply-worded brochure for the use of teachers and to be sent to parents. It will describe the benefits of this behavioral health school-based project and how to access these services. We plan to closely monitor the patient/parent(s) satisfaction/dissatisfaction with service aspects to increase this project's ability to engage both children and parents in addressing these behavioral health problems that affect each child's ability to perform well in school.

5-Year Expected Outcome for Provider and Patients:
Progressively assist those children served by this school-based project to increase their personal quality of life functioning in the school environment and their ability to successfully move up to the next grade level along with the children of their age group. By having this school-based behavioral health clinic in place for four successive years, we should see a dramatic reduction of the number of children experiencing school adjustment-type behavioral problems as they enter the fourth grade. This school-based behavioral health clinic should have a dramatic effect on lowering the number of children who do not pass to the next grade. By DY5 the number of 3rd grade children retained in grade 3 should be significantly below the state average (2%) for children being retained in grade 3.

Starting Point/Baseline:
Within the first several months of this project, TISD staff and staff hired by this project will develop an evaluation tool/process to assess how well children from age 5 through 9 are adapting to the school environment. This evaluation tool/process will be applied to all children in TISD grade K-3 (approximately 2,900) to determine their level of functioning in the school environment. This process will establish the number of children assessed as poorly adjusted to scholastic achievement, and will give them a scholastic adjustment score. Those children with the lowest scholastic adjustment scores will be the first children to be referred to the school-based behavioral health clinic staff. The children selected for referral to this project will then have an age-appropriate quality-of-life survey completed. The child's score/rating on this quality-of-life survey will serve as that child's baseline score/ranking for measuring future progress.

Rationale:

Community Need Addressed:

- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.7 - Lack of school-based behavioral health services in the Temple ISD

Our Center has a child/adolescent behavioral health clinic in Temple. That clinic serves about 180 children and has a waiting list for children/families seeking our services. The majority of our patients at this clinic are 10 years old and above. We find that many families bring their children who have behavioral adjustment problems to our clinic almost as a last resort. The parents have exhausted their own and their family's network resources in their attempts to cope with their multi-problem child. At this time, unfortunately, we see that these children with severe problems often have very young parents who themselves lack mature, adult coping skills. We have long desired to find a way to intervene with these children and their families at earlier stages of their problems, before the child and parents adopt such oppositional ways of relating around the problem behaviors.

When the 1115 Waiver was approved for Texas, Central Counties Services approached the TISD Superintendent to determine if there were any ways that we could implement school-based child behavioral health services for the youngest children in the TISD system and that discussion led to the development of this project which will focus on the youngest children in the TISD system. The need for school-based, early-intervention behavioral health services was soon demonstrated with the following facts from TISD (See Addendum 1F). 2,897 K-grade 3 students were in the TISD system in school year 2011-2012, and 5.2% of these children were retained in their current grade, compared with the state of Texas average rate of 2.9% retention for children in these same grades. The TISD staff informally identified 163 students in these 4 grades who were poorly adjusted to the school environment and the scholastic expectations for learning achievement. The TISD staff informally evaluated all of these 163 students of having personal or family behavioral health problems that were affecting the child's ability to function well in the school environment. These young children are just developing their social-relational skills, behavior patterns and school attitudes and have the most potential to benefit from behavioral health intervention, skill building activities and their parents can be the most motivated to make changes to increase appropriate family support. School-based behavioral health services are have "been shown to be effective because the health care is located conveniently for patients and is in a setting that is familiar and may feel 'safe' (see RHP Planning Protocol, p. 11, P-2.1.c.)." Such school-based services are viewed with less stigma than community-based behavioral health services. Effective early behavioral health intervention with these young children can have a very profound positive impact on their educational experience and vocational success as young adults.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project does not supplant any services or funds currently provided to Central Counties Services through the U.S. Department of Health and Human Services or the Texas Department of State Health Services. These services proposed to be provided under this project serve to enhance, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

Related Category 3 Outcome Measures:

- OD-10 – Quality of Life/functional Status
  - IT-10.1 Quality of Life

IT-10.1: Quality of Life; functioning for children enrolled in school-based behavioral health services for 6 months or more. Quality of Life functioning scores would improve by 10% over baseline scores in DY3, 15% in DY4 and 25% in DY5.

Showing improvement in the quality-of-life functioning of the children enrolled in these services will serve as the basis for demonstrating the positive impact of this school-based behavioral health clinic. The children's quality of life functioning/level of adaptation to the scholastic environment will be measured through the use of an evaluation tool when the children are first referred to the clinic (baseline score), and then again after 9, and 15 months participation in the clinic's services to demonstrate quality of life/level of adaptation to the scholastic environment improvement. The percentage of quality of life functioning/adaptation to the scholastic environment improvement is expected to be 15% and 25% at the respective reassessment intervals. For many of the children served in this project these improvement levels will make possible their passing from one grade to the next due to increased behavioral and social adaptation to the school group-learning environment. They will have learned how to adapt and thrive in the socio-learning environment so that they can successfully prepare for life as independent functioning adults. The long-term view of these children should show a lower than average school dropout rate, higher than average graduation rate and good educational/ vocational readiness for their next life stage as young adults.

It is expected that a very small number of children will have neurologically complicated behavioral adjustment problems who will not thrive as significantly as most children are expected to do in this project. Early identification of children who are in this circumstance can lead to early referral to more sophisticated diagnostic evaluations and more intensely structured services that will be beyond the scope of this project. Even these children will be well served by the early identification of their complex bio-neurological condition and an early referral to services qualified to care for these children's complicated developmental needs.

Relationship to Other Projects:

This project is focused on increasing access to behavioral health services and is similar to our telemedicine (#081771001.1.2) and clinical efficiency improvement projects (#081771001.1.5) which have a similar goal of increasing patient access to behavioral health services. This project will rely heavily on wireless access to our Center's electronic health record clinical system, (#081771001.1.5) and will require continuity of access to this record system throughout this project. The early identification and intervention with these young children are expected to reduce their likelihood of needing further behavioral health services as teenagers and young adults. By having these services school-based we want to reduce the stigma attached to being involved with behavioral health services among the children served and their classroom peers.

Other Center projects include:

- 081771001.1.3 Expand the number of community based setting where behavioral health services may be delivered in underserved areas
- 081771001.1.4 Develop and implement crisis stabilization services to address the identified gaps in the current community
- 081771001.2.1 Apply evidenced-based care management model to patients identified as having high-risk care needs
- 081771001.2.2 Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations
- 081771001.2.3 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Central Counties Services is committed to improvement of services and broad-level delivery system transformation. To our knowledge, no other provider is addressing the behavioral health needs of children ages 5-10. We are therefore quite willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Project Valuation:
This project is expected to help 120 children in DY3, 140 in DY4, and 160 in DY5 – most children's services will be quite complex and will include family counseling as well as individual and group counseling. The valuation of this project includes the development of a student assessment system that identifies children who are poorly adjusted to scholastic achievement; hiring 6 properly credentialed mental health/behavioral intervention staff; cost of on-going clinical training of direct care staff on early childhood behavioral health issues; cost of equipment/supplies that they will need to perform their work and to insure the confidentiality of their work with TISD children and to remotely connect to the Center's clinical data system (EHR); cost of satisfaction surveys and training to properly administer them; cost of formulating and delivering reports at the learning collaborative sessions; cost of clinical activity and teaching materials, and consumable activity supplies; design and printing of brochures/pamphlets describing the services provided by this project for distribution among teachers and parents; clinical supervisory time to insure clinical quality of services; communication devices to efficiently interact and receive clinical support/guidance from their supervisor; the offsetting cost of children repeating a year of school; the value of early intervention and its positive impact on children's academic achievement in future school years and in their beginning vocational years; valuation also includes program indirect costs and administration overhead costs; valuation for DYs 3-5 include provisions to cover staff compensation increases and inflation. Valuation includes the **impact** of significant behavioral change expected for at least 210 children 5-9 years old that will make a quality of life, social and vocational difference in the 70 plus years for each child (14,700 person-years) that follow these effective interventions and skill development activities.

Central Counties Services – 081771001.1.1 (Project 1.1.1) Category 1 Milestones and Metrics				
081771001.1.1	1.1.1		Establish More Primary Care Clinics	
Central Counties Services				081771001
Related Category 3 Outcome Measure (s):	081771001.3.1	IT-10.1	Quality of Life	
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)	
Milestone 1 [P-X] *(see page 7 of the Planning Protocol):* Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development and or program/process redesign. **Metric 1** [P-X.7]: Documentation of detailed behavioral health, school-based clinic implementation plan **Baseline/Goal:** Baseline **-** No school-based behavioral health services are currently being delivered at the Temple ISD sites; Goal - Design a school-based behavioral health services program with a capacity of serving an active caseload of 120 children/families. **Data Source:** School-based Mental	**Milestone 3** [P-X] *(see page 7 of the Planning Protocol):* Establish a baseline, in order to measure improvement over self. **Metric 1** [P-X.6.1]: Select and administer patient satisfaction surveys to enrolled children to establish a services satisfaction baseline. a. Numerator: Sum of all survey scores, b. Denominator: Number of surveys completed. **Baseline/Goal:** Baseline - No service satisfaction rating is known as this is a new service; Goal - Establish a baseline service satisfaction rating for these services. (The Center expects that at least 50% of the children will score in the moderate	**Milestone 4** [I-11]: Patient satisfaction with school-based clinic services. **Metric 1** [I-11.1]: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period. a. Numerator: Sum of all survey scores, b. Denominator: Number of surveys completed. **Baseline/Goal:** Baseline - Baseline service satisfaction rating was determined in DY3. Goal - Increase the average service satisfaction rating The Center expects 84 of the children served in the program will score in	**Milestone 6** [I-11]: Patient satisfaction with school-based clinic services. **Metric 1** [I-11.1]: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period. a. Numerator: Sum of all survey scores, b. Denominator: Number of surveys completed. **Baseline/Goal:** Baseline - Determined in DY3. Goal - Increase the average service satisfaction rating. The Center expects 112 of the children served in the program will score in the moderate to high satisfaction range. **Data Source:** CG-CAHPS[20] or other	

20 http://www.ahrq.gov/cahps/clinician_group/

Health: An Empirical Guide for Decision-Makers**,** School-based Mental Health Network – Arkansas Dept. of Education, School-based Mental Health Tool Kit-2008-Cuyahoga County School Districts, American Academy of Pediatrics: School-based Mental Health Services, School-based Mental Health in Illinois, et al. **Milestone 1 Estimated Incentive Payment: $281,555** **Milestone 2** [P-X]: Designate/hire personnel or teams to support and/or manage the project. **Metric 1** [P-X.8]: Documentation of hiring behavioral health providers to staff the newly implemented school-based behavioral health clinic. **Baseline/Goal:** Baseline – No existing school based health clinic staff; Goal - Hire 6 properly trained behavioral health staff to provide services in this project. **Data Source**: Human Resource Department hiring records	to high satisfaction range.) **Data Source:** CG-CAHPS[18] or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. **Metric 2** [P-X.6.1]: Documentation of the number of children served by clinical staff during the school year. **Baseline/Goal:** Baseline - No service encounter number/level is known as this is a new service. Baseline is estimated to be 120 children served in DY3. Goal - Establish a baseline service number of children served by clinical staff by which to measure future improvement. **Data Source**: Center's electronic health record system. **Milestone 3 Estimated Incentive Payment: $632,611**	the moderate to high satisfaction range. **Data Source:** CG-CAHPS[19] or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. **Milestone 4 Estimated Incentive Payment: $340,681** **Milestone 5** [I-12.2]: Increase the number of children receiving behavioral health services. **Metric 1** [I-12.2]: Documentation of increased number of unique patients. **Baseline/Goal:** Baseline – Estimate 120 children will be served DY3; Goal - Increase total number of children served to 140 children in DY4. **Data Source:** Center's electronic health record system. **Milestone 5 Estimated Incentive Payment: $340,682**	developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. **Milestone 6 Estimated Incentive Payment: $369,750** **Milestone 7** [I-12.2]: Increase the number of children receiving behavioral health services. **Metric 1** [I-12.2]: Documentation of increased number of unique patients. **Baseline/Goal:** Baseline – Estimate 120 children will be served DY3; Goal – Increase total number of children served to 160 children in DY5. **Data Source:** Center's electronic health record system. **Milestone 7 Estimated Incentive Payment: $369,750**

18 http://www.ahrq.gov/cahps/clinician_group/
19 http://www.ahrq.gov/cahps/clinician_group/

Milestone 2 Estimated Incentive Payment: $281,555			
Year 2 Milestone Bundle Amount: $563,110	**Year 3 Estimated Milestone Bundle Amount: $632,611**	**Year 4 Estimated Milestone Bundle Amount: $681,363**	**Year 5 Estimated Milestone Bundle Amount: $739,500**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,616,584			

Category 1 Project Narrative
Central Counties Services – 081771001.1.2

Project Area, Option and Title: 1.11.2 Implement technology-assisted behavioral health services by psychologists, psychiatrists, and other qualified providers.
RHP Project Identification Number: 081771001.1.2

Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012 we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
- **Intervention:** This project will double our telepsychiatry use from 1 FTE to 2 FTEs by enabling up to 4 simultaneous telepsychiatry/telehealth users on a high quality telemedicine system. This project also funds a second FTE psychiatric provider, to improve both timely patient access to psychiatry services and medication compliance.
- **Project Status:** This project upgrades existing marginally-functioning telepsychiatry equipment. It is an expansion of current telepsychiatry services and will serve an additional 400 patients in DY5, compared to 100 patients now served by telepsychiatry.
- **Project Need:** CN.2.8 Lack of access for adult behavioral health care in Bell, Lampasas, and Milam Counties. The Center's current telemedicine equipment is unreliable and cumbersome to use. Improved telepsychiatry equipment will expand the number of patients served by telepsychiatry, thus improving access to residents *i*n rural areas who may not have means of transportation to receive psychiatric services.
- **Target Population:** This project's target population is adults with severe and persistent mental illness living in the more rural parts of our service area. 97% of the Center's patients are Medicaid (41.89%), uninsured, or indigent. We expect the same percentages of Medicaid, uninsured and indigent patients will benefit from this project.
- **Category 1 or 2 Expected Project Benefit for Patients:** Improved access to psychiatry services via telemedicine technology. We are currently serving 121 persons per month (September 2012) via telepsychiatry and this project should enable us to increase the number of persons receiving psychiatric services via telepsychiatry to 200 persons per month in DY3; 300 persons per month by the end of DY4; and 400 persons per month by the end of DY5.
- **Category 3 Outcomes:** IT-6.2: Other Improvement Target: TBD% of patients receiving psychiatric services via the improved telepsychiatry technology will be satisfied with

quality of those services. The Center expects greater than 50% of the 900+ patients to be served by telepsychiatry under this project will be satisfied with the quality of the services they have received. Patient level of satisfaction with their services is a touchstone measure for the patient's confidence in the services they are receiving and how willing they are to adhere to their service provider's directions regarding their medication, suggested behavioral/lifestyle changes encouraged by their provider, and their attendance/participation at their assigned service appointments.

- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. The improved telemedicine system and additional telemedicine FTE in this project is transformational in that it will finally give us the means to overcome our psychiatric care shortage for our medically underserved behavioral health populations of our service region, which we have experienced for several years. We will now be able to electronically recruit psychiatric services instead of depending on our ability to physically recruit psychiatry services to our geographic service region.

Project Description:

Increase service access to hard-to-recruit psychiatrists and advanced nurse psychiatric practitioners by revamping Central Counties Service's (Center) telepsychiatry/telehealth system.

This project is essential to our Center's ability to obtain/provide sufficient psychiatric services to meet the behavioral health service needs of citizens in our 5-county service region. Having a highly efficient/effective telemedicine/telehealth system will greatly increase our ability to contract for adequate psychiatric coverage which has been a problem in the recent past. See more detailed information in the "Rationale" section below.

Our Center obtained a Telecommunications Infrastructure Grant in 2001 to install a telemedicine system among its 13 facilities in our 5 county region. This analogue system presents difficulty with telepsychiatry services for psychiatrists who are outside of our service region, in that the video often pixilates such that the other person's image can't be seen. We also have difficulty in which we get a picture, but no sound, so the psychiatrist has to manage the audio portion of the service via a speaker phone with long distance charges. Our current system cannot support more than one telemedicine provider on the system at a time.

The new system to be obtained under this project will have a digital, high definition signal rather than analogue signal and be much more crisp in both picture and audio. The new system would be engineered to manage 4 telemedicine sessions at once. It would be available for our Center's centralized intake services for adults with severe/persistent mental illness. New telemedicine transmission lines would separate our electronic telemedicine signals from our data and voice-over-internet-protocol (VOIP) phone system signals. This new, dedicated

transmission lines would accommodate increased electronic transmissions of multiple, simultaneous telemedicine sessions with no degradation of audio/video signals. This upgraded system will also increase service-delivery efficiency by our current contract telepsychiatry providers. With increased productivity comes increased access (capacity) to psychiatry services. This project includes the expansion of telepsychiatry services by adding one FTE telemedicine psychiatrist and a remote site LVN service facilitator in DY3 through DY5.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to increase access to telepsychiatry services in a manner that results greater operating efficiency (productivity), and in patients being well satisfied with the services they receive via this technology. It is the intent of this project to put into place a telepsychiatry system that has a very reliable, high definition video/audio signal that can accommodate 4 simultaneous sessions, and which always synchronizes the audio and video portions of the transmissions so that movement on the screen is very fluid/life-like, and colors in the video pictures are undistorted. These video transmission qualities are important factors in our patients' willingness to receive services via this technology.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

The Center has several projects that are focused on increasing access to behavioral health services and providing levels of care that can help divert persons in behavioral health crisis from being admitted to a psychiatric hospital or incarcerated in a local jail due to the committing of minor offenses (#081771001.2.3 - Social Rehab Day Services and #081771001.1.4 - Crisis Respite Services). All of these projects document the shortcomings of our current behavioral health system, and seek to put into place levels of safety-net infrastructure services to more adequately meet the behavioral health needs of our regional citizens. The more prevalent tele-psychiatry services are, the more community centers can share their specialized psychiatric staff, and the more future potential there is to also provide psychiatry service links to local jail booking areas and to small rural emergency departments that have no psychiatry access.

Challenges:

Our five counties contain several phone grids which have to be used to get continuous high quality signals. We will need highly professional consultation on what parts of our current system (if any) can be used in the new system. The length of time to carry out this upgrade may be longer than we anticipate, and spread into DY3. Our main Center facility that houses the new video system core elements is in an older section of Temple where all utilities are above ground and subject to wind/weather damage from trees/branches falling. A power outage at our Temple main Center building would result in our telemedicine services being inoperable throughout our 5 county region. The Center is taking steps to insure the continuity of electrical supply (#081771001.1.5) and the telemedicine system's availability at all times.

5 Year Expected Outcome for Provider and Patients:
The Center expects to improve our access to psychiatrists over the next five years. We intend the telemedicine system to deliver audio/visual access to the Center's remote locations at a high level of quality that is satisfactory for our patients' participation in our services delivered via technology by providers who live outside of our service area. We are expecting to serve 279 more people per month via telepsychiatry in DY5 than we are currently serving per month prior to this project-that equals 3,468 more patients served (contains some duplication) in DY5 than our Center was serving prior to this project implementation. This upgrade of telemedicine equipment and transmission lines will also give improved access to our centralized intake service staff who will be able to connect with any Center clinic's telemedicine equipment to perform remote intake evaluations.

Starting Point/Baseline:
Our Center currently contracts with 2 psychiatrists to provide telepsychiatry services and provided telepsychiatry services to 121 patients (baseline) in September 2012. Our Center has its billing systems and data collection systems set up to manage telemedicine services. All services can only be scheduled with only one provider active in the telepsychiatry system at a time. With the combination of our cumbersome clinical software system and our difficulty maintaining a good video/audio signal with our current televideo system, our telepsychiatrists are averaging only a little above 40% productivity, which will serve as the baseline to measure productivity improvement (Milestones 8, 11, 13) with the new system. Our patients' satisfaction level with behavioral health services provided via the new telemedicine technology will be measured by patient surveys beginning in DY3 to establish a baseline regarding each patient's level of satisfaction/dissatisfaction with services delivered via the new telemedicine technology.

Rationale:
Community Need Addressed:

- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.8 - Lack of access for adult behavioral health care in Bell, Lampasas, and Milam Counties

Our starting point with this project is that we are well organized to deliver behavioral health services via telemedicine, but are hampered by inadequate equipment.

a. *Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations.* We have an existing clinical/operations telemedicine protocol manual which we will update to reflect the changes in newly acquired equipment/systems.
b. *Determine if a pilot of the telehealth, telemonitoring, telementoring, or telemedicine operation is needed. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications.* We have been operating a telemedicine system for several years and do not need to pilot a telemedicine system.
c. *Identify and train qualified behavioral health providers and peers that will connect to provide telemedicine, telehealth, telementoring or telemonitoring to primary care providers, specialty health providers (e.g., cardiologists, endocrinologist, etc.), peers or*

behavioral health providers. Connections could be provider to provider, provider to patient, or peer to peer. We have 3 psychiatrists who are currently trained to provide telepsychiatry and provide such services regularly for our patients. We also currently have remote site staff trained and providing telepsychiatry assistance.

d. *Identify modifiers needed to track encounters performed via telehealth technology.* We have been providing telepsychiatry services and already have appropriate modifiers in place to bill and track services.

e. *Develop and implement data collection and reporting standards for electronically delivered services.* We are currently providing telepsychiatry services and have an adequate data collection and reporting system in place for electronically delivered services.

f. *Review the intervention(s) impact on access to specialty care 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 interventions(s), including special considerations for safety-net populations.* Our current telepsychiatry services are provided for patients with severe and persistent mental illness and increase our psychiatry capacity to see patients rapidly who are in the midst of a mental health crisis.

g. *Scale up the program, if needed, to serve a larger patient population, consolidating the lessons learned from the pilot into a fully –functional telehealth, telemonitoring, telementoring, or telemedicine program.* Continue to engage in rapid cycle improvement to guide continuous quality improvement of the administrative and clinical processes and procedures as well as actual operations. We have been providing telepsychiatry services with three psychiatrists (each part time) and we see a need to expand our telepsychiatry services – we have included the hiring of one tele-psychiatrist FTE and one LVN in this project proposal so we can expand our telepsychiatry services.

h. *Assess impact of patient experience outcomes (e.g. preventable inpatient readmissions).* In DY4 and DY5 we are implementing Improvement 6 [I-X.1] to show an increase in the number of persons served via telepsychiatry as our method of showing the positive impact of services available via telepsychiatry.

This project is essential to our Center's ongoing ability to obtain and provide sufficient psychiatric services to meet the behavioral health service needs of the citizens in our 5-county service region. Our Center is approximately 65 miles from Austin, Texas and over the years we have been able to employ psychiatrists and advanced nurse practitioners with psychiatric credentials from the Austin area to provide services in our Center. Over the last 10 years we have recruited 8 professional (psychiatrists and advanced nurse practitioners) staff and within 3 years left our Center with the complaint that they were tired of commuting and were seeking employment opportunities closer to their homes. We have been successful in recruiting telepsychiatry psychiatrists from the Dallas area and the Houston area who provide their services from their own homes. We have found that recruitment of psychiatrists from longer distances into our geographical area to be very difficult because they don't wish to move to our area. The use of contract telepsychiatrists is becoming a more common practice among community centers and some beginning psychiatrists are going into full time practice providing telepsychiatry services. We are also finding that some psychiatrists wish to "semi-retire", but do not want to commute out of their home area. As part of this project we intend to have at

least two units of telepsychiatry equipment that could be deployed to psychiatrists' homes to facilitate their willingness to provide telepsychiatry services without the burden of technically supporting the specialized equipment. Having a highly efficient/effective telemedicine system will greatly increase our ability to contract for adequate psychiatric coverage which has been a problem in the past.

This upgrade will give us the flexibility to have up to four external prescriber conducting telepsychiatry sessions at the same time (increased service capacity/access). Our most distant clinic is more than 80 miles from our largest clinic, and having this high-tech telemedicine system in place will eliminate the 3 hours of travel time needed by the psychiatrist to provide services in this most rural clinic, thus gaining three hours of direct clinic service capability that would have been consumed by the commuting time. With the availability of this very reliable, high technology telemedicine/telehealth system we will also be able to more productively use our prescribers' time that is available due to our patients not attending their service appointments. If a telemedicine prescriber has a patient no-show, then the scheduling staff can survey the other clinics to see if any of their schedules have backed-up and are in need of relief services. The prescribing staff who had a no-show patient could then remotely provide services to patients via the telemedicine system in the clinic that has a patient back-up. This will result in less inadvertent idle time of our most expensive staff due to patient no-shows and be responsive to patient needs in other locations.

We have contracts with two very competent psychiatrists to provide services for our patients via telemedicine technology, but our current telemedicine system has operational problems which prompt the productivity of these providers to be around 40% of their contracted time being used for direct services. With a new high quality, reliable telemedicine system in place, their productivity could easily rise to 60-70% of their time being spent in direct services, thus improving our telepsychiatry capacity by 50-75% over its current capacity. The advent of the electronic health record and the ability to e-prescribe medications from distance locations has greatly expanded the potential use and efficiency of telepsychiatry provided from distant locations and supports our desire to expand our Center's capability to provide such services. We have identified a multi-disciplinary team to work on the analysis of our current system and new system. Their goal is to have all of our telemedicine sites identified and a final recommendation on how to upgrade/replace our telemedicine network in early 2013.

Continuous Quality Improvement: The Center 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: The funding for this project will not supplant any current funding from the U.S. Department of Health and Human Services being used to serve persons with severe and persistent mental illness. This project will increase our Center's ability to obtain and retain

adequate psychiatric coverage to meet the behavioral health needs of persons residing in our services region.

Related Category 3 Outcome Measure(s):

- OD-6 Patient Satisfaction
  - IT-6.2 - Other Improvement Target: Percent improvement over baseline of patient satisfaction scores

Our Center has taken a dual approach to insuring positive outcomes from our implementation of telemedicine/telehealth behavioral health services. We have chosen IT-6.2 as a stand-alone improvement measure to monitor patient satisfaction with services delivered via telemedicine technology, with the goal of improving both individual levels of satisfaction with the service (is the person more satisfied now than they were in the past with the telemedicine services they are receiving), but also to achieve a higher and higher percentage of persons served through telemedicine who are satisfied with their telemedicine services (percentage of patients who receive telemedicine services who are satisfied with those services).

Relationship to Other Projects:
This project is inter-related to our technology assisted capacity improvement projects. It is very closely related and interdependent with our Planning Protocol 1.10 Enhance Performance Improvement and Reporting Capacity project (#081771001.1.5) to improve the operating efficiency (and capacity) of our behavioral health services delivered via telemedicine technology. Since behavioral health services delivered via telemedicine technology is heavily reliant on consistent access to the patient's electronic health record, our project that insures continuity of electronic health record access is also closely related to this project. We also have a telehealth project in RHP 16 (#081771001.1.1) which will serve Coryell and Hamilton County citizens - see Valuation paragraph.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
As more and more community behavioral health centers and rural hospitals obtain telemedicine capacity, we expect that in the future we will be able to provide telepsychiatry support for these rural locations that do not have ready access to a psychiatrist. This technology may also be utilized for doing patient follow-up consultations with patients who are hospitalized in the state psychiatric hospital system. The Center for Life Resources (#133339505.1.1) and Hill Country MHDD (#133340307.2.3) also have telemedicine projects.

Central Counties Services has several DSRIP projects and is committed to improvement of services and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Project Valuation:
The improved telemedicine system and additional telemedicine FTE in this project is transformational and of high value in that it will give us the means to overcome our psychiatric care shortage for our medically underserved behavioral health populations of our service region, which we have experienced for several years. We will now be able to electronically recruit psychiatric services instead of depending on our ability to physically recruit psychiatry services to our geographic service region. By DY5, we expect 279 more persons of our underserved behavioral health population to be served per month via our updated telepsychiatry system than we are capable of serving without this project. The valuation of this project includes the engineering and technical design of our new system; competitively acquiring the equipment; and specialized technicians to install and test the equipment, and integrate all the equipment into a highly functional telemedicine system. The valuation of this project also includes the establishment of a new and separate T-1 line system for the exclusive use of the telemedicine technology system and its ongoing service costs for each year of the project (the longest point-to-point distance between our service sites is approximately 125 miles). The valuation includes a large portion of our Information Technology (IT) staff to coordinate the design and installation of the upgraded system, and to be trained how to technically operate and support the new system's functions. It also includes training our medical staff and contract medical staff on how to professionally use the system. It also includes professionally designed lighting at each site that yields a commercial TV quality of picture, and adds to the warmth of the visual images. Also the cost of the new transmission lines would be on-going after the upgrade is completed. The valuation contains mental health program indirect costs, as well as the Center's administrative cost rate. DYs 3-5 valuations include the equipment warranty/ maintenance contracts, training time for new system users, mental health program indirect costs and the Center's administrative cost rate. DYs 3-5 also include the cost of adding one FTE psychiatrist and one telemedicine support nurse to expand our telemedicine capability to improve timely accessibility to our behavioral health services. Without this telemedicine technology project and its improved access to services, we would see many more persons from our service region entering into psychiatric hospitals, emergency medicine departments and local jails; all of which are expensive to our communities, and which tax our small emergency departments' ability to respond to general health emergencies when they present in the local communities. This valuation represents 79.5% of the project's total valuation (Bell, Lampasas,& Milam Counties), with the other 20.5% of the project's total valuation being assigned to RHP 16 (Project #081771001.1.1) based on the percentage of population (Coryell & Hamilton Counties) from each region has in our 5-county service area.

Central Counties Services 081771001.1.2 (Project 1.11.2) Category 1 Milestones and Metrics			
081771001.1.2	**1.11.2**	**1.11.2.a - 1.11.2.h**	**Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers).**
Central Counties Services			**081771001.1.2**
Related Category 3 Outcome Measure (s):	**081771001.3.2**	**IT-6.2**	**Other Improvement Target: Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)**

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)
Milestone 1 [P-4]: Selection, procurement and installation of telehealth, telemedicine, telementoring equipment. **Metric 1** [P-4.1]**:** Inventory of new equipment purchased. **Baseline/Goals:** Baseline -Center has an antiquated telemedicine system, parts of which may or may not be useable in a new system; Goal - procure a digital signal based high definition telemedicine system for the Center's clinics. **Data Source:** Equipment orders and receipts. **Milestone 1 Estimated Incentive Payment: $478,185** **Milestone 2** [P-5]: Procurement of	**Milestone 4** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service **Metric 1** [P-10.1]: Project planning and implementation documentation that describes plan, do study, act quality improvement cycles. **Baseline/Goals:** Baseline - Determine the types of information readily available in the Center's scheduling system and patient electronic health records that would be indicators for potential process improvement; Goal - Establish the items to be tracked and analyzed that informs the providers and managers how to improve the delivery of behavioral health services via telemedicine technology. **Data Source:** Project reports	**Milestone 7** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service **Metric 1** [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles. Project reports also may include output measures which describe the number and type of telemental transactions which occur. **Baseline/Goals:** Baseline - Review the reports regarding the items chosen for tracking in DY3. Goal - Based on the reports, determine what factors can improve appointment attendance and participation by patients, what procedural activities can be re-organized or streamline to improve the efficiency of documenting services provided by telemedicine technology. Revise the items to be tracked and	**Milestone 9** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service **Metric 1** [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles. Project reports also may include output measures which describe the number and type of telemental transactions which occur. **Baseline/Goals:** Baseline - Review the reports regarding the items chosen for tracking in DY4. Goal -Based on the reports, determine what factors can improve appointment attendance and participation by patients, what procedural activities can be re-organized or streamline to improve the efficiency of documenting services provided by telemedicine technology. Revise the items to be tracked and reported upon for future

Broadband Connection – new T-1 lines ordered and tested. **Metric 1** [P-5.1]: Documentation of presence of active broadband connection. **Baseline/Goals:** Baseline - Currently all data, phone and telemedicine signals are transmitted on a single T-1 line system; Goal - Establish a separate transmission line system for the telemedicine network to insure sufficient bandwidth for high quality audio/video service. **Data Source:** Service contracts for the transmission lines and test results insuring their proper functionality. **Milestone 2 Estimated Incentive Payment: $478,184** **Milestone 3** [P-8]: Training for current providers/peers on use of new equipment and software system. **Metric 1** [P-8.1]: Documentation of completions of training on use of equipment/software and the Center's revised telemedicine protocol manual.	including 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). Project reports may also include output measures which describe the number and type of telemental transactions which occur. **Milestone 4 Estimated Incentive Payment: $258,869** **Milestone 5** [P-X] : Hire personnel or teams to support and/or manage the project **Metric 1** [P-X.8]: Contract for one full-time-equivalent (FTE) telemedicine provider(s), and hire one LVN to assist with expanded remote site facilitation **Baseline/Goals:** Baseline - Center currently has three part-time telemedicine providers who provide one FTE of services; Goal - Center seeks to expand telemedicine services by contracting for one more FTE telemedicine providers (2 FTEs totally) to meet the expanding need for behavioral health telemedicine	reported upon for future improvement. **Data Source:** The Center's patient scheduling system, the patients' electronic health records and project reports focused on telemedicine services. **Milestone 7 Estimated Incentive Payment: $438,273** **Milestone 8** [I-X]: Increase the number of persons served via telepsychiatry. **Metric 1** [I-X.1]: Increase the number of persons served via telepsychiatry over the baseline. **Baseline/Goals:** Baseline – 121 persons per month receive telepsychiatry visits; Goal - Serve an average of 300 persons via telepsychiatry in each month of FY 2015, which represents an increase of 179 more persons served via telepsychiatry over the baseline. **Data Source:** Claims, and Encounter data, and patient electronic health record data **Milestone 8 Estimated Incentive**	improvement. **Data Source:** The Center's patient scheduling system, the patients' electronic health records and project reports focused on telemedicine services. **Milestone 9 Estimated Incentive Payment: $458,607** **Milestone 10** [I-X]: Increase the number of persons served via telepsychiatry. **Metric 1** [I- X.1]: Increase the number of persons served via per month over the baseline. **Baseline/Goals:** Baseline –121 persons per month receive telepsychiatry visits; Goal - Serve an average of 400 persons via telepsychiatry in each month FY 2016, which represents an increase of 279 more persons served via telepsychiatry over the baseline. **Data Source:** Claims, Encounter data and patient electronic health records **Milestone 10 Estimated Incentive Payment: $458,608**

Baseline/Goals: Baseline - Center currently has 3 telemedicine providers and 4 remote site facilitators that will need training on how to operate the new telemedicine system; Goal - Have all current telemedicine providers and remote site facilitators trained on how to operate the new telemedicine equipment/system. Expand the number of site facilitator staff who are trained to use the equipment to be back-up staff if the regular facilitator is absent. **Data Source:** Revised telemedicine protocol manual, Training rosters **Milestone 3 Estimated Incentive Payment: $478,184**	services for our area. One more LVN will be needed to provide remote site medical/medication assistance for the expanded telemedicine services. **Data Source**: Service contracts and Center Dept. of Human Resources hiring documentation. **Milestone 5 Estimated Incentive Payment: $258,870** **Milestone 6** [I-X] (Page *133 of the Planning Protocol)*: Increase the **average** number of persons served via telepsychiatry. **Metric 1** [I-X.1]: Increase the **average** number of persons served per month via telepsychiatry over the baseline measure (September 2012) **Baseline/Goals:** Baseline - It is 121 persons who received telepsychiatry services in September 2012 prior to the implementation of this project. Goal - Serve an average of 200 persons per month via telepsychi-atry in DY3, which represents an increase of 79 more persons served via telepsychiatry per month over the baseline (121).	**Payment: $438,274**	

	Data Source: Claims and Encounter Data, and patient electronic health records. **Milestone 6 Estimated Incentive Payment: $258,870**		
Year 2 Milestone Bundle Amount: $1,434,553	**Year 3 Estimated Milestone Bundle Amount: $776,609**	**Year 4 Estimated Milestone Bundle Amount: $876,547**	**Year 5 Estimated Milestone Bundle Amount: $917,215**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $4,004,924			

Category 1 Project Narrative
Central Counties Services – 081771001.1.3

Project Area, Option and Title: 1.12.2 Expand the number of community based setting where behavioral health services may be delivered in underserved areas
RHP Project Identification Number: 081771001.1.3

Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
- **Intervention:** The project will implement group social skills training for persons diagnosed with High-functioning Autism or Asperger's disorder in the Bell County area.
- **Project Status:** This is a new project. There is currently no model like this project in the local service area.
- **Project Need:** CN.2.9 Lack of social support services for high intellectual functioning Autism & Asperger's population (18 years & older) in Bell County.
- **Target Population:** Those persons currently served by the Center and the Department of Assistive and Rehabilitative Services (DARS) who are diagnosed with High-functioning Autism or Asperger's disorder number between 90 – 100 people with approximately 80% of them being Medicaid eligible. We expect to serve 28-52 people per year.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to serve a cumulative total of 28 (31% of the target population) in DY4 and 52 (57% of the target population) in DY5. Group social skills training is expected to lead to enhanced social skills for the participant (Improvement Milestone I-11.1). Enhanced social skills would necessarily mean better attendance at training sites, medical clinics, schools and places of employment; less interaction issues with family and friends and the public at large; lower instances of involvement with law enforcement; and increases the person's ability to cope with the community environment, making the person more independent.
- **Category 3 Outcomes:** IT-10.1: In DY3, the baseline scores for the satisfaction survey will be obtained. In DY4, we anticipate 50% of the participants served in the program 6 months or more to show increased satisfaction. In DY5, we have a goal of 75% of the participants served in the program for 1 year or more to show increased satisfaction.
- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its

allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. The method of intervention is transformative in that there is no group social skills training in the local area that addresses the high need for services to those diagnosed with high-functioning autism or Asperger's. Consumers have individual plans of intervention but the synergy associated with group social skills training does not exist. It is expected that the level of engagement will be enhanced via the social skills training provided in a group setting. Further, the framework for this training is expected to transform the way services are provided to this focused disabled population.

Project Description:

"Coffeehouse" Model of Social Skills Training

The social group setting or "coffeehouse" model for persons diagnosed with Asperger's Disorder or High Functioning Autism will be a skills training program where people with these conditions can find a community of support and can learn and rehearse skills that promote their ability to find jobs, remain employed, go to college and manage satisfying relationships without exhibiting inappropriate behaviors including aggression.

There are an increasing number of consumers with a diagnosis of Autism or Asperger's Disorder whose needs do not fit within the typical program areas of day habilitation or behavior management. Specifically, the goal is to create a "coffeehouse" model for intensive day service for adults with Asperger's or High Functioning Autism with and without co-occurring mental illness. This represents a coordinated social skills training model that currently does not exist within the local provider network.

The Center would move to lease a site in the Bell County area to house the model. The program will be overseen by a Certified Behavioral Analyst. The "coffeehouse" will be staffed by professionals and paraprofessionals who are skilled in the specialty area of adult autism with its accompanying symptoms of poor social communications skills, failure to understand the subtleties of language, and obsessive or repetitive routines. Participants can attend daily or as their schedule permits. The "coffeehouse" will be a relaxed environment of interactive training and support, with peer support an integral part of the strategy.

The project will be scheduled approximately 240 days per year, five-days per week. A full day will be about 6 hours, which allows for transportation, to and from the training site. Several types of engagement activities will be carried out, based on evidenced-based social skills training curriculae. Each consumer will participate in a highly interactive group learning session while attending.

The curriculum, to be developed, will be based on benchmark social skills training curricula chosen and developed by the professional staff involved. Over DYs 3-5, from 14 to 52 consumers will be trained and/or supported via this model. The day will include several

interactive and engaging sessions facilitated by the staff, using evidenced-based social skills training curricula. If the consumer stays the day, he/she is expected to participate in 5-6 hours of social skills training, a half-day would be 3-4 hours. Group recreational activities will also be conducted as a way to teach and support normalization. Regular schedule of attendance will hopefully be maintained with a schedule of activities published and marketed. Transportation will be provided to those who are in need of transportation.

Three-ring binders will be kept for each person showing the progress (or lack of) for the training sessions. Regular meetings will be held at which time staff will discuss each case and the barriers, if any, to training.

Goals and Relationship to Regional Goals:
The goal is to create a social group setting for persons diagnosed with High functioning Autism or Asperger's Disorder in which social skills training becomes the focal point for learning and enhancing the person's ability to interact with persons in the community and to function more appropriately.

Project Goals:

- Increase the number of persons participating in social skills training for those with high-functioning Autism or Asperger's disorder;
- Enhance the quality of life for persons participating in the "coffeehouse" model of social skills training; and
- Transform the service delivery system for persons with High-functioning Autism or Asperger's disorder.

This Project meets the following Regional Goals:

- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

Challenges:
The challenges facing this project are varied including the fact that people with Asperger's Disorder and High-functioning Autism are reluctant to leave the perceived security of their homes to participate in a group, even if the group is of like-minded individuals. They like their routine and the new routine of attending the "coffeehouse" must evolve. Program staff will need to exercise patience and a more involved approach to motivate people to take the first step and visit the group. Once in the group, people will find a community of others they did not know existed. The challenge of achieving a high level of "engagement" exists and a strong teacher/mentor/facilitator is needed. It is also expected that persons will separate or "graduate" from the group but will need at times a booster of support from the staff and peers. Hiring the staff versed in these specialties will also be a challenge due to the dearth of specialists in the Central Texas rural area to address this type of disability. We expect to market the positions at the various graduate school programs around the State as well as consider contracting with key providers if a full time staff person cannot be attained.

5-Year Expected Outcome for Provider and Patients:
The five-year outcome includes the expansion and enhancement of behavioral health services to better meet the needs of the patient population with High-functioning Autism and Asperger's Disorder; a heightened awareness in the community of this model as a viable learning module; increased satisfaction on the part of the individual consumer, due to enhanced social skills; and the person's increased ability to exhibit appropriate behavior in relationships, in family, community and employment settings. The person diagnosed with high-functioning autism or Asperger's is expected to show improvement in social skills which leads to improved social and personal relationships, longer tenures in employment, and less acting out or exhibition of inappropriate behaviors. Their quality of life will be enhanced through peer-support and reinforcement of social activities.

Starting Point/Baseline:
Within, the local service area, there is currently not a formally structured social group setting in which persons with High-functioning Autism or Asperger's Disorder participate in social skills training. Baseline for AQoL Satisfaction Survey and number of persons served will be established in DY3.

Rationale:
Community Need Addressed:

- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.9 - Lack of social support services for high intellectual functioning Autism & Asperger's population (18 years & older) in Bell County.

According to the August 23, 2010, State of Texas Study on the *Costs and Benefits of Initiating a Pilot Project to Provide Services to Adults with Autism Spectrum Disorders and Related Disabilities*, in 2009, 4,300 adults with autism spectrum disorders (ASD) received services from the Department of Aging and Disability Services (DADS), the Health and Human Services Commission (HHSC), and/ or the Department of Assistive and Rehabilitative Services (DARS) (http://www.dads.state.tx.us/autism/publications/HB1574Report.pdf). An estimated 4,000 adults with ASDs have requested DADS services, but have been placed on an interest list due to a lack of funding. Nearly half of these 8,300 adults are between 18 and 25 years of age. The costs of providing supports to these individuals will only increase as they, and their caregivers, age. The Study states that the decisions that Texas makes in response to the unmet demand for services, the aging of the population, and increasing diagnoses of autism will have significant human and financial consequences.

The Study researched various pilots and initiatives in other states and determined that several benchmark outcomes needed to be present. Included were the need for services specifically designed to meet the needs of individuals with ASDs including training programs and outreach campaigns; and a team-based, person-centered planning process that focuses on the individuals' strengths, interests, and goals to develop seamless service plans.

Within the local service area served by Central Counties Services, we have seen an increase in the number of individuals diagnosed with Autism or Asperger's Disorder. These include referrals through intake, who have never received services from a social service agency,

consumers served by the Children with Special Needs Network, individuals served in the public schools and persons discharged from State Supported Living Centers. We now have enough consumers with this diagnosis to form a separate caseload at Central Counties and the nuances associated with high-functioning autism or Asperger's warrants a separate caseload with a special emphasis on the challenges of this group. Like the network of private providers in our area, we are serving these persons based on their individual needs but there is a need to provide a social group experience in which persons with similar challenges can participate.

Although this group of individuals has normal or above-average intelligence and language development, traditional mental health programs struggle to meet their needs because the characteristics of the Autism are so dominant that they interfere with standard treatment modalities. Likewise, traditional behavior management techniques used for persons diagnosed with pure developmental disability (formerly mental retardation) do not meet their needs. Further, the skill-set of the typical case manager working with those persons diagnosed with developmental disability is lacking as the Autism or Asperger's consumer presents a whole new set of challenges.

According to the Texas Autism Research and Resource Center and the Autism Treatment Network, studies have shown that various social skills strategies such as social stories, structured teaching, thoughts and feelings activities, the use of peer mentors, role playing or behavioral rehearsal have a positive effect on the interpersonal skill enhancement of the person diagnosed with Autism or Asperger's Disorder. Again, these are skill-set modalities not present within the skill-sets of the typical case manager. A variety of these strategies will be part of the on-going curriculum utilized at the "coffeehouse". The intervening variables of social group setting and a structured curriculum are expected to result in an enhanced quality of life as reported by the person. This enhanced Quality of Life Satisfaction is reflected as the Category 3 Outcome Measure. This would include enhancing the quality of the person's relationships with caregivers, their parents and members of the community. Enhanced social skills would necessarily mean better attendance at training sites, medical clinics, schools and places of employment. Enhanced social skills would mean less interaction issues with family and friends and the public at large and lower instances of involvement with law enforcement. An enhanced social skill also increases the person's ability to cope with the community environment, making the person more independent. The model of social skills training is wholly consistent with the recommendations set forth in the 2010 State of Texas Study mentioned above. Finally, we expect this model to transform the service delivery system for persons with High-functioning Autism or Asperger's using a model of group social skills training as the core for learning.

<u>How the project represents a new initiative or significantly enhances an existing delivery system reform initiative</u>: In terms of funding, it should be noted that the U.S. Department of Health and Human Services does not fund services that address the needs of persons with High-functioning Autism or Asperger's Disorder.

Related Category 3 Outcome Measure(s):

- OD-10 Quality of Life /Functional Status
    - IT-10.1: Quality of Life

Quality of Life - demonstrate improvement in quality of life satisfaction scores, as measured by the QoL Survey, an evidence based and validated assessment tool. This survey will be given to participants upon entry into the program and again at six months and one year intervals. It is expected that the scores on the survey will improve over time revealing an increase in the participant's quality of life. In DY3, the baseline scores for the satisfaction survey will be obtained and in DY4, we desire 50% of the participants who have been in the program six months or more to show increased satisfaction. In DY5, we have a goal of 75% of the participants who have been in the program for one year or more to show increased satisfaction.

Relationship to Other Projects:
The need to address services to persons with autism is a high priority need in the region. This has been recognized by the Central Texas Aging and Disability Resource Center (CTADRC), the A+ Support Group and the public at large through a series of public forums facilitated by Central Counties' staff. It is also recognized by the Center's Planning and Network Advisory Committee (PNAC) and the Center's Board of Trustees.

Within the local service area of the Center, there are informal groups of persons with Autism or Asperger's Disorder. There is an Asperger's support group (about 20 persons) that meets once per month for social activities. This group does not have a formal social skills training format. There is a current active census at the Center of 30-35 person diagnosed with High Functioning Autism or Asperger's. These persons receive services according to individualized Plans. Also, within the local district of the Department of Assistive and Rehabilitative Services (DARS) there is a census count of 50-60 persons diagnosed with Autism or Asperger's. Finally, the A+ Support Group in Belton is a support group for persons diagnosed with Autism. Programs are schedule for the parents/guardians once per month on a Saturday. Although these individuals participate informally in these activities, there is not a formal strategy to provide social skills training. These individuals and others could readily benefit from the "coffeehouse" model with its focus on social skills training.

Other Center projects include:

- 081771001.1.1 Establish more primary care clinics
- 081771001.1.2 Implement technology-assisted behavioral health services by psychologists, psychiatrists, and other qualified providers
- 081771001.1.4 Develop and implement crisis stabilization services to address the identified gaps in the current community
- 081771001.1.5 Enhance improvement capacity through technology
- 081771001.2.1 Apply evidenced-based care management model to patients identified as having high-risk care needs
- 081771001.2.2 Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations
- 081771001.2.3 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Central Counties Services is committed to improvement of services and broad-level delivery system transformation. We are willing to participate in a learning collaborative with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Within the Regional Healthcare Plan 8, there are two projects of a similar nature in which one provider is expanding the number of community based setting where behavioral health may be delivered (see Project #126844305.1.1 and #126844305.1.5). These two projects will occur in a different service area than the service area of this project.

Pertaining to the Project Milestones, an integral element of this project is the Learning Collaborative that will take place two times per year beginning in year three. It is expected that the project coordinator will hold a "summit" meeting of key stakeholders including ISD Special Education departments, the DARS, the A+ Support Group in Belton, Texas, and partners of the Aging and Disability Resource Center. Efforts to include the Texas A&M Medical School in Temple will also be made. What we have learned from this project will be shared with this stakeholder group to enhance a coordinated effort of services in the local community.

Project Valuation:
The project will be scheduled approximately 240 days per year, five-days per week. A full day will be about 6 hours, which allows for transportation to and from the training site. Several types of engagement activities will be carried out, based on evidenced-based social skills training curriculae. Each consumer will participate in a highly interactive group learning session while attending. The person diagnosed with high-functioning autism or Asperger's is expected to show improvement in social skills which leads to improved social and personal relationships, longer tenures in employment, and less acting out or exhibition of inappropriate behaviors. Their quality of life will be enhanced through peer-support and reinforcement of social activities.

The benefit to the community of this "coffeehouse" model of social skills training lies in the consumer's ability to cope with and function in a variety of community settings. The consumer should have an enhanced quality of life, feel more valued in inter-personal relations and is expected to interact positively in all phases of community life. There should be less crisis events, less hospitalizations, and less entanglement with law enforcement. Family members, friends, neighbors and the community-at-large should see a more positive stance from the individual participant in the group social skills training.

The valuation of this project also includes the following: staff time in marketing the positions required and interviewing and hiring the positions; staff time in researching appropriate sites for the social group setting; staff time in negotiating the lease arrangement; staff time in purchasing the van for transportation; staff time in developing the curriculum; staff time in researching the survey, both in terms of administering and scoring; staff time in selecting and purchasing the equipment involved. The valuation also includes direct costs of staff salaries

and benefits, equipment, vehicle and lease, as well as program indirect costs, administrative costs and cost of inflation. It also includes a cost savings value reflected in savings on mental health/IDD benefits due to decreased incidents of behavioral crisis; less involvement with law enforcement and increased earnings in the workplace due to employment.

Central Counties Services 081771001.1.3 (Project 1.12.2) Category 1 Measures				
081771001.1.3	**1.12.2**		**Expand the number of community based settings where behavioral health services may be delivered in underserved areas**	
Central Counties Services				**081771001**
Related Category 3 Outcome Measure (s):	**081771001.3.3**	**IT-10.1**	**"Coffeehouse" Model of Social Skills Training**	
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)**	
Milestone 1 [P-2]: Identify licenses, equipment requirements and other components needed to implement and operate options selected. **Metric 1** [P-2.1]: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components • Research existing regulations pertaining to the licensure requirements of psychiatric clinics in general to determine what requirements must be met. • When required, obtain licenses and operational permits as required by the state, county or city in which the clinic will operate. • Develop specific training materials for staff members. Examples of training could include travel and road safety,	**Milestone 4** [P-7]: Evaluate and continuously improve services. **Metric 1** [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/Goal:** Baseline of Project status will be determined to include efficacy of learning, what is going well and what needs to be improved upon; Goal - achieve the milestone and metric **Data Source**: Project reports including 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), Project management tools from benchmark quality improvement	**Milestone 7** [I-11]: Increased utilization of community behavioral healthcare **Metric 1** [I-11.1]: Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare services from clinics after access expansion. b. Denominator: Number of people receiving community behavioral health services after access expansion **Baseline/Goal:** Baseline - 14 persons served. Goal – Serve 14 additional persons in DY4 (estimated cumulative total of 28 persons) **Data Source:** Claims data, encounter data and attendance rosters from community behavioral health site and expanded transportation	**Milestone 8** [I-11]: Increased utilization of community behavioral healthcare **Metric 1** [I-11.1]: Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare services from clinics after access expansion b. Denominator: Number of people receiving community behavioral health services after access expansion. **Baseline/Goal:** Baseline: 14 established in DY3. Goal - Serve 24 additional persons in DY5 (estimated cumulative total of 52 persons) **Data Source**: Claims data and encounter data from community behavioral health sites and expanded transportation programs	

clinic operations, evidence based behavioral health practices, engagement and outreach strategies. **Baseline/Goal:** Baseline – none; Goal – Developed project plan and timeline. **Data Source**: Project Plan, leases obtained, equipment purchased, etc. **Milestone 1 Estimated Incentive Payment: $229,179** **Milestone 2** [P-3]: Develop administrative protocols and clinical guidelines for projects selected **<u>Metric 1</u>** [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines **Baseline/Goal**: Baseline – none; Goal – Complete the manual of operations **Data Source:** Reference Center and other agency policy and procedure manuals	processes. **Milestone 4 Estimated Incentive Payment: $208,145** **Milestone 5** [P-10]: 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. **<u>Metric 1</u>** [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Baseline – Framework for the meetings will be established**.** Goal – Use the framework to conduct the Learning Collaboratives. **Data Source**: Documentation of semiannual meetings including meeting agendas, slides from	programs **Milestone 7 Estimated Incentive Payment: $670,722**	**Milestone 8 Estimated Incentive Payment: $709,893**

Milestone 2 Estimated Incentive Payment: $229,179 **Milestone 3** [P-4]: Hire and train staff to operate and manage projects selected. **Metric 1** [P-4.1]: Number of staff secured and trained **Baseline/Goal:** Baseline – 0; Goal - hire and train staff **Data Source**: Project records; Training curricula as develop in Milestone 1. Personnel records. **Milestone 3 Estimated Incentive Payment: $229,179**	presentations, and/or meeting notes. Facilitation processes from previous stakeholder meetings, benchmarks on "how to hold effective meetings." **Metric 2** [P-10.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting. **Baseline/Goal**: Baseline – 0; Goal - Implement initiatives **Data Source**: Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. **Milestone 5 Estimated Incentive Payment: $208,145** **Milestone 6** [I-11]: Increased utilization of community behavioral healthcare **Metric 1** [I-11.1]: Percent utilization of community behavioral healthcare		

	services. a. Numerator: Number receiving community behavioral healthcare services from clinics after access expansion b. Denominator: Number of people receiving community behavioral health services after access expansion **Baseline/Goal:** Baseline - No persons are currently served using this model; Goal - Serve 14 persons by year end, a 15 % increase in # in target population. **Data Source:** Claims data and encounter data from community behavioral health sites and expanded transportation programs **Milestone 6 Estimated Incentive Payment: $208,146**		
Year 2 Milestone Bundle Amount: $687,537	**Year 3 Estimated Milestone Bundle Amount: $624,436**	**Year 3 Estimated Milestone Bundle Amount: $670,722**	**Year 5 Estimated Milestone Bundle Amount: $709,893**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,692,588			

Category 1 Project Narrative – Pass 2
Central Counties Services – 081771001.1.4

Project Area, Option and Title: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.
RHP Project Identification Number: 081771001.1.4

Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
- **Intervention:** This project provides 24/7 residential-based crisis respite (15 beds), transitional living (15 beds) and supportive day services at a properly equipped facility within our service area to persons with severe and persistent mental illness who have experienced a recent mental health crisis, in lieu of these persons being sent to the state psychiatric hospital system or incarcerated in local jails.
- **Project Status:** This is a new project.
- **Project Need:** CN.2.10 Limited access for seriously mentally ill adults to crisis services in Bell, Lampasas and Milam Counties. Addendum 8-1G illustrates our Center's overuse of state psychiatric hospitals. Our service area currently does not have crisis residential services.
- **Target Population:** 97% of all of the Center's patients are Medicaid (41.89%), uninsured or indigent. We anticipate this project will benefit this same population, and expect this project to admit 640 in DY4 and 800 in DY5.
- **Category 1 or 2 Expected Project Benefit for Patients:** This project seeks to provide crisis services to patients in more appropriate and less costly setting than psychiatric hospitalization or incarceration (Improvement Milestone I-11.1 and I-11.2). This project intends to provide 3,200 crisis respite bed days of service in DY4 and 4,000 bed days of crisis respite services in DY5. Assuming an average length of stay of 5 days per patient admission, there would be approximately 640 admissions in DY4 and 800 admissions in DY5.
- **Category 3 Outcomes:** IT-9.1: An expected outcome for this project is to reduce the mental health admissions/readmissions to criminal justice and psychiatric hospital

settings with the percent of improvement to be determined once the baseline is set in DY3.

- **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project. This project is transformational in that these services are currently not available in our service region, and this project will make crisis respite services available to all regional communities and the cost of up to 4000 hospital ($461/day/FY'12 at Austin State Hospital – average length of stay = 21 days*)/incarceration ($50+/day with average time in pre-trial services is 145 days**) days will be avoided by these services in DY5.
  *****Austin State Hospital Regional Planning Meeting Oct.31, 2012, pp.30, 35.
  ******"A Simulation Modeling Approach for Planning and Costing Jail Diversion Programs for Persons with Mental Illness. David Hughes, et al, Criminal Justice and Behavior, Vol. 39 No 4 April, 2012, p. 438.

Project Description:

Crisis Respite Services

The Center's service region has an immediate need for crisis respite services/transitional living services for those persons in mental health crisis who have no place to live (see Rationale Section below). The description of crisis respite services to be implemented in this project is: Crisis Respite Services (CRS) provides short-term (3-7 days) structured residential treatment organized in a non-medical, psycho-social recovery-focused service model that focuses on the person's strengths to manage/reduce their crisis. CRS provides a calm, protected, and supervised non-hospital setting where the patient can stabilize, resolve problems and link with possible sources of ongoing support. CRS includes supervised, structured room/board available 24 hours/day, 7 days/week and is an immediate alternative to acute hospitalization or incarceration in emergency situations. The CRS facility would be an unlocked unit that relies on voluntary patient participation. It serves as an early intervention for persons showing signs of deteriorating ability to self-manage their behavioral health problems/symptoms, and can be a "cooling off" place for persons whose home situation has become intolerable. It can serve as a "step-down" (less intensive service) for someone being discharged from inpatient psychiatric services. Treatment services offered at this CRS are intended to keep the person safe, stabilize the person's acute psychiatric symptoms, and return the person to their familiar living situation and treatment quickly. Actual treatment services may include milieu therapy, psychotropic medications, solution-focused brief therapy, assertive case management, housing assistance, etc. The CRS target population is described as: adults with a diagnosed or suspected mental illness; in behavioral health crisis, but whose behavior is under sufficient control to not be considered an immediate risk of self-harm, or harm to others; agree to voluntarily participate in CRS; for whom CRS is deemed a safe, appropriate, beneficial level of care; and do not have medical problems requiring regular medical treatment beyond a self-care level. Persons excluded from CRS would be persons who are: under 18 years old, have a blood alcohol/drug level putting them at risk of withdrawal symptoms, or impaired judgment about their behavior; unwilling to voluntarily take part in services or comply with services rules; have a medical condition requiring intervention above a self-care level; have not yet fully recovered from the

physical symptoms associated with a suicide attempt; or has any other condition/circumstance judged to be beyond the service capability of the crisis respite staff.

The Center is planning a multiphase project approach to address this unmet service need as soon as possible with interim arrangements while more desirable ways of addressing these unmet behavioral health needs gets worked out. The first step contracts for CRS with Heart of Texas Regional MHMR Services (HOTRMHMRS) in Waco Texas (40 miles north of Temple). While this CRS is not in our service region, it is closer than Austin State Hospital (68 miles from Temple). HOTRMHMRS has extra CRS capacity and can make 5-10 beds available to our Center, depending on their daily census. This will provide some immediate relief to our Center's recent overuse of our state psychiatric hospitals (See RHP Addendum 1G). Within 3 months of project approval Coryell County will begin to remodel, furnish, and equip the former Coryell County Hospital for interim use as transitional living services, with a target start date of Oct. 1, 2013. This project may also include partnering with the Coryell Memorial Healthcare System (CMHS) for medical screening, patient minor health issues treatment, and food services contracting. It will have 16 beds and can serve both male and female patients. During DY2, the Center will convene the main stakeholders for behavioral health CRS, namely, every local law enforcement agency, hospital emergency department, and the Bell, Coryell, Hamilton, Lampasas and Milam County Judges to ask them to support an intense needs gap analysis process on the amount of CRS needed by our service area and the best location of these services. This gap analysis process would track the number of persons who present or are brought to local emergency departments in mental health crisis, and if a CRS care level would have met their needs. We will also collect data on the number of persons in mental health crisis arrested for minor crimes who could benefit more from CRS than jail. This gap analysis process will also document if post-crisis respite service is needed by the person in crisis (e.g. housing, day support services, transportation, transitional living support, medical care, substance abuse services, medicine, etc.). The maximum capacity of CRS will be set by Health and Safety code and licensing requirements – likely 16 beds. Two admissions per day would lead to someone having to be discharged by the 7th day to allow further admissions. If the patient is homeless, it is difficult to stabilize the patient and set up a new living situation in 7 days. The only way to have an effective, accessible CRS would be to also have step-down, transitional living services so patients who are stable, but homeless, could be in a transitional living setting a few more days while living arrangements are worked out.

Goals and Relationship to Regional Goals:

Project Goals:

This project's goal is to establish crisis-responsive residential services within our service area that provides a less restrictive/costly level of care for persons in behavior health crisis than admission to the state psychiatric hospitals or jailed for a minor offense. The goal is to provide successful interventions for persons in early stages of crisis before the crisis situation reaches the complexity that institutional level of care becomes the only care option resulting in the person's support system and living arrangements being disrupted and jeopardized.

This Project meets the following Regional Goals:

- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

Challenges:
Perhaps the biggest challenge will be managing the gap analysis, local planning, program design/documentation, securing an appropriate facility that meets licensing and health/safety codes requirements of CRS, and staffing up/fully operationalizing the services by the end of DY3 so project outcomes can be properly measured in DY4 and DY5. Our Center will do as much local organizational work with stakeholders, gap analysis partnering, and CRS planning as it can in early 2013 in order to have as much information in place as possible to expedite the actual establishment and operations of these CRS for our area.

5-Year Expected Outcome for Provider and Patients:
In 5 years, our Center intends to have fully functioning CRS with step-down transitional living services available to our service area. It is also our goal to have strong working relationships with our local hospital EDs and our local law enforcement agencies such that persons are identified in early stages of behavioral health crisis and assisted through these proposed services, rather than admitted to the state psychiatric hospital system or local jails. We would expect that psychiatric hospitalizations and the incarceration of persons with mental illness would decrease/100,000 population in our service area.

Starting Point/Baseline:
Our Center and its staff have previously provided both crisis stabilization services (16 bed medical model) and transitional living services (15 bed capacity), and both were usually close to capacity by serving persons from our area until they closed due to funding reductions. Our service demand for residentially-based behavioral health crisis services exceeds our regional capacity at this time as shown by our Center's overuse of state psychiatric hospitals, the keeping of patients in EDs while waiting for a state psychiatric hospital bed to be open, and the anecdotal reports from local law enforcement agencies/County Judges that persons who have committed minor crimes while in a behavioral health crisis who would be better served in a mental health residential facility than incarcerated as is currently occurring. The Bell County 2010 Community Needs Assessment (see Addendum 1 supplemental) also notes (p. 262) that 27% of the 715 homeless persons interviewed had mental health problems and were at risk of mental health crisis due to homelessness
http://www.co.bell.tx.us/2010%20Needs%20Assessment.pdf.

Rationale:
Community Need Addressed:

- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.10 - Limited access for serious mentally ill adults to crisis services in Bell, Lampasas and Milam Counties

The Center provided Crisis Stabilization Services from the late 1980's until June 2000 when the services closed due to higher service demand and less resources to provide them. The Center also provided transitional living services from the late 1980's until 1995 when these services had to close due to state funding reductions. Now Bell, Lampasas, Milam, Coryell, and Hamilton Counties do not have any residential services to assist residents experiencing a mental health crisis. Persons in a mental health crisis in this service region must be guided to one of four options, namely, 1) admission to the state psychiatric hospital, 2) kept in a local ED for stabilization while waiting for a state psychiatric hospital bed (most recent severe case was for 13 days), 3) being jailed for a minor crime, or 4) released to community supports; at times, a less-than-desirable choice. Our county jails now track the number of inmates having a mental illness/take psychotropic medications and report that 28% of the inmates have mental health problems. The Center is allotted a portion of state psychiatric hospital days in proportion to its percent of the state's population being in our service area. Last fiscal year (ending 8/31/12), our service area used 110.87% of the bed days allotted for our service area, thus demonstrating a much greater demand for resources than are available to respond to persons in our region who experience severe mental health crises. Comparing our use of bed days to Local Mental Health Authorities (LMHA) who have CRS near us proves this point. The LMHA to the North used 99.27% of their bed days and the LMHA to the South used 71.9% in FY2012. HB2292 in the 78th Texas Legislature required each LMHA to have a Jail Diversion Task Force to expedite the diversion of mentally ill persons arrested for minor crimes while in a mental health crisis. The Center's Community Jail Diversion Task Force consists of local law enforcement agencies, community social service agencies and local Judges. This Task Force's jail diversion efforts are hampered by the lack of residential options needed to divert a mentally ill offender from incarceration.

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.* There was much stakeholder support for CRS prior to our having to close them.
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.* There are no residential crisis stabilization or CRS, and consequently, no crisis residential service capacity in our area at this time.
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. minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings)*. Having operated crisis stabilization and transitional living services for 10+ years in the past, we know that these two levels of CRS are needed in our area and were well received and supported by the EDs and law enforcement agencies in our service area. These partnering agencies were greatly

disappointed and adversely affected when these services ended. Our partners had to transport crisis patients to Austin State Hospital instead of accessing local services.

d) *Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.* Our past experience of providing CRS and transitional living services, which were in separate communities, has brought us to the conclusion that these two levels of care can operate best if they are proximate to each other, perhaps in the same building, if possible. Having them in the same building would give more flexible use of staff and gain various operating efficiencies, such as meal preparation, laundry facilities, etc.

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.* See Milestones 9 and 11. Our Center's project #081771001.1.5 – Enhance Improvement Capacity through Technology, will also assist our Center with its commitment to continuous quality improvement of these services.

Continuous Quality Improvement: The Center 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project does not supplant any services or funds currently provided to Central Counties Service from the U.S. Department of Health and Human. The services proposed to be provided under this project serve to enhance, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

Related Category 3 Outcome Measures:

- OD-9 – Right Care, Right Setting
  - IT-9.1 – Decrease in mental health admissions and readmissions to criminal justice and psychiatric hospital (Planning Protocol 1.13) settings (Standalone measure).

This outcome measure is chosen because it directly addresses and measures the impact of this project's goal or purpose, namely to provide effective local crisis residential services that can be utilized by persons in behavioral health crisis in lieu of admissions and readmissions to more restrictive/expensive institutional levels of care in EDs, psychiatric hospitals or local jails.

Relationship to Other Projects:

This project is related to our Temple Day Services (#081771001.2.3) which also has the purpose of lowering the frequency of admissions/readmissions to psychiatric hospitalization and /or incarceration. Our telemedicine project (#081771001.1.2) is also intended to improve patients'

access to psychiatric care and compliance with anti-psychotic medication, both of which are key elements in persons with severe and persistent mental illness maintaining stability in their community setting. The Center's "enhance improvement capacity through technology" project (#081771001.1.5) has as its service objective to increase the number of timely follow-up visits with patients after they have been discharge from psychiatric hospitalization – also a very important service that is aim at reducing hospital readmissions. The use of data dashboards created under this project will greatly assist the Center's work with Milestones 6, 9, and 11 to continuously improve our crisis respite services.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Bluebonnet Trails is also proposing 3 crisis respite services projects (#126844305.1.2, #126844305.1.3, and #126844305.1.4) for Williamson and Burnet Counties.

The Center is committed to improving services and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis allows providers to strengthen their partnerships and continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Project Valuation:
The project valuations takes into account that this project is of great value to our service region and is transformational in that these services are currently not available in our service region, and this project will make crisis respite services available to all regional communities and the cost of up to 4000 hospital ($461/day/FY12 at Austin State Hospital – average length of stay = 21 days*)/incarceration ($50+/day with average time in pre-trial services is 145 days**) days will be avoided by these services in DY5. Assuming that all days of crisis respite services would take the place of days in the state hospital, this project would save the State of Texas $1,383,000 in DY4 and $1,844,000 in DY5.

DY2 project valuation includes contracting costs for CRS from HOTRMHMRS, a minivan, costs to trans-port persons to/from CRS in Waco, costs for screening and follow-up for persons referred to HOTRMHMRS, renovation, furnishing and equipping costs to make the former Coryell County Hospital building useable for our service region and hiring/training costs for staff to provide these post-crisis, respite transitional living services. DY2 also has costs for convening stakeholders multiple times, hiring consultants to complete the in-depth gap analysis/service planning implications and final project proposal required by this project. DY3 valuation continues the HOTRMYMRS contract for CRS, and includes transitional living service costs, while ramping up operation of CRS within our service area, which involves acquiring office and patient area equipment/furnishings, vehicles, operating supplies, food storage/handling equipment, telemedicine equipment, phone, electronic health record access, and data services, etc. needed to start CRS in our service area (see Milestone 8). DY3 also includes hiring/training crisis respite staff, including a psychiatric advance nurse practitioner, obtaining proper Dept. of State Health Services' site approval/licensing, the design and writing of service protocols and

manuals. DY4 and DY5 valuation reflects the operations of the residential crisis services called for in the gap analysis, planning and design process. The DYs 2-5 valuation includes Center indirect program and administrative overhead costs. This project's valuation also considers the psychiatric hospitalization and incarceration costs that can be saved by local access to CRS. If this project keeps half of its patients (10-15) out of psychiatric hospitals (15 days/admission) or jails (30 days/event), it will save our state/communities considerable financial and personnel costs. Admission/ readmission to criminal justice settings is disruptive/deleterious to behavioral health crisis recovery. Studies of recidivistic criminal justice patients in Texas and other states show poorer physical health status, increased homelessness, increased use of ED and inpatient services. Services that keep persons from cycling through the criminal justice system help avert poor health/ mental health outcomes, reduce long term medical costs and improve personal functioning. This valuation reflects 79.5% of the total valuation (Region 8 has 79.5% of our service region's population) while 20.5% of this project's valuation is reflected in our project submitted to RHP 16.

Central Counties Services – 081771001.1.4 (Project 1.13.1 – Pass 2) Category 1 Milestones and Metrics				
081771001.1.4	1.13.1		Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system	
Central Counties Services				081771001
Related Category 3 Outcome Measure (s):	081771001.3.7	IT-9.1	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons	
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)	
Milestone 1 [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 (Economy of scale may lead to service region options rather than individual community options) **Baseline/Goal**: Baseline - No data-driven CRS plan is available. Goal - A written, data-driven implementation crisis respite services plan would be presented and endorsed by the stakeholder group. **Data Source:** Interviews with other LMHAs who have crisis residential services; Hospital Diversion Services-A Manual on Assisting in the	**Milestone 3** [P-X] (See p. 7 of the Planning Protocol): Hire staff to support the project/intervention **Metric 1** [P-X.8]: Hire staff to implement the interim transitional living services at the former Coryell Memorial Hospital renovated quarters, which will serve the Center's patients from RPH 8 and RPH 16 **Baseline/Goal**: Baseline – Not enough staff to operate the proposed crisis transitional living services. Goal - Hire sufficient staff to operate this crisis transitional living services for patients from RHP 8 and RHP 16. **Data Source:** Center Dept. of Human Resources hiring records **Milestone 3 Estimated Incentive Payment: $554,917**	**Milestone 9**[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. **Baseline/Goal**: Baseline – Use the reports and improvement tasks from DY3 to set improvement goals for DY4. Goal - Staff will sustain the improvements achieved in DY3 and achieve improvement in at least 3 areas of crisis respite identified by staff as problematic/lower achievement than desired. **Data Source:** Project reports include examples of how real-time data is used for rapid-cycle improvements to guide continuous quality improvement (i.e. how the project continuously used data such as weekly run charts or monthly	**Milestone 11** [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 **Baseline/Goals:** Baseline - Utilize the reports and improvement tasks from DY4 to set improvement goals for DY5. Goal - Staff will sustain the improvements achieved in DY4 and achieve improvement in at least 3 new areas of crisis respite identified by staff as problematic/lower achievement than desired. **Data Source:** Project reports include examples of how real-time data is used for rapid-cycle improvements to guide continuous quality improvement (i.e. how the project continuously used data such as weekly run charts or monthly dashboards to drive improvement)	

Development of a Respite/Diversion Service in Your Area; Mental Health Peer-Operated Crisis Respite Programs – compiled by the National Empowerment Center; Behavioral Health Crisis Study – Crisis System Overview and Exemplary Models – Colorado Division of Behavioral Health; Behavioral Health Crisis Services – Tennessee Dept. of Mental Health & Substance Abuse Services, etc. **Milestone 1 Estimated Incentive Payment: $259,104** **Milestone 2** [P-X] (See p. 7 of the Planning Protocol): Hire staff to support the project/intervention **Metric 1** [P-X.8]: Hire staff to implement the interim contract crisis respite services contract with HOTRMHMRS **Baseline/Goal:** Baseline – Not sufficient staff to provide the transportation and support for persons sent to HOTRMHMRS for crisis respite services. Goal - Hire sufficient staff to provide transportation and support of area patients referred to HOTRMHMRS	**Milestone 4** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis respite/residential services **Metric 1** [P-5.1]: Completion of policies and procedures **Baseline/Goal:** Baseline - No written administrative and clinical protocols/manual to guide the operation of crisis respite/ residential services. Goal - Have written administrative and clinical protocols prior to opening these crisis respite/residential services. **Data Source:** See Data Source information listed in Milestone 1. **Milestone 4 Estimated Incentive Payment: $554,917** **Milestone 5** [P-4]: Hire and train staff to implement identified crisis stabilization/respite/residential services **Metric 1** [P-4.1]: Number of staff hired and trained.	dashboards to drive improvement) **Milestone 9 Estimated Incentive Payment: $834,750** **Milestone 10** [I-X]: Provide crisis respite residential services **Metric 1** [I-X.1]: Provide increased crisis respite days of service for adult behavioral health patients. **Baseline/Goals:** Baseline will be established in DY3 (estimated to be an average daily census of 5). Goal – Provide 3,200 patient days of service. **Data Source:** Claims encounters, and service event data from the Center's EHR system **Milestone 10: Estimated Incentive Payment: $834,750**	**Milestone 11 Estimated Incentive Payment: $953,000** **Milestone 12** [I-X]: Provide crisis respite residential services **Metric 1** [I-X.1]: Provide increased crisis respite days of service in DY5 **Baseline/Goals:** Baseline - Established in DY3 (estimated to be an average daily census of 5). Goal – Provide 4,000 patient days of service. **Data Source:** Claims encounters, and service event data from the Center's EHR system **Milestone 12 Estimated Incentive Payment: $953,000**

for crisis respite services. **Data Source:** Center Dept. of Human Resources hiring records **Milestone 2 Estimated Incentive Payment: $259,104**	**Baseline/Goal:** Baseline – Not sufficient staff working at the appropriate skill levels to operate a residential crisis services. Goal - Develop a staffing pattern to appropriately operate its CRS and then hire and train people to serve in these staff positions. **Data Source:** Staff roster training records, and training curricula **Milestone 5 Estimated Incentive Payment: $554,917** **Milestone 6** [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. **Baseline/Goal**: Baseline – No regular reports to monitor CRS operations. Goal - Develop reports that monitor key functions of the crisis respite service and when anomalies occur, problem-solving and corrective actions can be taken promptly. **Data Source:** Project reports		

	include examples of how real-time data is used for rapid-cycle improvements to guide continuous quality improvement (i.e. how the project continuously used data such as weekly run charts or monthly dashboards to drive improvement) **Milestone 6 Estimated Incentive Payment: $554,917** **Milestone 7:** [P-X] (See p. 7 of the Planning Protocol): Establish a baseline in order to measure improvement over self. **Metric 1** [P-X.6]: Determine the baseline of crisis respite days of service provided for adult behavioral health patients. **Baseline/Goal**: Baseline – this is a new service so the baseline number of crisis respite service days provided is not known. DY3 is a transitional year for implementing the new crisis respite services (see Milestones 4 and 5) and the average daily census of crisis respite service will be ramping up during the course of the year. Goal – Determine the baseline average daily census for the new crisis respite service by using		

	the average daily census (estimated to be 5) from the last 2 months of DY3. **Data Source:** Claims encounters, and service event data from the Center's EHR system **Milestone 7 Estimated Incentive Payment: $554,916** **Milestone 8:** [P-X] (see p. 7 of Planning Protocol) Implement, adopt, upgrade, or improve technology to support the project <u>Metric 1</u> [P-X.9] Resize the Center's clinical data system to accommodate medical and counseling staff of the crisis respite program to have ready access to the Center's electronic health record (EHR) system and to accommodate the EHR capacity needed for processing up to a 1,000 admission/year (DY5). This would include having telepsychiatry equipment to access psychiatry services when needed. This would include the equipment needed to insure continuous access to the local clinical EHR application, telepsychi-atry, telephone access to law		

	enforcement and medical resources, security system, medication refrigeration, and other such equipment/ technology to insure the safe, continuous operation of this service. **Baseline/Goal:** Baseline – The Center's EHR and technology systems are insufficient to support a free-standing crisis respite service operation. Goal – To acquire and install technology in the crisis respite service area to appropriately support the level of patient services expected for this operation. **Data Source**: Center purchase orders, receipts and billing statements for completed work. **Milestone 8: Estimated Incentive Payment: $554,916**		
Year 2 Milestone Bundle Amount: $518,208	**Year 3 Estimated Milestone Bundle Amount: $3,329,500**	**Year 4 Estimated Milestone Bundle Amount: $1,669,500**	**Year 5 Estimated Milestone Bundle Amount: $1,906,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $7,423,208			

Category 1 Project Narrative – Pass 2
Central Counties Services – 081771001.1.5

Project Area, Option and Title: 1.10.2 Enhance improvement capacity through technology
RHP Project Identification Number: 081771001.1.5

Performing Provider Name: Central Counties Services (Center)
Performing Provider TPI #: 081771001

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012, we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations (MUP).
- **Intervention:** This project provides improved data management and organizational process improvement capacity which the Center wants to focus on reducing readmissions to state psychiatric hospitals and local jails by improving post discharge follow-up services. This project seeks to improve the efficiency of clinical service operations through improved technology, and thus increase the Center's service capacity.
- **Project Status:** This is a new project.
- **Project Need:** CN.2.11 Improve behavioral health service access and capacity in Bell, Lampasas and Milam Counties. 41% of admissions to the state psychiatric hospital system in FY2012 were re-admissions and the Center overused its share of state psychiatric beds in FY2012 by 10.87% (see Addendum 1G).
- **Target Population:** The focused target population for this project are persons with severe and persistent mental illness who have recently been discharged from a psychiatric hospital (496 in FY2012) or jail. 97% of all of the Center's patients are Medicaid (41.89%), uninsured or indigent. We anticipate this project will benefit this same population.
- **Category 1 or 2 Expected Project Benefit for Patients:** The Center will create data dashboards to monitor and guide the clinical improvement processes for our 7 other direct service 1115 Waiver Service Enhancement Projects which will impact an additional 2,000 persons in DY4 and an additional 4,000 persons DY5 who will be served through these innovative/transformational behavioral health projects implemented through DYs 3-5.
- **Category 3 Outcomes:** IT-1.18: Improved post-hospital discharge follow-up services at 7 days and 30 days to engage the patients in ongoing mental health treatment and medication support. We will strive for prompt follow-up with over 1,200 discharged

patients in DYs 3-5, and in so doing, keep as many of these patients engaged in our behavioral health system of care. We believe the timely service follow-up with patients recently discharged from a psychiatric hospital will reduce readmissions.

- **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

Project Description:

Process Improvements through Technology

This project seeks to establish a process improvement approach to increasing the Center's effective utilization of its talent and resources to serve persons in our local area who need behavioral health services, intellectual and developmentally disability services, and early childhood intervention services (addresses infant development/delay needs). For example, the Center had 496 state psychiatric hospital admissions in FY2011. Of the 496 admissions, 12 were children under 18 years of age. Twenty of these admissions were forensic admissions to restore competency to stand trial, and were discharged back to the referring County jail. 203 (41%) of these admissions were readmissions of people who had been previously hospitalized, while 293 (59%) were first admissions to the state psychiatric hospital system. In FY2011, between 9 and 10 patients were hospitalized each week, 4 of whom were re-admissions. Our Center wants to study the primary causes for these readmissions and, through organizational/service process improvement efforts, lower these readmissions to the state psychiatric hospital system. Finding ways to improve our post-discharge patient follow-up/engagement will be one of these improvement efforts.

The key to such an effort is easy, efficient and reliable access to a highly sophisticated clinical data system in which Center staff enter real-time patient demographic and service data that documents the clinical and support activities of Center staff, patient response to these activities and how these service activities interact with the patient to support the patient's functional improvement. This project will regularly seek system improvement ideas and feedback from Center clinical line staff, support staff, clinical leadership staff, administrative staff and patients to harvest the creative ideas and insights of those who are closest to service production successes and failures. This project will include the implementation of sophisticated software tools and systems with the efficient and error reducing capability of auto-sharing/auto-filing patient demographic and event data across the Center's internal divisions so that no data needs to be entered more than once and will have robust report writing capabilities. The project will include data/system analyst services that can design/redesign and implement data dashboards for the different parts and functions of our Center, to include the quality control/improvement strategies impacting the approximately 4,000 persons served through the Center's proposed 1115 Waiver projects. This project will establish data interfaces with other agencies (law enforcement, state psychiatric hospitals, local and regional health agencies, Temple Independent School District, etc.) in order to regularly draw information from them regarding factors that affect Center service access, delivery, and outcomes. This project will proactively explore ways that advancing technology can bring efficiencies to our Center operations, and consequently stretch our service dollars to increase our service access, quality and capacity. This project will form the operational hub for gathering data and monitoring the Center's

performance outcomes associated with its 8 Category 3 performance improvement plans. It will also utilize various internal and external sources of information to identify Center operational procedures (scheduling, use of telemedicine vs. in-person services, use of evening/weekend clinics, etc.), practices (community based services vs. office based services, collaborative patient charting, use of dictation vs. direct record entry, etc.), and patient events (e.g., patient no-show rates by clinic and by provider, medication non-compliance, etc.) that are deemed key to the Center's improving its operational efficiency, quality of services and service efficiency/capacity. This project will also focus on patient services as a customer service and seek to improve the Center's workflow so as to increase patient satisfaction with their time spent waiting for and receiving services. This process will seek to identify and remove non-value-added activities in the patient service process, while maximizing the value-added activities in the best possible sequence that supports efficient/effective patient service delivery (p.3, Chapter 44, Patient Safety and Quality: An Evidence-Based Handbook, Ronda Hughes, chapter author-http://www.ncbi.nlm.nih.gov/books/NBK2682/?report=printable).

On a semi-annual basis the Center staff involved with this project will summarize the outcome findings of the Center's improvement projects, analyze these outcomes to establish the Center's improvement progress, to set new goals for further organizational improvement, and to recommend new or related performance processes or indicators that would be considered for the Center's next phase of organizational/operations improvement.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to:

- Improve organizational service delivery efficiency, service quality and effectiveness of its service outcomes by enhancing access and use of operating data;
- Improving our data technology system to be more user-friendly, less cumbersome, highly reliable, high capacity, user responsive system for our 8 clinical operations over long distances (farthest distance between clinics is 120 miles – telemedicine providers are about 200 miles from Center clinics);
- Be able to have the right data at the right place at the right time;
- Use data to inform and support our Center's improved performance and service capacity; and
- Provide the data management tools and capacity to effectively manage the Center's direct care 1115 Waiver expansion/transformation projects.

This Project meets the following Regional Goals:

- Increasing coordination of prevention and care for residents, including those with multiple needs; and
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

Challenges:
The activities planned for DY2 are complex to accomplish if project approval comes in late Spring 2013. The Center recognizes this potential challenge and has already begun its work on Milestone 1 (data system planning/selection) to prepare the Center to take action upon project approval notice. We will need to identify a source for the data analyst/system analyst support needed by this project. The Center will be hiring at least one staff person to assist with the data gathering, data monitoring, data analysis, and formulation of system improvement paths based on the analyzed data, so will insure that the person hired has the professional knowledge and skills to support this and the 7 other system improvement projects.

5-Year Expected Outcome for Provider and Patients:
In 5 years, the Center expects to have a well-designed, user-friendly, high-speed data system that facilitates and supports multiple, simultaneous organizational improvement projects. The data system/technology will facilitate our service delivery system with unobtrusive, accurate automation support. This support will improve operation efficiency and improved service capacity/access to meet the behavioral health needs of our service area citizens. As a result, patient service episode time will be very efficiently organized and satisfying to the patients.

Starting Point/Baseline:
The Center is not currently using an organizational improvement process and does not have in place any quality management dashboards. The Center struggles with a data system that is dragging the clinical staff productivity down to unacceptable levels (around 40%). The data system is slow for our 80+ clinical users and at times unreliable due to its applications locking-up, which prompt staff to reboot their computers, having lost all work completed since last saving their work. Our data system is also vulnerable to power outages caused by storm damage, brown-outs due to power grid overuse in the hot summer months, and occasional utility work that disrupts the Center's electricity. Electrical power interruptions in the Temple area prompt our data system, phone system and telemedicine system to be inaccessible to our 80+ clinical staff whose work depends on access to the Center's electronic health record system. It is difficult and cumbersome to extract data from this system to be used for system monitoring and performance improvement. The Center recognizes that its 8 clinics all operate differently with various levels of efficiency and patient service satisfaction. Needless to say, we recognize that our service delivery system functions at a lower level than it can or should function. This recognition prompts us to undertake this project to enhance the Center's improvement capacity through technology.

Rationale:
<u>Community Need Addressed</u>:
- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Need: CN2.11- Improve behavioral health service access and capacity in Bell, Lampasas, and Milam Counties

The Center recognizes that technology and operating practices for our current behavioral health service environment are increasingly complex and intrusive to our historical operating

style of delivering behavioral health services. Our staff says they are spending more time documenting patient work than they are in delivering actual patient services. The Center has tried to get the best functional use from its technology and now clearly sees that our current data system and how it is applied in our practices is hampering our daily operations and has become a barrier to the Center's ability to efficiently access operating information needed to undertake an efficient, effective organizational improvement process. We are eager to improve our data system capability and to initiate processes that will engage our staff in a Center-wide organizational improvement process that is within our reach through this project. The Center believes it has committed, willing, professional staff that will promote and support improvement processes to increase our operational efficiency, service capacity and service effectiveness with long term, difficult-to-serve populations. Staff will be energized by their input and inclusion in systems improvement processes. We expect this project's outcome to be a well-designed workflow pattern that accommodates collaborative documentation (documenting services as they are being provided) and other technology supported efficiencies which enable us to operate with increased service access and capacity within the resources available to the Center. The outcome should also result in a fully functional, efficient data system that will address patient needs in a timely and accurate manner.

Project Components:

a) *Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.* The Center will have training sessions for all Center staff regarding our Center's process improvement strategies, methodologies and work culture implications within DY2. The Center will also use its established means of communicating organizational change through our quarterly Leadership Forums (all supervisors) and our monthly Human Resources Newsletter.

b) *Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction.* The Center will organize a suggestion system that will accommodate both identified and anonymous suggests regarding areas of the Center operations that could be improved upon. We will also utilize periodic electronic surveys (Survey Monkey) on focused topics under consideration/study for improvement.

c) *Design data collection system to collect real-time data that is used to drive continuous quality improvement (possible examples include weekly run charts or monthly dashboards).* This component will be addressed in DY4 through Milestone 6. We will also work with leadership and Quality Management staff to determine what data will be monitored on the continuously evolving Dashboards that we design and put in place to guide and monitor our 7 direct care 1115 Waiver projects and general Center operations in DY4.

Continuous Quality Improvement: The Center 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project does not supplant any services or funds currently provided to the Center from the U.S. Department of Health and Human Services. The services proposed to be provided under this project serve to enhance and expand, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

Related Category 3 Outcome Measures:

- OD-1 – Primary Care and Chronic Disease Management
  - IT-1.18 – Follow-up Hospitalization for Mental Illness - NQF 0576

This Outcome Measure was chosen due to its importance to persons with a severe and persistent mental illness to engage in outpatient services to continue receiving medications and support services directed at helping the person's potential for long-term negative symptom reduction and better ability to live in a stable manner in their community. For those patients who were suicidal when hospitalized, they are at higher than average risk of suicide within 30 days of hospital discharge. When discharged, their medications have brought more control over their disorganized thinking patterns and they are more able to formulate suicide plans and have the mental organization to carry them out. Thus, it is imperative to get them re-involved with the local behavioral health treatment system so that their suicidal risk can be assessed, their treatment/medications to be continued to consolidate and build on the symptom management gains from their hospitalization, and that the patients feel supported as they work to re-establish their living arrangements/ support system engagement in their home community.

"Nationally, only 42% of initial appointments following psychiatric hospitalization are kept. Missed appointments increase readmission frequency and increase costs of outpatient care. Among several recent studies looking at missed outpatient follow-up after hospital discharge, rates of failure to attend a first outpatient appointment ranged from 18 to 67%, with a median rate of 58%. Over time periods ranging from one to nine years about 30 % of patients disengage from mental health services. Taken together, research suggests that a significant proportion of individuals with serious mental illness are not engaged in mental health treatment as a result of dropping out of some form of care" (p. 3 National Quality Forum publication #0576 – http://www.qualityforum.org/WorkArea/linkit.aspx?Linkidentifier=id&ItemID=70617).

Relationship to Other Projects:

This project relates to the Center's telemedicine project (#081771001.1.2; RHP 16 #081771001.1.1 serving 900 people in DYs 3-5) which seeks to use highly reliable telemedicine and high-speed clinical EHR technology to increase timely access to psychiatric services in our service area. This project also relates to our School-based Mental Health project (#081771001.1.1 serving 420 children in DYs 3-5) which will need to flawlessly access the

Center's EHR system in a remote wireless, secure manner to interact with the Center's data system and make patient EHR entries. This project also relates to our Crisis Respite Services Project (#081771001.1.4; RHP 16 #081771001.1.2 serving 1,200 patients in DYs 4 & 5) that will need to use the Center's new telemedicine technology, the EHR clinical data system and the VOIP telephone system in a quick and reliable manner. This project relates to all of our Category 3 Quality Improvement Outcome Projects (#081771001.3.1, #081771001.3.2, #081771001.3.3, #081771001.3.4, #081771001.3.5, #081771001.3.6, #081771001.3.7, and #081771001.3.8) which will depend on a robust, user-friendly, high-speed reliable data system to collect, monitor and manipulate data into reports that document our Center's accomplishments through these projects.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Our Center is not aware of other Provider's Projects which relate to this project. We are committed to service improvement and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8 (see Milestones 5, 7, 8, 9 and 10).

Project Valuation:
This project's valuation includes the very core data functions and capabilities that are necessary for our Center to meet and manage the data needs of the Center's eight Medicaid 1115 Waiver Transformation Projects (including this project) that are proposed by our Center (See "Relationship to Other Projects" paragraph above). This project's valuation includes the value of improved service access by the people we serve, their improved quality of life and the cost-avoidance value gained from reduced psychiatric hospital readmissions through better discharge follow-up (over 1,200 patients are expected to be discharged from a psychiatric hospital in DY3 through DY5 and will need this follow-up), as shown in the Project Description section above. It also reflects the value of the clinical hours gained by the ability to complete patient records while serving the patient, and being able to complete EHRs in the field rather than traveling back to offices to accomplish this – both of which translate into increased service capacity. It includes the cost-avoidance value of an inaccessible data system that halts the work of 80+ clinical staff. The valuation also includes the technology assessment team's time spent in reviewing data systems, narrowing the choices, making site visits where different data systems are in use, understanding the computer hardware systems needed by each option, and then coming to a final data system recommendation. In addition, the valuation includes:

- Receiving our IT Department's technical support to this team process;
- Procuring, implementing and training IT staff needed to efficiently update our data system and stabilize its power supply to insure its 24/7 availability;
- Establishing the external data interfaces with key organizations in our service area;
- Providing staff training for those who will use the new data system, to include the costs of taking them away from their regular work duties to participate in the training;

- Composing, assembling and printing instructional/procedural manuals to help staff learning how to operate and get the best organizational use from the updated data system, to include computer lab instruction for those staff who will train others (train-the-trainer);
- Getting data analyst and system analyst assistance in designing our use of our data system to support Center's process improvement projects;
- Implementing process improvement training, the production of training documents/visual training presentations/ setting up an employee suggestion system and overseeing its use – evaluating the feasibility of suggestions for process improvement projects, etc.;
- Identifying technology applications that facilitate the Center's workflow and efficiency (e.g. technology that assists with the reduction of patient no-show events, etc.);
- Reviewing and analyzing the data for its organizational improvement implications, and formulate a report/presentation for the RHP Collaborative Learning conferences; and
- The Center's indirect program and central administrative costs.

This valuation reflects 79.5% of the total valuation (Region 8 contains 79.5% of our service region's population) while 20.5% of this project's valuation will be reflected in our project submitted to Region 16 (081771001.1.2).

Central Counties Services – 081771001.1.5 (Project 1.10.2 – Pass 2) Category 1 Milestones and Metrics			
081771001.1.5	1.10.2		Enhance improvement capacity through technology
Central Counties Services			081771001
Related Category 3 Outcome Measure:	081771001.3.8	IT-1.18	Follow-up after hospitalization for mental illness

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)
Milestone 1 [P-X] (see Planning Protocol, page 7): Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/ process redesign. **Metric 1** [P-X.7]: Establish and utilize a technology assessment team to delineate the functional requirements for the Center's data management capabilities needed to support the Center's care delivery system and service improvement projects. The team will review data system vender's products to ascertain which vender has a system that best matches the list of technological system required and desirable performance capabilities **Baseline/Goal:** Baseline - Center does not have a technology improvement plan. Goal - Center would have a written list of	**Milestone 4** [P-5]: Enhance or expand the organizational infrastructure and resources to store, analyze and share 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/Goal**: Baseline - Number of patient experience or quality measures data being collected was established under Milestone 3 in DY2. Goal - Increase the number of patient experience or quality measure data being collected by 6 patient data measures. **Data Source**: The Center's patient EHR system; patient survey results; reports generated to document the progress/outcomes of the Center's other improvement/transformation	**Milestone 6** [I-8]: Create quality dashboards or scoreboards to be shared with organizational leadership 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 dashboards or scoreboards **Baseline/Goal:** Baseline - The Center currently has no quality management dashboards for use by Center staff. Goal - Have at least 8 quality dashboards to monitor data streams of information that are key to our Center's improvement of its clinical operations and patient treatment outcomes, and the skillful, effective management of the Center's eight 1115 Waiver projects, particularly the timely clinical follow-up of patients being discharged from psychiatric facilities (estimated to be 400+ in DY4) associated with this project.	**Milestone 9** [P-9]: Participate in face-to-face learning 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. **Metric 1** [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP **Baseline/Goal:** Baseline - Progress reports presented in DY3 and the improvement goal(s) that was mutually agreed to by the providers. Goal - Prepare and deliver reports/ presentations on the accomplishments/ lessons learned from its implementation of organizational/ service delivery system improvement projects

technological system required and desirable performance capabilities and which data system best support these desired capabilities. **Data Source:** Technology team meeting notes and their final list of technological system required and desirable performance capabilities. The technology assessment team list of required and desirable data system capabilities, their vender scoring grids, and their choice of venders to upgrade the Center's data management system. **Milestone 1 Estimated Incentive Payment: $565,211** **Milestone 2** [P-X] (see Planning Protocol, page 7): Implement, adopt, upgrade or improve technology to support the project **Metric 1** [P-X.9]: The acquisition and implementation of the chosen data system upgrade. **Baseline/Goal:** Baseline - Center has a data system that does not adequately support the Center's clinical and organizational management needs. Goal - Center	projects; documentation of methodology for patient experience and/or quality measures data collection, analysis, and reporting **Milestone 4 Estimated Incentive Payment: $191,590** **Milestone 5** [P-9]: Participate in face-to-face learning 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. **Metric 1** [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP **Baseline/Goal:** Baseline -No organized forum for sharing or receiving health systems improvement project outcomes. Goal - Will have an organized forum for sharing its improvement project	**Data Source:** Quality improvement data systems **Milestone 6 Estimated Incentive Payment: $106,951** **Milestone 7** [P-9]: Participate in face-to-face learning 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. **Metric 1** [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP **Baseline/Goal:** Baseline - Have its progress reports presented in DY3 and the improvement goal(s) that was mutually agreed to by the providers. Goal - Prepare and deliver reports/presentations on the accomplishments/lessons learned	**Data Source**: Documentation of semiannual meetings including meeting agendas, Center presentations/ slides from presentations and/or meeting notes **Milestone 9 Estimated Incentive Payment: $176,013** **Milestone 10** [I-X]: Provide behavioral health services. **Metric 1** [I-X.1]: Provide documentation of increased behavioral health encounters resulting from increased organizational efficiency. **Baseline/Goal:** Baseline - the number of behavioral health service encounters delivered in DY3; Goal - 4,000 behavioral health encounters over baseline. **Data Source:** Standards will be set and routinely monitored through our electronic health record system. **Milestone 10 Estimated Incentive Payment: $176,013**

will implement upgrade that will adequately support the Center's clinical and organizational management needs **Data Source:** Purchase orders, receipts, data system operating manuals **Milestone 2 Estimated Incentive Payment: $565,211** **Milestone 3** [P-X] (see Planning Protocol, page 7): Establish a baseline, in order to measure improvements over self. **Metric 1** [P-X.6]: Establish a baseline of the number of quality measures and/or patient experience data currently being collected to be used as the baseline for Milestone P-5 to be implemented in DY3. **Baseline/Goal:** Baseline - Center does not currently have a master list of the quality measures and/or patient experience data. Goal - Center will have a master list of quality measures and/or patient experience data being collected **Data Source**: The technology	outcomes and hearing reports of improvement project outcomes that may be adapted to the Center's operations **Data Source**: Documentation of semiannual meetings including meeting agendas, Center presentations/slides from presentations and/or meeting notes **Milestone 5 Estimated Incentive Payment: $191,590**	from its implementation of organizational/service delivery system improvement projects **Data Source**: Documentation of semi- annual meetings including meeting agendas, Center presentations/slides from presentations and/or meeting notes **Milestone 7 Estimated Incentive Payment: $106,950** **Milestone 8** [I-X]: Provide behavioral health services. **Metric 1** [I-X.1]: Provide documentation of increased behavioral health encounters resulting from increased organizational efficiency. **Baseline/Goal:** Baseline - The number of behavioral health service encounters delivered in DY3; Goal - 2,000 behavioral health encounters over baseline. **Data Source:** Standards will be set and routinely monitored through our electronic health record system. **Milestone 8 Estimated Incentive**	

assessment team's data system list of required and desirable data system functions/capabilities, information gathered from the Center's Quality Management Dept. **Milestone 3 Estimated Incentive Payment: $565,211**		**Payment: $106,951**	
Year 2 Milestone Bundle Amount: $1,695,633	**Year 3 Estimated Milestone Bundle Amount: $383,180**	**Year 4 Estimated Milestone Bundle Amount: $320,852**	**Year 5 Estimated Milestone Bundle Amount: $352,026**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,751,691			

Category 1 Project Narrative – Pass 2
Little River Healthcare – 183086102.1.1

Project Area, Option and Title: 1.1.2 Expand Existing Primary Care Capacity
Unique Project Identifier: 183086102.1.1

Performing Provider Name: Little River Healthcare
Performing Provider TPI: 183086102

Project Summary:

- **Provider Description:** Little River Healthcare is the operator of a 25 bed Rural Hospital located in Rockdale, Milam County, Texas. Milam County is 1,016.93 square miles and has a population of approximately 24,757 according to the 2010 census report.
- **Intervention:** This project will increase the number of Primary Care Physicians (PCPs) which will allow the hospital to increase clinic hours by 5 hours per week and provide earlier diagnosis of chronic and life-threatening disease states prior to the disease requiring an emergency department (ED) visit and urgent care. This will better utilize the ED for true emergencies.
- **Project Status:** This project is expansion of an existing initiative to better utilize the ED, provide a positive experience when visiting the clinic, and improving the health of Milam County residents.
- **Project Need:** Milam County is considered a physician shortage area and medically underserved area as evidenced by the 2010 Census report showing a ratio of residents to Primary Care Physicians of 2,071:1. This is almost double the ratio for the State of Texas which is 1,050:1 (see CN.1.1—Limited access to primary care within Milam County). Milam County also has a high premature death rate of 9,592 which is ranked 160th of 221, according to the most recent (2006-2008) data from County Health Rankings & Roadmaps.
- **Target Population:** During the calendar year 2011, LRH treated over 1,500 individuals in the ED which were non-emergent, of which 23% were Medicaid claims, 24% were Medicare Claims, and 24% were services for the uninsured and indigent. Targeting these non-emergent visits by providing access to additional PCPs (I-12.1) is projected to benefit a minimum of 75 patients during DY4 and a minimum of 113 patients during DY5 that would be considered non-emergent patients. This will reduce claims by the Medicaid eligible, indigent, and uninsured patients while improving the care of Milam County residents.
- **Category 1 or 2 Expected Project Benefit for Patients:** By increasing access to PCPs, the project seeks to increase the volume of clinic appointments and visits (Improvement Milestone I-12.1). As the confidence, comfort level, and willingness of patients to seek treatment from PCP's in a primary care setting increases, the capacity to provide better care in this same setting will increase. We anticipate having an additional 500 new patient visits for primary care services in DY4 and 1,000 new visits in DY5. The additional PCPs will also benefit the over 17,000 people that visited the current clinics during the calendar year 2012 with improved convenience and shorter waiting times. A potential

4,828 individuals could benefit by the ability to have a convenient appointment that may prevent a condition from becoming an emergency. If only 25% or 1,200 individuals realize the benefit of the ability to have an appointment with a PCP, the cost savings would be over $2,000,000. Furthermore, the entire population of 24,757 of Milam County will benefit from the increased number of PCP's. The convenience of being able to have an appointment with the same physician when necessary will build confidence and trust to use the LRH clinics rather than driving elsewhere when their illness may have become more serious because the patient did not want to drive, have the time, or did not have the transportation necessary. During the calendar year 2012 there were approximately 17,000 visits to the LRH clinics. Many of these visits were more than likely the same individuals due to follow ups and general poor health of the individuals. If you were to estimate that 50% of these were the same individuals, the result would be approximately 16,000 people within the population who for various reasons have not benefited from the local clinic being convenient. With an increased number of PCPs, the number of excuses of why they do not see a physician would decrease.

- **Category 3 Outcomes:** IT-9.2: Our goal is to reduce all ED visits by a TBD% in DY4 and DY5. Using the base year of 2011 with the 1,500 non-emergent cases treated by the ED, and the estimated increases over the baseline, a minimum of 5% or 75 individuals would not visit the ED in DY4 and a minimum of 113 individuals would not visit the ED in DY5. In addition, with an increased number of available hours by PCP's, the State of Texas estimate of 19.5% residents of Milam County considered in poor or fair health will benefit also.

Project Description:

Expand Existing Primary Care Capacity

Within the State of Texas, 19.5% of rural residents report being in only "fair" or "poor" health compared with 15.6% of urban residents. Chronic conditions such as cardiovascular disease and diabetes are a bigger problem for rural populations than in urban or suburban areas. This is particularly the case in the South, and amongst rural minority communities, for whom obesity rates and other risk factors are markedly elevated. Rural clinics, community health centers and small rural hospitals provide the backbone of facility-based rural health care.

Little River Healthcare (LRH) will expand existing primary care capacity so as to promote "the right care at the right time in the right setting". LRH will accomplish the desired outcome of this project by hiring additional physicians and midlevel practitioners. The lack of timely and efficient access to physicians and midlevel practitioners in rural communities often result in over utilization of regional Emergency Departments (EDs) and/or Urgent Care Clinics. LRH will extend clinic hours to provide better access to preventive and non-emergent care services so as to avoid costly and unnecessary trips to the ED. Clinic hours will be extended by a minimum of 5 hours (either an additional hour per day or multiple hours on targeted high volume days of the week) each week by end of DY3 and then increase as needed based on availability of existing and new physicians. In addition, LRH will establish a hospital-based "Fast Track" process and program whereby patients will be able to see a primary care healthcare provider 24 hours a day 7 days a week as an alternative to utilizing the hospital ED for non-emergent after hour care needs. LRH will triage patient appointments to ensure that same day

appointment slots are available for most urgent patients. Patients will be identified as clinic candidates based on the level of a "tiered" triage system. The triage program and patient flow process will be researched and established during the planning process timeframe of DY2. Documentation of the medical care within the Fast Track program will be coordinated in a single hospital-owned electronic medical record. The Fast Track primary care provider will be able to interact electronically, via the "cloud based" electronic record system, with the patient's routine primary care provider so as to improve efficiency and accuracy of care as well as aid in the reduction of unnecessary duplicate medical tests and treatment. Statistical data will be extracted from the EHR on a monthly basis. Further, LRH will develop a house call program to more fully meet the primary care needs of patients who have limited or no means of transportation to primary care clinics. We will also use the house call program to follow discharges from the inpatient and ED of the Hospital. A primary intention of following inpatient discharges with House call providers will be avoiding potentially preventable readmissions. In addition and in cooperation with the Rockdale Independent School System (RISS), LRH will develop a school-based clinic program to insure all children in the RISS have access to primary care.

Goals and Relationship to Regional Goals:

Project Goals:

- Reduce ED utilization and redirect appropriate utilization to the primary care clinic; and
- Expand capacity to care for more children and young adults.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs; and
- Reducing inappropriate utilization of services.

Challenges:

A major challenge is attracting additional physicians to locate to Milam County. Milam County currently has a shortage of primary care physicians. That shortage impacts access to care which leads to poorer health outcomes. In Milam County, low income, uninsured and minority populations are steadily increasing due in part to the migratory nature of low income jobs prevalent to rural agricultural work opportunities, distressed rural economies, high unemployment rates as well as a migratory trends beginning to emerge where populations are leaving more urban areas looking for a lower cost of living generally thought to be associated with rural living in Texas. Because of a general lack of routine primary care, these groups of people are more likely to become chronically ill resulting in premature death. Lack of transportation, delays, and/or long wait times to see a physician can impact the outcome of the patient's willingness to seek primary and preventive care. In addition, underserved populations and the under-insured populations create critical issues for Milam County. In summary, increasing access to primary care physicians in Milam Count is imperative.

Little River plans to address these challenges in the following ways:

- Upgrade current facilities and equipment in the rural area;
- Educate the population about the availability of Primary Care Services available;

- Offer higher and completive salaries;
- Continue to recruit providers having a rural background; and
- Loan repayment and scholarship programs

5-Year Expected Outcomes:
The five year expected outcome will be to attract additional physicians to locate their practice in Milam County. With the additional primary care physicians there will be more primary care visits for preventative services, reduced ED use, and better education about primary care availability and prevention, resulting in overall better health within Milam County. Increasing primary care availability in Milam County will improve access for low income, uninsured and minority populations. Such populations are steadily increasing and are more likely to become chronically ill resulting in premature death. We expect to impact that through improved primary care availability. We further anticipate reducing the current delay and long wait times. We anticipate the improved access will impact patient outcomes through early detection and patient's willingness to seek primary and preventive care.

Starting Point/ Baseline:
Little River Healthcare currently employs 2.5 physician full time equivalents (FTEs) and 3 midlevel provider FTEs. While current patient needs are being served adequately, patient volume is growing and adequate accessibility and appointment availability will be difficult to maintain due to the increasing uninsured, underinsured and increasing minority population of Milam County. Milam County is a medically underserved population, not only do we need additional primary care providers for our current population but the ability to serve more patients as the county continues to grow. By increasing the number of physician FTE's, mid-level provider FTE's and hours of availability over the current baseline of FTE's and hours of availability, the health needs of the residents of Milam County will be better served. The exact number of additional primary care providers and the expanded hours of coverage will be determined as a result of the DY2 Milestone 1 and Metric 1.

Rationale:
<u>Community Need Addressed:</u>
- Community Need Area: CN.1 – Limited Access to primary care
- Specific Community Needs:
  - CN.1.1—Limited access to primary care within Milam County
  - CN.1.8—Limited access to preventive care (cancer screenings) in Milam County

Milam County residents often utilize the Hospital's ED for conditions that could be managed in a more coordinated manner if provided in a primary care setting. For certain segments of the population, it is culturally acceptable to seek non-emergent care in the ED. 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 these 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 outcomes, patient satisfaction, and appropriate utilization and reduced cost of services.

Healthy People 2020 outline several goals and objectives that also align with the goals of transformation waiver over the next 4 years: 1) patients should have a source of ongoing care; 2) have a usual primary care provider (PCP); and 3) reduce avoidable hospitalizations. By increasing the number of available healthcare providers and resources to support a growing population in Milam County, these goals can be achieved.

Milam County is considered both a HPSA (physician shortage area) and MUA (Medically Underserved Area), bordered by counties of the same designation. In order to expand primary care services, LRH will have to expand staffing base, clinic resources and increased hours of operations during times convenient for patients. Due to the *Affordable Care Act*, an additional 6 million people will be eligible for healthcare benefits in 2014. According to the Texas Department of Rural Affairs (2008), nearly 60% of office visits were for primary care, which puts severe strain on those providers.

Project Components:
The required core components will be fulfilled as follows:

a) *Expand primary care clinic space* – Existing space in the primary care clinic will be repurposed to expand primary care for additional practitioners.
b) *Expand primary care clinic hours* – In order to address overutilization in the ED for non-emergent care, clinic hours will be expanded as needed to provide better access in the primary care clinic.
c) *Expand primary care clinic staffing* – To meet the demand for additional hours and available appointments, LRH will add additional staff to meet patient's expectations and utilization needs.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Expansion of primary care is absolutely necessary for system wide improvement. With this expansion, more patients have access to preventive care, which increases opportunities to prevent disease and further deterioration of health status and will keep people out of the hospital. It is especially important for inpatients to get follow-up appointments after a hospital discharge for optimal recovery and to avoid readmission. The expansion of primary care and the increased availability of primary care level healthcare will reduce unnecessary ED utilization and streamline the delivery of primary care to the residents of Milam County and Rockdale, Texas. Reduced ED utilization will save Medicare and Medicaid dollars as well and aid in the prevention of chronic health issues as the result of early diagnosis and more coordinated care and prevention.

LRH receives funding from the U.S. Department of Health and Human Services for uncompensated trauma care; however, these funds will not be used for this project.

Related Category 3 Outcome Measure(s):

- OD-9 Right Care Right Setting

- IT-9.2 ED Appropriate Utilization (Standalone measure)

Through expanding primary care capacity, patients will have more access to primary care which will improve patient experience, improve preventive screenings and outcomes but most importantly improve availability. With the additional primary care physicians there will be more primary care visits for preventative services, reduced ED use, and better education about primary care availability and prevention, resulting in overall better health within Milam County. This is why we choose ED Appropriate Utilization as an Outcome Measure.

Relationship to Other Projects:
This project will assist in our efforts to develop a more expansive primary care base. An expanded primary care base will aid our organization to identify patients who would benefit from our other projects associated with health promotion and disease prevention (#183086102.3.1) as well as the reportable metrics for Category 4 Population-Focused Improvements. LRH has another proposed project (#183086102.1.2) which will address limited access to specialty care providers. These proposed projects will work together and communicate with each other; however, the projects will not overlap or duplicate each other. The specialty care providers, e.g. gastroenterologists and gynecologists, will be providing screening services and specialty care where as the primary care providers will be promoting better health and identifying patients needing specialty care and screening.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
LRH is proposing a project to expand primary care access. Two other providers are also expanding primary care: Williamson County and Cities Health Department (#126936702.1.1) and St. David's Medical Center Round Rock (020957901.1.1).

LRH will participate in an RHP 8 learning collaborative that meets semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better serve the populations in their projects.

Project Valuation:
Milam County is considered both a HPSA (physician shortage area) and MUA (Medically Underserved Area). Expanding the hours of service and locations for providers will provide greater access to care to people who have to this point utilized ED service for non-emergent health care needs. The 1,500 non-emergency patients that visited the ED in 2011 would have been better and faster served if they had easier access to PCP's through additional service hours or providers. In addition, the over 17,000 patients that visited LRH in calendar year 2012 would benefit from more convenient access to PCP's. The more convenient access to a PCP will encourage the current number of 4,308 individuals over 65 in Milam County to seek medical attention early, rather than waiting until admittance to an ED is necessary. Using this segment of 17.4% the population, or only 4,308 individuals taking advantage of the increase in PCP's and available hours over the project years of DYs 2–5, the cost of the project would equate to only $745 per individual. Which is much less than the $1,750 average charge of an ED visit.

In addition, patients will experience greater coordination of care, access to an integrated health system that includes primary care, specialty care, home health, case management and mental

health services. In 2011, Little River Healthcare experienced over 1,500 non-emergent patients in the ED, with each visit having an associated charge of $1,750. Redirecting those patients would provide a cost savings of over $2,625,000 in the ED. Considering that Medicare and Medicaid comprise 71% of total ED utilization, this program would result in reduction of nearly $1,800,000 to State and Federal payers. Additional cost savings would unquestionably be realized as a result of increased primary care hours and providers, through early detection and prevention of chronic illnesses, and as a result, reduce the need for emergent care services or patients' perceived need for emergent care services.

Little River Healthcare 183086102.1.1 (Project 1.1.2 – Pass 2) Category 1 Milestones and Metrics				
183086102.1.1	**1.1.2**	**1.1.2.a - 1.1.2.c**	**Expand Existing Primary Care Capacity**	
Little River Healthcare				**183086102**
Related Category 3 Outcome Measure (s):	**183086102.3.1**	**IT 9.2**	**ED Appropriate Utilization**	
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)**	
Milestone 1 [P-X]: Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign **Metric 1** [P-X.7]: Producing a plan to implement a process, system, infrastructure and staffing necessary to reduce unnecessary ED utilization **Baseline/Goal:** Report/Plan **Data Source:** Hospital Medical Record and Statistical Data **Milestone 1 Estimated Incentive Payment: $347,119** **Milestone 2** [P-X]: Establish a baseline, in order to measure improvement of primary care services over self	**Milestone 3** [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/Goal:** Establish a hospital based non-emergent primary care clinic **Data Source:** Clinic Operational Documentation **Milestone 3 Estimated Incentive Payment: $405,405** **Milestone 4** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric 1** [P-4.1]: Increased number of hours at primary care	**Milestone 5** [P-5]: Train/hire additional primary care providers and staff / 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. **Baseline/Goal**: Increase primary care providers by two (2) **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. **Milestone 5 Estimated Incentive Payment: $460,466** **Milestone 6** [I-12]: Increase primary care clinic volume of visits and	**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. **Baseline/Goal**: Increased volume for primary care visits by 1000 visits over DY2 baseline. **Data Source**: Registry, HER, claims or other Performing Provider scheduling scores **Milestone 7 Estimated Incentive Payment: $391,948** **Milestone 8** [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.	

Metric 1 [P-X.6]: Formulation of a baseline by which to monitor both the expansion of primary care services and the reduction of unnecessary ED Utilization **Baseline/Goal:** Creation of the baseline of unnecessary ED utilization; Baseline of PCPs is 2.5 FTEs **Data Source:** Hospital Medical Record and Statistical Data **Milestone 2 Estimated Incentive Payment: $347,119**	clinic **Baseline/Goal**: Increase Primary Care clinic hours by 5 hours a week **Data Source**: Clinic Documentation **Milestone 4 Estimated Incentive Payment: $405,405**	evidence of improved access for patients seeking services. **Metric 1** [I-12.1]: Documentation of increased number of visits. **Baseline/Goal**: Increased volume for primary care visits by 500 visits over DY2 baseline. **Data Source**: Registry, HER, claims or other Performing Provider scheduling scores **Milestone 6 Estimated Incentive Payment: $460,466**	**Metric 1** [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Identify and agree with the other providers on simple initiatives to "raise the floor" on performance. **Data Source:** Documentation of meetings including agenda and meeting notes. **Milestone 8 Estimated Incentive Payment: $391,949**
Year 2 Milestone Bundle Amount: $694,238	**Year 3 Estimated Milestone Bundle Amount: $810,810**	**Year 4 Estimated Milestone Bundle Amount: $920,932**	**Year 5 Estimated Milestone Bundle Amount: $783,897**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $3,209,877			

Category 1 Project Narrative – Pass 2
Little River Healthcare – 183086102.1.2

Project Area, Option and Title: 1.9.2 Improve access to specialty care
Unique Project Identifier: 183086102.1.2

Performing Provider Name: Little River Healthcare
Performing Provider TPI: 183086102

Project Summary:

- **Provider Description:** Little River Healthcare (LRH) is the operator of a 25 bed Rural Hospital located in Rockdale, Milam County, Texas. Milam County is 1,016.93 square miles and has a population of approximately 24,757 according to the 2010 census report.
- **Intervention:** This project will increase the access to Specialty Care Physicians (SCPs) by expanding the number of specialty providers and/or increasing clinic hours by 5 hours per week for the specialists most in demand. This will promote early diagnostic, screening, referral, and treatment services for at risk patients including low income and uninsured individuals.
- **Project Status:** This is a new project to improve access to timely, high quality and specialty care for the residents of Milam County.
- **Project Need:** CN.1.8 – Limited access to preventative care (cancer screenings) in Milam County. Milam County is considered a physician shortage area and medically underserved area. In addition to being older, the population of 24,757 has a higher percentage than the State of Texas for obesity and physical inactivity as well as a greater number of sexually transmitted infections which can lead to conditions and illnesses which are treatable when diagnosed early by the proper screening and diagnostic services. These risk factors warrant screening for breast cancer, (IT-12.1), cervical cancer, (IT-12.2), and colorectal cancer (IT-12-3). In addition, this project will address the need for referrals from other specialists in the same specialty, to oncologists for the treatment of positive screening results, and the referral to specialists and primary care providers when other health issues are diagnosed during a screening process, thus promoting general and long term health care, (I-25.1).
- **Target Population:** Milam County's population consists of 56.1% of individuals between the ages of 18 to 64, 17.4% 65 and older with 50.6% of the population being female, according to the 2010 Census. LRH is estimating that with the proper referral system (P-2.1) and education about the importance of screening, 200 – 1,000 individuals within Milam County will seek diagnostic services over DYs 2-5. However, this quantity of total diagnostic services is a only a "hoped for" result as this may take longer to achieve due to human nature, even when a diagnostic test may result in early detection of a potentially life threatening disease. The older population of Milam County, which is also primarily female, will benefit from preventive care and screening services, for breast cancer (IT-12.1), cervical cancer (IT-12.2) and colorectal cancer (IT-12.3) and will also benefit from the regular follow up screenings for the years thereafter. For those patients that receive a

positive diagnosis from a SCP, the referrals to another SCP for a second opinion or to an oncologist for a treatment plan will benefit the long term health and prognosis of the patient.

- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide SCPs and related access to preventive care and screenings, as well as oncologists and referrals to Primary Care Providers subject to the diagnosis of the SCP, for those groups which are considered to be at-risk, by increasing the number of providers, clinic hours, and procedure hours (I-22.1). According to the Agency for Healthcare Research and Quality, 19.5% of residents in rural areas consider themselves in only fair or poor health and could be labeled "at risk" because rural residents tend to smoke more, exercise less, and have less nutritional diets compared to urban areas. Currently, due to the shortage of SCPs there is a lack of access to preventive care and screenings and there is little to none targeting of these mentioned groups. Providing improved access to specialty care will be extremely important for referrals to other specialists (I-25) and follow up testing and care when there are positive test results from screening and diagnostics. Also, the expanded specialty care access will provide the patient the opportunity for follow up appointments in a familiar location in close proximity to their home or work rather than traveling a longer distance for an appointment. In addition, should a particular service or test not be available, the patient will be more likely to trust the referral of a specialty care physician that the patient has visited multiple times and is familiar with. The goal of the project with the improved access to SCP's, is to have a minimum of 100 referrals in DY4 with a 20% increase or 120 referrals in DY5 (I-25.1). As residents of the community do become familiar with the specialty care physicians they will be more willing to have regular screenings annually or as prescribed by the specialty care physician. Thus, the specialty care physician will notice any changes or differences between screenings. Currently there is no access to these services in Milam County.
- **Category 3 Outcomes:**
    - IT-12.1: Our goal is to increase by TBD% access to mammography and breast cancer screening services, as well as to inform and educate the Target population on detection.
    - IT–12.2: Our goal is to increase by TBD% access to cervical cancer screening services as well as to inform and educate the Target Population on prevention.
    - IT–12.3: Our goal is to increase by TBD% access to colorectal cancer screening services as well as inform and educate the Target Population on prevention.

Project Description:

Specialty Care Access

As of the census of 2010, Milam County had a population of 24,757 with a racial makeup of 78.1% White, 10.0% Black or African American, and 11.9% other races. The population was 6.9% under the age of 5, 26.5% under the age of 18, 49.2% over the age of 18 and under 64, and 17.4% over 65 years of age. The per capita income per household for the county was $21,509 and 17.6% of the population is below the poverty level. According to a report published by Agency for Healthcare Research and Quality, 19.5% of residents in rural areas report being in only "fair" or "poor" health compared with urban residents in the United States. Chronic conditions such as cardiovascular disease, pulmonary disease and diabetes are a bigger

problem for rural populations than in urban or suburban areas. This is particularly the case in the rural Texas for whom obesity rates and other risk factors are markedly elevated. In an excerpt from a CDC urban and rural chart book, "rural residents smoke more, exercise less, have less nutritional diets, and are more likely to be obese than suburban residents". Rural clinics, community health centers and small rural hospitals provide the backbone of facility-based rural health care. Supplementing the primary care services offered in such rural and community clinics with specialty care physician services is a rare, but very necessary, opportunity. Despite the overwhelming need for access to specialty services in rural populations, the access often simply does not exist. Milam County is no exception to this rule. It has an older, poorer population and access to physician specialty services, such as gastroenterology, mammography, and gynecology are necessary to ensure the health and vitality of Milam County residents.

LRH will expand specialty care capacity by providing additional space and resources for physicians and mid-level practitioners such as physician assistants and nurse practitioners to meet the population of our community most struggling to gain access to high impact specialty care services. Initially, we will identify through patient surveys and LRH's electronic health record (EHR) system the specialty services that are most critical to our population given current coverage and/or lack of coverage. We will then develop a clinical schedule that will increase the number of hours that are available to provide expanded specialty care for our patients by five (5) hours a week by either adding hours during the week or on Saturdays. We will implement a standardized referral processes across the system as well as expanding diagnostic testing capabilities specifically aimed at addressing medical screening and treatment needs of high impact specialty care services. We will provide improved access to specialty care and specialty diagnostic testing for our patients. We believe we will be able to aid our patients with avoiding costly trips to physicians located outside of Milam County and improve the overall health of our rural community.

Providing improved access to specialty care will be extremely important for follow up testing and care when there are positive test results from screening and diagnostics. The expanded specialty care access will provide the patient the opportunity for follow up appointments in a familiar location in close proximity to their home or work rather than traveling a longer distance for an appointment. In addition, should a particular service or test not be available, the patient will be more likely to trust the referral of a specialty care physician that the patient has visited multiple times and is familiar with.

In addition, as residents of the community become familiar with the specialty care physicians they will be more willing to have regular screenings annually or as prescribed by the specialty care physician. Thus, the specialty care physician will notice any changes or differences between screenings.

Goals and Relationship to Regional Goals:

Project Goals:

- Conduct a gap analysis to determine the specific specialty care needs of the community;

- Expand the number of specialty providers and/or clinic hours for highest demand specialties; and
- Complete planning and installation of new specialty diagnostic systems.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs; and
- Reducing inappropriate utilization of services.

Challenges:

A major challenge is attracting additional physicians to locate to Milam County. Milam County currently has a shortage of primary care physicians, let alone specialty care physicians. Certain high impact specialty care physician coverage is nonexistent all together. That shortage impacts access to care which leads to poorer health outcomes. In Milam County, low income, uninsured and minority populations are steadily increasing and are more likely to become chronically ill resulting in premature death. Lack of transportation, delays and long wait times to see a physician can impact the outcome of the patient's willingness to seek primary care, preventive care and specialty care. In addition, underserved populations and the under-insured populations create critical issues for Milam County. In summary increasing access to high impact specialty care physicians in Milam County is a must.

Little River plans to address these challenges in the following ways:

- Upgrade current facilities and equipment in the rural area;
- Educate the population about the availability of Specialty Care Services available;
- Offer higher and completive salaries;
- Continue to recruit providers having a rural background; and
- Loan repayment and scholarship programs.

5-Year Expected Outcomes:

The five year expected outcome will be to attract additional specialty physicians to locate their practice part-time and/or full-time in Milam County, thereby addressing the current shortage of high impact specialty care physician problem in Milam County. Addressing that issue will positively impact access to care which should lead to better health outcomes. Increasing specialty care availability in Milam County will improve access for low income, uninsured and minority populations. Such populations are steadily increasing and are more likely to become chronically ill resulting in premature death. We expect to impact that through improved specialty care availability. We further anticipate reducing the current delay and long wait times associated with our patients having to seek specialty care outside of Milam County. We anticipate improved access will impact patient outcomes and patient's willingness to seek treatment for specialty care needs once the patient is referred for specialty care by their primary care provider.

Starting Point/ Baseline:

Milam County is a medically underserved population. As such, LRH often refers patients to physicians located at least 45 miles outside of Milam County, one-way. This is not sufficient to

care for a growing and aging population and provide the level of services for those unable to afford or have access to suitable transportation over great distances from rural areas for care associated with high impact/most impacted medical specialties and specialty imaging and diagnostic services. The demand for services is reflected in the number of patients who are referred from our clinic to other physicians, the minority population and the number of citizens with Medicaid and those who are uninsured. LRH believes that the three (3) measures of testing for breast cancer (IT-12.1), cervical cancer (IT-12.2), and colorectal cancer (IT-12.3) are the basic level of specialty care necessary for Milam County and are the starting point for specialty care services.

Rationale:

Community Need Addressed:

- Community Need Area: CN.1 – Limited Access to Primary Care
- Specific Community Need: CN.1.8 – Limited Access to Preventive Care (cancer screenings) in Milam County

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed.

Project Components:

a. *Increase service availability with extended hours.* LRH will review EHR records and conduct a patient survey to determine the specialties needed locally and the expanded hours that would satisfy the demand.
b. *Increase number of specialty clinic diagnostic testing and imaging capabilities*. LRH will work with its specialty care physicians to expand the Hospital's specialty care diagnostic testing and screening/prevention capabilities to improve local access to high impact patient populations.
c. *Implement standardized referrals to specialty care providers across the system*. LRH will develop a process for the specialty and primary care physicians and clinics to have access to a specialty carereferral system available through LRH's "cloud" based EHR system. The referral system would be available whenever there is a positive screening result or a provider's diagnosis is that a patient's health would benefit from treatment by a specialty care provider. This will expedite patient care and improve patient access to a specific specialty care provider when treatment is prescribed.
d. *Conduct quality improvement for project using methods such as rapid cycle improvement.* LRH will develop a process where primary care providers and specialty care providers will be able to easily communicate concerning patient treatment plans as well as share test results and clinical findings within through the EHR and referral management system.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Expansion of specialty care is absolutely necessary for system-wide improvement of LRH's services. With this expansion, more patients have access to preventive care, which increases opportunities to prevent disease and further deterioration of health

status and will keep people out of the hospital. The expansion of specialty care and the increased availability of specialty healthcare will reduce unnecessary ED utilization and streamline the delivery of specialty care to the residents of Milam County and Rockdale, Texas. Reduced ED utilization will save Medicare and Medicaid dollars as well and aid in the prevention of chronic health issues as the result of early diagnosis and more coordinated care and prevention.

LRH receives funding from the U.S. Department of Health and Human Services; however, these funds will not be used for this project.

Related Category 3 Outcome Measure(s)

- OD-12: Primary Care and Primary Prevention
  - IT-12.1 – Breast Cancer Screening
  - IT-12.2 – Cervical Cancer Screening
  - IT-12.3 – Colorectal Cancer Screening

These three Category 3 Outcome measures were chosen because currently there is no known mammography screening available in Milam County. With females comprising 50.6% of the population, LRH foresees a need for this service as the population ages. Milam County also ranks above the State of Texas in percentage points for adult obesity and physical activity which are both factors on colorectal cancer. The incidences of sexually transmitted diseases and teen birth rate, which are risk factors of cervical cancer, are also higher in Milam County than Texas. Given these health related factors and Milam County ranked 201st out of 221, LRH feels that the three (3) outcome measures are needed to screen for potentially life-threatening conditions.

Relationship to Other Projects:

This project will assist in our efforts to address high impact specialty care services. An expanded specialty care base will aid our organization to identify patients who would benefit from our other projects (#183086102.3.2, #183086102.3.3 and #183086102.3.4) associated with health promotion and disease prevention as well as the reportable metrics for Category 4 Population-Focused Improvements. LRH has another proposed project (#183086102.1.1) which will address limited access to primary care providers. Through our primary care project (#183086102.1.1) and this project, local specialists will be able to better coordinate care and provide health status reports to the referring patient's primary care providers.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:

LRH will participate in an RHP 8 learning collaborative that meets at least semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better serve the populations in their projects. As well as identify and agree on improvement initiatives to raise performance.

Project Valuation:

Milam County is considered an HPSA (physician shortage area) and MUA (Medical Underserved Area). Expanding the hours of service and diagnostic testing and screening capabilities for specialists will provide greater access to care for the target population. In addition, patients

will experience greater coordination of care, access to an integrated health system that includes primary care, specialty care, house call services, home health, case management and mental health services. Providing additional specialty services locally such as Hospitalist Coverage, Breast Cancer Screening and Mammography, Breast Biopsy and Breast Surgery, Gynecology, Gastroenterologist, Neurology, Pain Management, Cardiac and Pulmonary Rehabilitation, Wound Care and Geriatric Phycology should lead to lower hospitalization costs, better access to care and improved quality of life for those patients with chronic illnesses and those patients that screening and early detection prevented a life threatening condition. According to the 2010 Census, 17.6% of the Milam County population was below the poverty level and 27% of Milam County was uninsured. We expect that the benefits from this project will lead to lower costs to Little River Healthcare and Texas' health care system overall and it will provide better patient satisfaction and outcomes since early detection and follow-up would be more readily available. Based on 2010 Census data and a publication by the Agency for Healthcare Research and Quality, this Project could benefit a range of Milam County residents of anywhere from 3,215 individuals that represent the 19.5% of rural Texas residents that only consider themselves in fair or poor health, to 8,344 individuals, representing the female population over the age of 18. This is largely due to rural residents smoke more, exercise less, and have less nutritional diets compared to urban areas, as published by Agency for Healthcare Research and Quality.

Screening services associated with specialty care physicians are unavailable in Milam County. Using the 2010 Census population for Milam County of 24,757, if only 10%, or 2,475 individuals over DY3, DY4 and DY5, take advantage of the screening tests which could result in early detection of cancer. The cost of the project, would equate to $1,212 per individual, which if anyone of these individuals have a positive result, would be less than the treatments for cancer or chronic diseases in later stages.

The associated cost for completing this project include the personnel and external entities we will utilize to establish a project plan and perform a gap analysis, the physician and support personnel that will need to be hired to effect the implementation of our plan and the on-going cost of support personnel and diagnostic technology to effect expanded specialty care screening, prevention and treatment. Other ongoing costs include but are not limited to patient education material needed to inform patients of their treatment plan and health condition as well as survey material needed assess patient satisfaction level and monitor outcome.

Little River Healthcare 183086102.1.2 (Project 1.9.2 – Pass 2) Category 1 Milestones and Metrics				
183086102.1.1	**1.9.2**	**1.9.2.a – 1.9.2.d**	**Improve Access to Specialty Care**	
Little River Healthcare				**183086102**
Related Category 3 Outcome Measure(s):	**183086102.3.2** **183086102.3.3** **183086102.3.4**	**IT-12.1** **IT-12.2** **IT-12.3**	**Breast Cancer Screening** **Cervical Cancer Screening** **Colorectal Cancer Screening**	
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)**	
Milestone 1 [P-7]: Complete a planning process/submit a plan to implement electronic referral technology **Metric 1** [P-7.1]: Development of a staffing plan for referral system **Baseline/Goal:** One (1) Staffing Plan **Data Source**: Referral plan, describes the number and types and staff and their respective roles needed to implement the system. **Metric 2** [P-7.2]: Development of an implementation plan for e-referral **Baseline/Goal:** One (1) Implementation Plan for e-Referral **Data Source:** Referral plan, which describes the technical mechanisms needed to operate e-referral system.	**Milestone 4** [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/Goal:** Create the capacity to consistently and uniformly manage all referrals into medical specialties on One (1) System **Data Source:** Log of specialty care personnel trained and Curriculum for training. **Milestone 4 Estimated Incentive Payment: $221,130**	**Milestone 7** [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, clinic hours and/or procedure hours in targeted specialties a. Numerator: Number of specialist providers in targeted specialties over baseline or change in the number of specialist providers in targeted specialties b. Denominator: Number of monthly or annual referrals into targeted medical specialties clinic or number of specialist providers in targeted specialties at baseline **Baseline/Goal:** Increase the number of equivalent hours by 20% over baseline	**Milestone 10** [I-25]: Increase the number of referrals for the most impacted specialties that are reviewed and assigned into appropriate categories (i.e., urgent appointment, routine appointment, or e-consult) **Metric 1** [I-25.1]: Number of referrals appropriately categorized **Baseline/Goal:** Increase referrals in DY5 120 over baseline as determined in DY2. **Data Source**: Referral management system, patient's paper or electronic medical record. EHR system is "cloud" based system **Milestone 10 Estimated Incentive Payment: $320,684** **Milestone 11** [P-21]: Participation in face-to-face learning (i.e. meetings or	

Milestone 1 Estimated Incentive Payment: $189,338 **Milestone 2** [P-11]: Launch/expand a specialty care clinic **Metric 1** [P-11.1]: Establish/expand specialty care clinics **Baseline/Goal:** One(1) Clinic **Data Source**: Documentation of new/expanded specialty care clinic **Milestone 2 Estimated Incentive Payment: $189,337** **Milestone 3** [P-13]: Complete planning and installation of new specialty systems (e.g., imaging systems). **Metric 1** [P-13.1]: Documentation of planning and installation of new systems **Baseline/Goal:** One (1) Specialty System **Data Source:** Specialty Care provider GAP Analysis	**Milestone 5** [P-6]: Develop and implement standardized referral and work-up guidelines **Metric 1** [P-6.1]: Referral and work-up guidelines **Baseline/Goal:** Operational Referral and work up guideline manual **Data Source:** Best practices and policy and procedure manuals from other rural hospitals **Milestone 5 Estimated Incentive Payment: $221,129** **Milestone 6** [P-11]: Launch/ expand specialty care clinics **Metric 1** [P-11.1]: Establish/ expand specialty care clinics **Baseline/Goal:** Increase by One (1) (for a total of 2) the number of specialty care clinics over the Baseline determined in DY2 **Data Source**: Documentation of new/expanded specialty care clinic **Milestone 6 Estimated Incentive**	**Data Source:** HR documents or other documentation demonstrating employed/contracted specialists with a "cloud" based EHR system. **Milestone 7 Estimated Incentive Payment: $251,164** **Milestone 8** [I-25] : Increase the number of referrals within Referral System **Metric 1** [I-25.1]: Number of referrals within Referral System **Baseline/Goal:** 100 referrals in DY4 over the baseline as determined in DY2 **Data Source**: Referral management system, patient's paper or electronic medical record. EHR system is "cloud" based system **Milestone 8 Estimated Incentive Payment: $251,163** **Milestone 9** [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.	seminars) at least twice per year with other providers and the RHP to promote collaborative learning. **Metric 1** [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal**: Increase the initiatives that are identified and agreed upon with the other providers over the baseline determined in DY4. **Data Source:** Documentation of meetings including agenda and meeting notes. **Milestone 11 Estimated Incentive Payment: $320,685**

Milestone 3 Estimated Incentive Payment: $189,337	**Payment: $221,129**	**<u>Metric 1</u>** [P-21.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Identify and agree with the other providers on simple initiatives to "raise the floor" on performance. **Data Source:** Documentation of meetings including agenda and meeting notes. **Milestone 9 Estimated Incentive Payment: $251,163**	
Year 2 Milestone Bundle Amount: $568,012	**Year 3 Estimated Milestone Bundle Amount: $663,388**	**Year 4 Estimated Milestone Bundle Amount: $753,490**	**Year 5 Estimated Milestone Bundle Amount: $641,369**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,626,259			

Category 1 Project Narrative
St. David's Round Rock Medical Center – 020957901.1.1

Project Area, Option and Title: 1.1.2 Expand Existing Primary Care Capacity
RHP Project Identification Number: 020957901.1.1
Performing Provider Name: St. David's Round Rock Medical Center
Performing Provider TPI #: 020957901

Project Summary:

- **Provider Description:** Round Rock Medical Center (RRMC) is a 173 bed hospital located in Round Rock serving the Williamson and Travis County communities representing approximately 2,100 square miles and a population of approximately 1.5 million.
- **Intervention:** This project entails RRMC expanding the availability of primary care services to a targeted low-income population in Williamson County that does not have existing health coverage, by paying existing local clinics and/or FQHCs to provide services to the population.
- **Project Status:** This project represents a new initiative for RRMC.
- **Project Need:** CN.1.2 - Limited access to primary care for Williamson County residents under 200% FPL. In Williamson County, 16.5% of adult residents are uninsured (See Table 3-3). These patients often use hospital emergency departments (EDs) as their primary source for care and, between 2006 and 2010, Williamson County had almost $327 million in charges for Potentially Preventable Admissions (see Table 3-6). Low income patients in Williamson County have a need for expanded availability of primary care services, which will only occur if primary care physicians are willing to see these patients. The only FQHC in Williamson County that accepts indigent patients currently, Lone Star Circle of Care, is at capacity for adult patients and has a three-four week waitlist for appointments.
- **Target Population:** The target population for this project is Williamson County residents who are uninsured or underinsured, can demonstrate income levels at or below 200% of the Federal Poverty Level, and do not have any source of payment such as existing public assistance programs. RRMC anticipates this will represent approximately 5,000 individuals, all of whom are low-income. This project will also benefit Medicaid and low-income patients who do not qualify for the program indirectly, by reducing utilization of EDs within the region and thereby increasing access for these other patients. Based on current volumes and patient demographics, RRMC provides between an estimated 40,000 to 45,000 distinct encounters of care in its ED annually, of which an estimated 40% to 45% represent Medicaid or low-income patients, which RRMC expects to increase over time.
- **Category 1 or 2 Expected Project Benefit for Patients:** In DY2, RRMC will establish a baseline for availability of these services and develop an implementation plan regarding eligibility determinations, partnering with local providers, and putting the program into action during DY3. In DY3, this project seeks to increase the number of services hours available in at least one participating clinic by 5 hours per week over DY2, and to implement the primary care expansion program by enrolling eligible patients. By the beginning of DY4, RRMC expects to have at least 900 uninsured individuals enrolled in the program to receive services through this project. RRMC expects at least 225 additional individuals to benefit from the program in DY4, and at least 280 additional individuals to benefit from the project in DY5 (over the DY4 total of 1,125 patients).

- **Category 3 Outcomes:** IT-9.2: RRMC's goal is to reduce the use of RRMC's ED for non-emergent episodes stemming from diabetes, by a percentage yet to be determined from the baselines established in DY2.

Project Description:

Community Clinic Services Project

RRMC wishes to expand the availability of primary care services to a targeted low income population in the Williamson community that is currently uninsured or underinsured and does not qualify for existing public assistance programs, but still meets the following income thresholds: at or below 200% FPL and has no other payment source ("working poor"). RRMC also sees the potential to add specialty physician services, pharmacy services and laboratory services as necessary based on an assessment of the population that utilizes these primary care services. RRMC plans to expand the availability of these primary care services by paying existing local clinics and/or FQHCs in Williamson County to provide services to this population, and potentially by partnering with clinics and FQHCs in other communities to expand their services into Williamson County. The Williamson County and Cities Health District (District) will infrastructure and resources to assist in the delivery of care to the population RRMC wishes to serve.

Goals and Relationship to Regional Goals:

The goal of this project is to improve health outcomes and access for this population by allowing them to receive the right care in the right setting, and to help address the current challenges for these patients. Specifically, these patients often do not receive primary and preventative care from the current health care safety net in Williamson County and, as a result, miss the opportunity to obtain early screening and treatment for conditions that can be managed and/or prevented with proper early intervention. The consequence of this lack of care is that these patients suffer from worse short- and long-term health outcomes and quality of life, while the end cost of treating their conditions to the health care system is increased, as the patients will likely end up in the emergency department (ED) or admitted to the hospital if and when their conditions turn acute.

Specific Project Goals:

- A 5 hour increase in service hours in at least one participating clinic over the baseline established in DY2 – RRMC believes that increasing the hours of availability will allow local clinics to see new patients, both because some patients cannot access clinics during normal business hours and because some patients cannot obtain appointments due to local clinics being at or above their current capacity. A five hour increase in available hours per week in at least one clinic is intended to provide meaningful change while being realistic in consideration of the resources available in the community.
- Increase patient impact by 225 patients in DY4 (reflecting a 25% increase based on expected patient participation of 900 patients by DY4); Increase patient impact by 280 patients in DY5 (reflecting a 25% increase based on expected patient participation of 1125 patients by DY5). RRMC is targeting an increase in the volume of uninsured, working-poor patients seen at local clinics because RRMC believes more primary care will result in improved patient outcomes and reduced systemic costs for treating these patients. The targeted increases in patient volume, over baseline, will create a meaningful impact on

the community (health- and cost-wise), and be a realistic goal in light of current capacity and resources.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing the proportion of residents with a regular source of care;
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:
Expected challenges in implementing and maintaining this project include: identifying providers willing to serve this population on top of the current population they serve; allocation of resources in the most efficient manner to reach the maximum number of underserved patients; patient education on the availability of services; and eligibility screening. RRMC expects to address these challenges by effectively leveraging existing primary care capabilities to create additional capacity to treat a new population of patients.

5-Year Expected Outcome for Provider and Patients:
RRMC expects this project to result in increased primary care access for a currently underserved patient population. The increased primary care access should result in increased hours of availability by providers and increased volume of patients, which will ultimately allow providers to more effectively manage and/or prevent the onset of chronic conditions linked to poor lifestyle, lack of medication management, or lack of early intervention. The new patients seen in the existing clinics are expected to experience improved short- and long-term health outcomes, greater satisfaction with the healthcare system, great quality of life when managing chronic diseases, and a reduction in the misuse of the ED for primary care (which will reduce the systemic cost of providing healthcare for the Region).

Starting Point/Baseline:
Currently, Williamson County uninsured, indigent patients only have local access to care through Lone Star Circle of Care, which is a local FQHC. Lone Star is at currently at capacity for adult patients, and has a three to four week waitlist for appointments.

Rationale:
Community Need Addressed:

- Community Need Area: CN.1 - Limited access to primary care
- Specific Community Need: CN.1.2 - Limited access to primary care for Williamson County residents under 200% FPL.

From a population perspective, 16.5% of Williamson County's adult residents are uninsured and 10.7% of children are uninsured (RHP Plan, Section III, Table 3-3), 5.5% live below poverty levels (RHP Plan, Section 3, Table 3-1), and 7.4% are unemployed. These groups have very little access to primary and preventative care, especially in circumstances where their household income is slightly above the thresholds for existing public assistance programs in the County.

Between 2006 and 2010, Williamson County had $326,889,520 in charges for Potentially Preventable Admissions (RHP Plan, Section III, Table 3-6), with especially high rates of PPAs for angina, bacterial pneumonia, COPD, diabetes, and urinary tract infections (RHP Plan, Section III, Table 3-6). Each of those conditions can be either prevented or managed through regular access to primary health care, and avoiding hospitalization will benefit both patient outcomes and systemic healthcare costs. Specifically, these conditions can be prevented or managed with proper screening, intervention, patient education, and monitoring by primary care providers. It is imperative for improving Williamson County's overall health outcomes that underserved patients have access to primary care services. The District will assist in the provision of care to these patients by working with participating clinics to track the number of targeted patients served by this project, and to obtain documentation of increased hours at participating clinics. This project will seek to treat patients who are unable to receive primary care elsewhere, which will improve patient health outcomes and reduce the overall cost of treating these patients.

Core Project Components:
Project area 1.1.2 includes three core requirements: **a)** expand primary care clinic space, **b)** expand primary care clinic hours, and **c)** expand primary care clinic staffing. However, Section IV of the CMS-approved Planning Protocol allows providers to exclude core requirements if justified in the project narrative. With this project, RRMC envisions the local clinics with which it partners will necessarily expand their available hours to see additional patients, and RRMC will meet that core requirement with this project. However, RRMC does not intend to expand the physical clinic space available in the community, or to add additional clinical staff as a milestone, but RRMC will require contractors to maintain adequate staff levels in order to meet the needs of the patient population served by this program. This project is intended to make use of existing clinic space and staffing in the community, and expand the population treated by the existing staff in the existing space. By using existing primary care clinic settings, the need to achieve the core component of expanding clinic space is unnecessary. Participating clinics will be selected based on the accessibility for population served.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: RRMC does not receive funding from other U.S. Department of Health and Human Services initiatives that would be used for this project.

Related Category 3 Outcome Measure(s):

- OD – 9: Right Care, Right Setting
  - Process Milestones: P1, P2
  - Improvement Target: 9.2 – ED Appropriate Utilization

Expanding primary care is intended to improve patient health outcomes and satisfaction and transform the delivery system in a manner that reduces the institutional cost of providing healthcare to the indigent community. A large portion of the high cost of healthcare stem from inappropriate use of the ED, which is often the first and only destination for indigent patients seeking primary care services. RRMC intends for this project to give indigent patients currently unable to afford primary care an easier, earlier, and more appropriate setting in which to obtain the care they need. As a result, RRMC expects a reduction in the use of the ED by patients suffering from diabetes, which is a prevalent chronic disease in the county and the State.

Relationship to Other Projects:
Category 4 population focused measures: This project should impact RD1 (Potentially Preventable Admissions), RD2 (30 day readmissions), and RD4 (Patient-centered Healthcare).

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative:
This project relates to other RHP 8 projects performed by the District, including:

- 126936702.1.1 Expanded Capacity to Access to Care;
- 126936702.1.2 Expand Access to Urgent Care and Enhance Urgent Medical Advice;
- 126936702.1.3 Implement project to enhance collection, interpretation, and/or use of REAL data; and,
- 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.

Utilizing a multi-disciplinary team of case managers, community health workers, eligibility workers/program navigators, marketing staff, analysts, and healthcare professionals within our service area in the community, we can work to link residents to needed resources (i.e. medical home, programs that will promote a healthy lifestyle), assist with their preventive health needs, and capture the data necessary to identify community needs. Additional access to this type of primary care would reduce the elevated costs associated with urgent and emergent care services by allowing earlier screening, diagnosis, treatment and/or management, before the condition reaches the level that necessitates a higher level of care.

Project Valuation:
The valuation of each RRMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. RRMC considers this project as high need because it will serve at least 1,400 residents in the community who are currently without primary care access, and reduce the rate of this population misusing emergency departments for primary care services. Assisting this population in navigating the health care system and connecting them to a primary home rather than utilizing the ED results in significant cost savings to hospitals in the community. In addition, the return on investment for serving this population will also result in less number of work hours missed which in turn increases productivity and economic values. Furthermore, the project seeks to accomplish delivery system reform by understanding that clinical primary care providers are in a shortage in this community, the existing wait time for a primary care visit is more than 9 days, and additional financial support is needed in order to maintain and expand the availability of primary care services. The systemic cost of providing health care to the community will be reduced in the aggregate by making this investment in local primary care access.

St. David's Round Rock 020957901.1.1 (Project 1.1.2) Category 1 Milestones and Metrics			
020957901.1.1	1.1.2	1.1.2.a - 1.1.2.c	Expand Existing Primary Care Capacity
St. David's Round Rock			020957901
Related Category 3 Outcome Measure(s):	020957901.3.1	IT-9.2	ED Appropriate Utilization

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)
Milestone 1 [P-X] (*Additional Process Milestones listed on page 7 of the Planning Protocol*): Establish a baseline, in order to measure self-improvement. **Metric 1** [P-X.6]: Baseline number of service hours established at clinics identified as potential participants in the Community Clinic Services Project. **Baseline/Goal:** To determine the number of service hours currently available at participating clinics and to assess the potential for increasing those hours going forward. **Data Source:** Schedule of Primary Care clinics **Milestone 1 Estimated Incentive Payment: $1,670,761** **Milestone 2 [P-X]** (*Additional Process Milestones listed on page 7 of the*	**Milestone 3** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. **Metric 1** [P-4.1]: Increased number of hours at primary care clinic over baseline **Baseline/Goal:** The goal is to increase the number of service hours available for at least one clinic participating in the Community Clinic Services Project by at least 5 hours per week over the baseline established in DY2. **Data Source:** Clinic Documentation regarding open service hours **Milestone 3 Estimated Incentive Payment: $1,592,039** **Milestone 4 [P-X]** *(Additional Process Milestones listed on page*	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1** [I-12.2]: Documentation of unique patients. Demonstrate improvement over prior reporting period. **Baseline/Goal:** RRMC expects at least 900 eligible patients to be enrolled in the program and utilizing primary care clinic services by the end of DY3. The goal in DY4 is to increase that number by 225 (25% increase over estimated DY3 baseline), for a total patient impact of at least 1,125 uninsured patients in DY4. **Data Source:** Administrative data and claims **Milestone 5 Estimated Incentive Payment: $2,985,073**	**Milestone 6** [1-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1** [I-12.2]: Documentation of unique patients. Demonstrate improvement over prior reporting period. **Baseline/Goal:** RRMC expects at least 900 eligible patients to be enrolled in the program and utilizing primary care clinic services by the end of DY3 and 1,125 eligible patients to be enrolled by the end of DY4. The goal in DY5 is to enroll an additional 280 patients (25% increase over estimated DY4 total, 64% increase over estimated DY3 baseline), for a total patient impact of at least 1,405 uninsured patients. **Data Source:** Administrative data and claims **Milestone 6 Estimated Incentive Payment: $2,268,656**

Planning Protocol): Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development or program/process redesign **Metric 1** [P-X.7]: Development of a plan for implementing the collaboration between RRMC and WCCHD to enroll eligible uninsured patients into the new primary care program. **Baseline/Goal:** Develop a plan for determining eligibility of Williamson County residents, for garnering provider participation, and for effectuating the expanded primary care access to uninsured patients. **Data Source:** Documentation of plans between WCCHD and RRMC **Milestone 2 Estimated Incentive Payment: $1,670,762**	*7 of the Planning Protocol):* Pilot a new process and/or program **Metric 1** [P-X.2]: Implement the collaboration between RRMC and WCCHD to enroll eligible uninsured patients into the new primary care program. **Baseline/Goal:** Commence enrollment of eligible patients in the new program, who can then access primary care services from participating providers **Data Source:** Administrative data and claims showing enrollment **Milestone 4 Estimated Incentive Payment: $1,592,040**		
Year 2 Milestone Bundle Amount: $3,341,523	**Year 3 Estimated Milestone Bundle Amount: $3,184,079**	**Year 4 Estimated Milestone Bundle Amount: $2,985,073**	**Year 5 Estimated Milestone Bundle Amount: $2,268,656**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $11,779,331			

Category 1 Project Narrative
Williamson County & Cities Health District - 126936702.1.1

Project Area, Option and Title: 1.1.2 Expanded Capacity for Access to Care
Unique Project ID: 126936702.1.1

Performing Provider Name: Williamson County & Cities Health District (WCCHD)
Performing Provider TPI #: 126936702

Project Summary:

- **Provider Description**: Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
- **Intervention:** This project will expand capacity of access to preventive clinical care through availability of same day or next day appointments by increasing the level of health care professionals and extended hours.
- **Project Status:** This project is an expansion of an existing initiative and will add a total of 6,072 encounters in addition to the current 8,800 encounters by the end of DY 5.
- **Project Need:** CN.1.6 – Limited access to primary care for preventive services with same day or next day appointments and extended hours in Williamson County. Uninsured and underinsured residents of Williamson County have limited access to primary care, specifically same day or next day appointments and extended hours. Same day clinical services refers to those focused services for which access to walk-in or same day appointments is necessary to achieve maximum primary, secondary, and tertiary prevention of acute and chronic illnesses. These include but are not limited to: Pregnancy confirmation; integrated eligibility; WIC/Nutrition and vitamin supplementation; Sexually Transmitted Infections (STI) screening and Expedited Partner Therapy; and Vaccine Preventable Disease screening / immunization. WCCHD currently has one nurse per site, limiting the maximum number of appointments and walk-in patients able to be seen on any given day. With the limited number of appointments offered and the wait time of 3-4 weeks for a new patient visit to the local FQHC, patients are using the Emergency Department (ED) for preventable health services.
- **Target Population:** The target population of this project is approximately 80,000 uninsured or underinsured patients in need of preventive clinical services which also includes pregnancy confirmation offered through extended hours with same or next day appointment and/or walk-in basis. There were approximately 8,800 preventive health services delivered at WCCHD in 2012. Approximately 50% of our current patients are either Medicaid eligible, low income uninsured or indigent, so we expect them to benefit from about half of the proposed project's services.
- **Category 1 or 2 Expected Project Benefit for Patients:** By adding additional same or next day appointments and increasing health care personnel, the project seeks to provide 11,440 encounters in DY4 (2,640 over baseline) and 14,080 encounters in DY5 (5,280 over baseline (see Improvement Milestone I-12.1).
- **Category 3 Outcomes:** IT-6.1: Our goal is to improve patient satisfaction scores related to timely care, appointments and information by 10% over baseline in DY4 and 20% over

baseline in DY5. Satisfaction scores gathered from the patient satisfaction surveys will demonstrate improve utilization rates of clinical preventive services within the target population. The scores will also drive the continuous quality improvement (CQI) process to ensure appropriate health related activities are suitable for the patients served and addressing the issues of receiving health care in a timely fashion. Having the patients complete the satisfaction survey will enable WCCHD to share results with other local providers to make readily available appointment or walk-in schedules meet the need of targeted population.

- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. Approximately, 75,000 individuals are identified as uninsured in Williamson County. Increasing the capacity for access to primary care services where no public transportation is offered, will address a key need that currently exists in the region. Barriers to care lead to delayed care, overutilization of EDs for preventive health needs, and preventable hospitalizations. WCCHD feels that there is a direct correlation between expanded capacity for access to care, improving utilization rates of clinical preventive services, and improved patient satisfaction by having increased capacity to offer an appropriate level of care in at a timely manner, we will be able to improve utilization rates of clinical preventive services in our targeted population. Those patients should be able to report that their needs were met in the primary care setting (not necessitating care at an inappropriate level setting), which will have further positive impact on the medical community by reducing uncompensated care costs.

Project Description:

Clinical Prevention Program - WCCHD proposes to expand capacity and access to same day clinical preventive services and care through a) extended service hours and b) enhanced scope of services through expansion of clinic staffing.

Uninsured and underinsured residents of Williamson County have limited access to primary care, specifically same day or next day appointments and extended hours. Same day clinical services refers to those focused services for which access to walk-in or same day appointments is necessary to achieve maximum primary, secondary, and tertiary prevention of acute and chronic illnesses. These include but are not limited to: pregnancy confirmation; integrated eligibility; WIC/Nutrition and vitamin supplementation; Sexually Transmitted Infections (STI) screening and Expedited Partner Therapy; and Vaccine Preventable Disease screening/ immunization. To achieve maximum coordination with medical homes in FQHCs or private practices and benefit appropriate emergency department (ED) utilization, expansion of both the hours and scope of care availability is needed, as well as leveraging the IT infrastructure, to allow coordination of this care in and among the medical neighborhood. In contrast to the related St. David's Medical Center – Round Rock (RRMC) RHP 8 project, our project is focused on preventive health services (i.e. screening, counseling) for any uninsured or underinsured

individual, while the RRMC is primarily focused on acute care for individuals under the 200% FPL. WCCHD will not serve as a medical home; rather, we will complement the continuum of care received in other settings. By offering the availability for same day or next day services that do not require a physician, clients will be diverted to our offices rather than utilizing EDs for these types of services. In addition, women testing positive for pregnancy will be counseled and connected to a medical home to ensure access to care within the first trimester.

WCCHD currently has one nurse per site, limiting the maximum number of appointed and walk-in clients able to be seen on any given day. Nursing services are currently available 32 hours per week. With this project, increasing staff will allow us to add nursing services outside of business hours and through the lunch hours, for a total of 40 nursing service hours per site. This would enable client access to health services through the lunch hour and into the evening. Recent pilots of enhanced weekday hours have documented patient approval because of accessing same day service and/or next day appointments.

In addition to providing clinical preventive services, this project would also offer more same-day appointments and walk-in services for women seeking pregnancy confirmation. In this integrative model, staff will ensure that clients receive coordinated, timely, culturally competent and appropriate health care services, assist in communicating and coordinating health care services with the client's medical home to avoid inappropriate usage of EDs for primary/preventive health services. Staff will provide care coordination, when applicable, to ensure early entry into prenatal care and establishment of a medical home. Consequently, over the next four project years, it is anticipated that improved access to same-day services will significantly increase enrollment into prenatal care within the first trimester, and decrease the number of clients seeking to use an ED or urgent care facility for preventive health services.

Goals and Relationship to Regional Goals:
In alignment with the regional goals of improving access to timely, high quality care and reducing inappropriate utilization of urgent and emergent services, the goals of this project are:

Project Goals:
- Increase access points to care;
- Increase availability of same day and next day appointments;
- Offer enhanced level of preventive health services; and
- Prenatal women accessing care within the first trimester.

This Project meets the following Regional Goals:
- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing the proportion of residents with a regular source of care;
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:
Health disparities exist in this community, specifically among minority women of child-bearing age. Recent Williamson County data collected by WCCHD Epidemiology staff, suggests that less minority women, specifically Hispanic women, seek prenatal care in the first trimester than their white counterparts. From 2009-2010, for example, 64.3% of Hispanic women were reported to have had prenatal care in the first trimester in contrast to 68.7% Black women and 85.7 % of White women. Although this is an improvement over the previous two years (51.4% of Hispanic women, 54.6% Black women, and 75.9% of White women are reported to have had prenatal care in the first trimester in 2007-2008), evidence suggests that women, overall, and specifically Hispanic women, still need better connection to prenatal care. Furthermore, over the past year, financial cutbacks and the subsequent loss of healthcare settings which offered primary women's health services, have led to further limitations in this area of primary care. Thus, women are seeking care for preventable women's health services through urgent and emergent care settings.

We realize that one primary reason that people delay accessing care is related to program eligibility. Many clients are overwhelmed with navigating the health care system, thereby giving up or seeking care through an inappropriate level of care (such as an ED). By incorporating a patient navigator in each of our Public Health Centers, clients who access health services at our agency can be directly referred for a quick eligibility screening for internal and external programs and application assistance.

Furthermore, in regard to scope of services, our current healthcare professionals on staff, specifically nurses, have a limited scope of practice, limited to screening and treatment under standing delegation orders which precludes them from being able to provide more comprehensive care to symptomatic clients seeking clinical preventive health services.

5-Year Expected Outcome for Provider and Patients:
The goal is to consistently define and redefine gaps and needs and increase client access to preventive health services by 10% each project year, beginning DY4.

Starting Point/Baseline:
Currently, WCCHD serves as a safety net for the community in the provision of a number of preventive health services. There were approximately 8,800 client encounters for such services in 2012. There are five full-time nurses and one hourly nurse in the entire health district delivering these types of direct care services.

According to the WCCHD Annual Service Report, from 2009 through 2011, there were an average number of inquiries into the Healthcare Helpline equaling 4,421 contacts by 3,354 persons. The same report identified that there are an estimated 80,000 residents without health insurance coverage. This translates to approximately 17% of clients who do not have health insurance coverage, according to the 2012 Community Health Rankings and Roadmaps. This is clear evidence of the need for linkage to healthcare resources through expansion of services within our agency. With the recent loss of some of this county's Title 10 and Title 20 clinics, the lead time for new patient appointments at the local FQHC is 3-4 weeks. Clients may

not be admitted sooner based on more immediate needs, delaying treatment or leaving no option for them but to seek care at an urgent or emergent care setting.

Rationale:

Community Need Addressed:

- Community Need Area: CN.1 - Limited access to primary care
- Specific Community Need: CN.1.6 - Limited access to primary care for preventive services with same day or next day appointments and extended hours in Williamson County

In our current system, more often than not, 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 or outpatient setting. This often results in more costly, less coordinated care, a lack of appropriate follow-up care and missed opportunities. Patients who experience barriers in accessing primary care services due to lack of transportation, cost, lack of assigned provider, physical disability, and/or inability to receive appointments in a timely manner are those who benefit from and utilize same day and walk-in services to greatest advantage. The fact that the local FQHC lead time for new patients is 3-4 weeks demonstrates that the need for preventive health services exceeds the current capacity for primary care. Many WCCHD clients access services by taking advantage of the flexibility of our walk-in hours and an increasing number of clients are taking advantage of our extended hours for preventive health services. WCCHD has only been doing evening hours for just over a year and these clinics have been well-attended, especially in our high-volume sites (Round Rock and Cedar Park). Patients relay their gratitude for these services being offered outside of business hours, as it prevents them from having to take time off of work, which is sometimes a luxury they cannot afford. According to data obtained from 30,714 patients surveyed for the Medical Expenditure Panel Survey between 2000 and 2008, patients with access to care during extended hours reported less use and lower associated expenditures for office visits, prescription medications, ED visits, and hospitalizations (10.4% lower for the group with access to extended hours versus the group without such access). This was reported the September 2012 issue of the *Annals of Family Medicine* (*Ann Fam Med*. 2012; 10:388-395).

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 outcomes, patient satisfaction, appropriate utilization, and reduced cost of services (see Related Category 3 Outcomes).

Core Project Components:

Our goals address two of the three core components of this project: ***expansion of primary care clinic hours and expansion of primary care clinic staffing*.** With our Public Health Centers located in the heart of four of our major cities in the county, we offer close proximity for our clients that need to access our sites. Health Services, WIC, and social services are co-located within each of our Public Health Centers. This is designed to allow the clients to access various services at one location, keeping in mind that they are more likely to follow-through with care/referrals, when related services are more immediately available. Although ***expanding outpatient primary care clinic space*** is a core component of this project area, WCCHD does not believe expanding physical clinic space is the best use of resources at this time. Instead, the

agency will re-purpose existing space to accommodate increased staff and client volume. Since the goal of the Waiver is to reform health care in a cost-effective manner, we feel that we can accommodate the increased clinic volume within existing space, and believe our clients are better served by investing project dollars in increased staffing (thereby allowing us to serve our clients more hours each weekday) and enhancing the delivery of care by adding mid-level providers to our staff.

Clients currently seek services at urgent and emergent care settings, for conditions that could be managed or treated through a primary care setting. Many of these clients presenting to these facilities could have avoided that route, had the client sought access to care sooner. Reasons for this delayed entry into care may include: cost, desire for anonymity, lack of transportation, or the inability to receive appointments in a timely manner. By expanding service hours, increasing staffing, and offering an enhanced level of services at all four Public Health Center sites, clients may have increased access points to care, and become more aware of preventive health services available at an appropriate level of care. Consequently, earlier access to care can prevent inappropriate usage of our hospitals and urgent care settings, thereby decreasing uncompensated care costs.

- Williamson Burnet County Opportunities 2011 Community Needs Assessment: http://www.wbco.net/pdf/2011%20Community%20Needs%20Assessment.pdf
- Community Health Profile of Williamson County Precincts (2011) http://www.wcchd.org/statistics_and_reports/
- Central Texas Sustainability Indicators Project-2009 Data Report: http://www.centex-indicators.org/annual_rept/ar2009.pdf
- County Health Rankings (2012) www.countyhealthrankings.org

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: WCCHD does not receive U.S. Department of Health and Human Services program initiative funds which would be associated with this project.

Related Category 3 Outcome Measure:

- OD-6 Patient Satisfaction
  - IT-6.1 Percent improvement over baseline of patient satisfaction scores related to getting timely care, appointments, and information (*standalone measure*).

Reasons/rationale for selecting the outcome measure: This particular domain was chosen to help evaluate this project's interventions. As mentioned above, our goal is expanded capacity to access primary care. By measuring improvement of patient satisfaction scores, we will be able to determine effective intervention, and a positive impact on the community. As we do not currently capture this data on our client survey, we will perform a needs assessment DY2, so we can select a tool that will help us best capture all data in this domain. In DY3, we will be continuing to perform project planning activities, establishing a baseline for patient satisfaction. Simultaneously, we will have had time to increase staff and begin offering an enhanced level of services at all four sites. These interventions will have allowed us to begin increasing service hours, ultimately increasing access points. Meeting the needs of the clients in the primary care setting for preventive health services will decrease the possibility of their needing to seek care at an urgent or emergent care setting. Furthermore, this particular domain is centered on

patient satisfaction in getting timely care, appointments, and information. The above interventions seek to address all three components of this domain. So, by the end of DY4, our goal is to see a 10% increase over baseline, finally leading to a 20% increase in patient satisfaction over baseline by end of DY5 of project. Rates of increase are identified as Healthy People 2020 objectives by the federal government for improvement in persons obtaining necessary medical care in a timely manner.

Relationship to Other Projects:

This project relates to all other WCCHD projects, including:

- 126936702.1.2 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;
- 126936702.1.3 Implement project to enhance collection, interpretation, and/or use of REAL data;
- 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care; and
- 126936702.2.2 Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population

Utilizing a multi-disciplinary team of case managers, community health workers, eligibility workers/program navigators, marketing staff, analysts, and healthcare professionals within our clinics, and out in the community, we can work to link residents to needed resources (i.e. medical home, programs that will promote a healthy lifestyle), assist with their preventive health needs, and capture the data necessary to identify community needs. WCCHD seeks to remain easily identifiable as the local health department, with the understanding that the role of this agency is to protect and promote the health of the community, and prevent illness. The identification of and addressing of health disparities in the community follows the essential public health services that this agency strives to deliver. Conditions that lead to preventable urgent and emergent care utilization are conditions that could be screened, treated, and/or managed by a mid-level provider in the community (i.e. STIs, pregnancy confirmation). Additional access to this type of primary care would reduce the elevated costs associated with urgent and emergent care services by allowing earlier screening, diagnosis, treatment and/or management, before the condition reaches the level that necessitates a higher level of care.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

We realize that our community needs are not unique. Other communities within the RHP face similar issues in addressing the preventive health needs of their residents. Therefore, we anticipate that other projects will be developed and implemented to address these needs. It is the hope that in collaborating with other performing providers in this region working on similar projects, we can share our ideas, challenges, and successes. Conference calls and periodic meetings will be held, and newsletters will be distributed regularly to share progress of the projects and data related to interventions.

Project Valuation:
The valuation of each WCCHD project takes into account the degree to which the project accomplishes the goals of the Waiver, community needs, the aggregate population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. WCCHD considers this project as high need because it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing preventive health services. In 2012, 8,800 preventive health services were delivered by WCCHD, with approximately 370 clients presenting for STD services. The cost of treating STDs in EDs can be six times higher than treating in a primary care setting. Hospitalizations from complications of untreated or undertreated infections can cost 12 times higher than if having been identified and treated in a primary care setting. Providing timely, well-informed care, at the appropriate level and setting for targeted population will redirect them from unnecessary use of urgent and emergent care facilities. The ability to access theses services at an appropriate and affordable level of care will consequently reduce the amount of associated uncompensated care costs encountered through delivery of services to targeted population. Overall, the project seeks to accomplish delivery system reform by understanding that there is a shortage of clinics that provide preventive health services in this community; that due to this shortage, the average wait time for a new patient can be three weeks or longer; and that in order to fill in this gap in care, additional funding sources and support is needed. Moreover, the diversion of inappropriate non-emergent care services through urgent and emergent care facilities, to increase access points to timely and appropriate level of care, would improve patient care and satisfaction. The value cost of this project, including Category 3, for DYs 2-5 is estimated at $4,483,549 which is an added savings of over $4,000,000 when compared to the costs of ED visits.

Williamson County and Cities Health District 126936702.1.1 (Project 1.1.2) Category 1 Milestones and Metrics			
126936702.1.1	**1.1.2**	**1.1.2.a - 1.1.2.c**	**Expand existing primary care capacity**
Williamson County and Cities Health District			**126936702**
Related Category 3 Outcome Measure (s):	**126936702.3.1**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**

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)
Milestone 1 [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric 1** [P-4.1]: Increased number of hours at clinic over baseline **Baseline/Goal:** To develop baseline data and strategies followed by an implementation plan for expanding hours for service. **Data Source:** Current clinic schedule, skill sets for employees, and evidence of strategy for implementation of expansion **Milestone 1 Estimated Incentive Payment: $395,171** **Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for	**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 clinic sites **Baseline/Goal:** Baseline **-** currently there is one nurse per site, with one contract nurse. Staff needs ongoing training for quality delivery of services. Goal - Hire one mid-level provider to provide care at the appropriate level, and personnel to be able to expand to average 40 nursing service hours per site **Data Source:** Documentation of training and hiring plan **Milestone 3 Estimated Incentive Payment: $484,837**	**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. **Baseline/Goal:** Baseline – 8,800 client encounters in 2011; Goal - 30% increase in number of visits over baseline **Data Source:** Client visit log, EHR, CHASSIS Eligibility system **Milestone 5 Estimated Incentive Payment: $1,136,562**	**Milestone 6** [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. **Baseline/Goal:** Baseline – 8,800 client encounters in 2011; Goal - 60% increase in number of visits over baseline **Data Source:** Client visit log, EHR, CHASSIS Eligibility system **Milestone 6 Estimated Incentive Payment: $1,043,920**

existing providers **Metric 1** [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites **Baseline/Goal:** Baseline **-** currently, there are no mid-level providers on staff; Goal - hire sufficient staff to provide care at the appropriate level, for an expanded number of hours **Data Source:** Documentation of hiring and training plans; Human Resource Documentation **Milestone 2 Estimated Incentive Payment: $395,170**	**Milestone 4** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric 1** [P-4.1]: Documentation of increase in service hours in comparison to DY2 **Baseline/Goal:** Baseline - 32 hours per week per site; Goal – 40 hours per week per site **Data Source:** Scheduling database reports and documentation of posted hours **Milestone 4 Estimated Incentive Payment: $484,837**		
Year 2 Milestone Bundle Amount: $790,341	**Year 3 Estimated Milestone Bundle Amount: $969,674**	**Year 4 Estimated Milestone Bundle Amount: $1,136,562**	**Year 5 Estimated Milestone Bundle Amount: $1,043,920**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $3,940,497			

Category 1 Project Narrative
Williamson County & Cities Health District - 126936702.1.2

Project Area, Option and 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
RHP Project Identification Number: 126936702.1.2

Performing Provider Name: Williamson County Cities and Health District
Performing Provider TPI #: 126936702

Project Summary:

- **Provider Description:** Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
- **Intervention:** This project will implement Community Paramedicine in rural communities as an expanded scope of practice which will increase access to proactive health care, provide timely, well-informed care, appropriate transports and referrals which would prevent the cycle of accessing Emergency Medical Systems (EMS) for non-emergent events, leaving EMS to handle emergent needs.
- **Project Status:** Community Paramedicine is a new project.
- **Project Need-Community Need Area:** CN.1. (2, 3, 6 & 7) – Limited access to primary care: This project would increase access to primary care for individuals who reside in the rural areas of Williamson County with limited or inadequate access to care. In FY2012, 11,683 calls to EMS were identified for service that were generated from outside of an incorporated city and considered to be in the rural areas of the County. Of these calls, it is estimated that 40% of these events were generated as a result of the patient needing access to primary health care and were not related to an immediate life threatening emergency. Williamson County does not have a public transportation system and individuals living in the targeted rural areas of the county in need of health care for their chronic condition most often utilize the EMS system for transportation to a hospital.
- **Target Population:** Currently, a Community Paramedicine program does not exist for residents of Williamson County; however the initiative has the potential to reduce the established baseline approximately 6-10% for non-emergent responses in rural areas of the county which equates to approximately 470 responses. The target population is Medicaid-eligible, low income uninsured and indigent patients residing in rural areas with limited health care resources and diagnosed with a chronic condition.
- **Category 1 or 2 Expected Project Benefit for Patients**: This project seeks to increase the number of patient encounters from an initial baseline of 2,000 patients in DY3. Our goal is to increase our baseline by 10% in DY4 or 200 additional patients and 20% in DY5 or 400 additional patients (see Improvement Milestone I-17.1). Benefit for the patients includes improved access to care, linking to a medical home, empowering and educating them about their chronic condition and appropriate utilization of their medical care.
- **Category 3 Outcomes:** IT-9.2 – Our goal is to reduce:
  - ED appropriate utilization of EMS non emergent transports;

- Emergency Department visits by 5% in DY4 and 10% in DY5; and
- Rate of hospitalizations for targeted population as result of their chronic condition by 6-10%.

- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. Our goal is to expand our scope of practice providing outreach to underserved areas, educating the community about available resources for primary healthcare and identifying individuals with chronic health conditions. This will redirect patients to the appropriate types of services and building partnerships with local hospitals and agencies.

Project Description:

Community Paramedicine – Improving, Expanding & Delivering Healthcare to Rural Communities

This project would increase access to healthcare for individuals who are uninsured or under insured and reside in the rural areas of Williamson County with limited or inadequate access to primary health care. WCCHD proposes to incorporate the use of a team consisting of Paramedics, clinical support, education staff and medical direction to provide early primary medical assessment for those with limited access to care. In addition to primary care and preventive services, emergency medical services (EMS) are identified as crucial link in the chain of care. EMS, which includes basic and advanced life support, ensures that all persons have access to rapidly responding, pre-hospital EMS. WCCHD recognizes Community Paramedicine as an expansion of delivering healthcare services to rural communities and as a connection to an infrastructure in appropriate medical direction and system follow up. The landscape of healthcare is continuously evolving to becoming a more effective utilization of appropriate level of health care rather than the current system of using emergency departments (EDs) for primary and/or preventive care services.

WCCHD will position Community Paramedics in rural areas of the County on a scheduled and pre-determined basis to screen patients for chronic conditions such as diabetes, hypertension, obesity, congestive heart failure risk factors, and chronic respiratory risk factors. Positioning the team in rural areas identified with limited access to care, will reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care. In addition, the team will be trained to recognize possible risk for prescription drug interactions, monitor medication compliance, and provide diet counseling with the oversight and coordination of the patient's primary care physician.

Services provided by the Community Paramedicine team will include:

- Coordinating appropriate level of care;
- Facilitating follow-ups after discharge from hospital;
- Educating on when and how to access emergent and non-emergent services;

- Positioning team and Peak Demand Unit in underserved areas; and
- Community outreach and building partnerships with local hospitals and agencies.

According to the Computer Aided Dispatch (CAD) system, 11,683 calls were identified for service during FY2012 that were generated from outside of an incorporated city and considered to be in the rural areas of the County. Of these calls, it is estimated that 40% of these events were generated as a result of the patient needing access to primary health care and were not related to an immediate life threatening emergency. The Community Paramedicine project has the potential to reduce the established baseline approximately 6-10% for non-emergent responses in rural areas of Williamson County.

In addition to the CAD system data, the *Williamson County Community Profiles* identifies rural areas with targeted zip codes in having a higher rate of hospitalizations for chronic conditions such as Diabetes and Asthma as compared to the State rate. For example, in zip code area 76574 the hospitalization rate for diabetes was 22 per 10,000 population. The State rate was 16 per 10,000 population. Targeted zip codes identified are:

76574	76527	76537	76578
78634	78664	78641	78681

Goals and Relationship to Regional Goals

This project works to apply best practices and continuous quality improvement by reaching out to the underserved areas of the county. The Community Paramedicine Program will use a patient-centered and coordinated care navigation model which will improve appropriate and timely access to healthcare.

Goals:

- Reduce unnecessary emergency department visits;
- Reduce non-emergency EMS calls for service and help direct those in need to the appropriate care through available resources and case managers;
- Increase the number of patients connected to a medical home; and
- Decrease the rate of hospitalizations for targeted population as a result of their chronic condition.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing the proportion of residents with a regular source of care; and
- Reducing inappropriate utilization of services.

Challenges:

The primary challenge will be reaching out to the appropriate residents in need of these specific services and maintaining contact throughout the system. Next, identifying the needs and matching the appropriate resources to provide the necessary education and alternative ways to access the system specific to their needs. Lastly, correlating all the data, so we can improve our delivery of service and finding other ways to achieve objectives in a fiscally responsible manner. Through appropriate level of training in health literacy, med management, care coordination,

cultural competency, and involvement of hospitals, the team can address the needs and resources to facilitate patient and provider engagement.

5-Year Expected Outcome for Provider and Patients:
WCCHD expects to see improvements for this expanded scope of practice for patients clearly in need of appropriate medical care direction and system follow-ups. The provider expects to improve the hospitalization rates for targeted zip code areas.

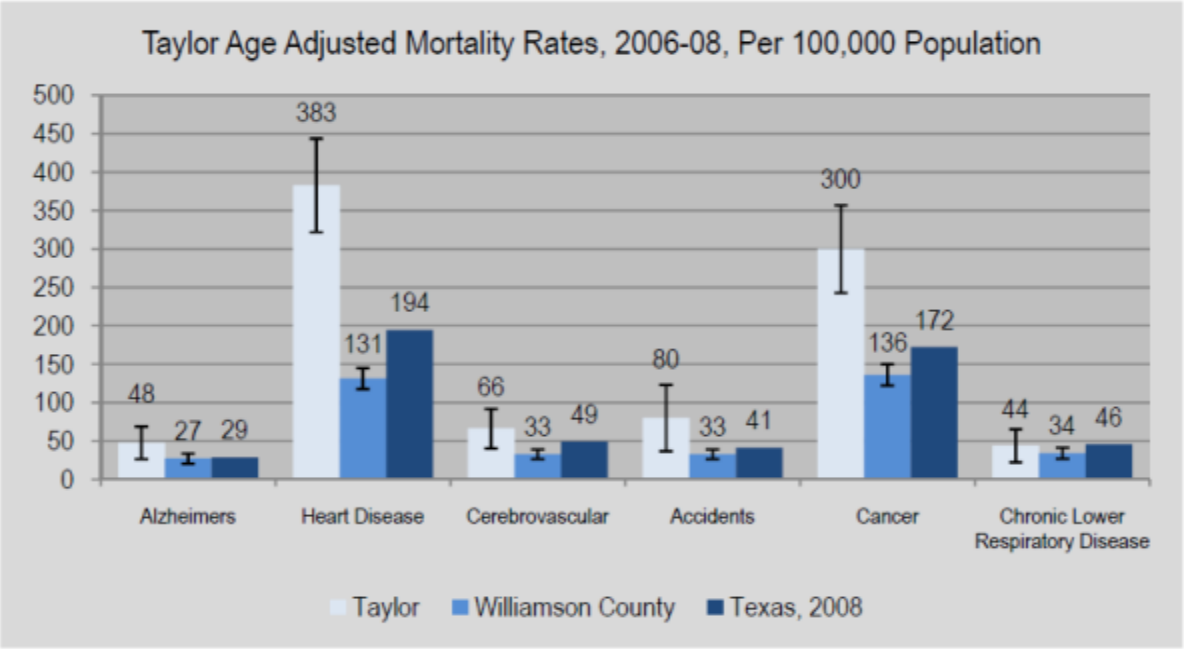
Starting Point/Baseline:
Currently, an expanded scope of practice, such as Community Paramedicine does not exist for targeted population in the WCCHD system. Therefore, the baseline for number of participants as well as the number of participating hospitals begins at 0 in DY2.

Rationale:
Community Need Addressed:

- Community Need Area: CN.1 – Limited Access to Primary Care
- Specific Community Needs:
  - CN.1.2 – Limited to access to primary care for residents under 200% FPL
  - CN.1.3 – Limited access to primary care
  - CN.1.6 – Limited access to primary care for rural residents
  - CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals with diagnosed chronic disease

In the current landscape of healthcare, EMS, as in the majority of the nation is considered a stand-alone public service like police and fire, with little or no integration into the larger health care system at the local level. Establishing Community Paramedicine in rural communities as an expanded scope of practice will increase access to proactive health care, provide timely, well-informed care, appropriate transports and referrals which would significantly decrease the overall cost of care and improve the quality of life for rural patients. This would also prevent the cycle of accessing EMS for non-emergent events, leaving EMS to handle emergent needs.

As noted in the table below, the age-adjusted death rate due to heart disease was over twice as high in the Taylor, TX zip code 76574 (383 per 100K population) when compared to both Texas (194 per 100K population) and Williamson County (131 per 100K population). The rate for cerebrovascular diseases (e.g. stroke) was twice as high in zip code 76574 (66 per 100K population) when compared to Williamson County (33 per 100K population) (Source: DSHS Vital Statistics analysis by WCCHD, 2006-08, http://www.wcchd.org/statistics_and_reports/docs/Precinct_4_Profile2011.pdf).



The ICare database includes health care encounters for the uninsured, and publically insured population, excluding Medicare patients, in Williamson County. Encounters at all but one hospital provider network are included, as are those from the local FQHC clinics.

- In 2010, ICare data showed that there were 144 frequent users of emergency departments (6 or more visits in a single quarter). This population averaged 15 visits annually and accounted for 2,111 patient visits.
- Analysis of vulnerable populations in Williamson County (defined as the near elderly, homeless, those with a behavioral health condition, and the disabled) showed that there were about are 10,600 vulnerable patients in the ICare database in 2011.
- This population averaged 2.3 emergency department visits each, with the maximum number of visit for a single patient being 52. Vulnerable frequent users (6 or more visits in a single quarter) averaged 15 visits per patient.

Key findings from the EMS data system, of all cardiac related calls in the first 3 quarters in 2011, 46 percent were in the target counties (n=693).

One simple conclusion can be drawn from this data and that is the expanded scope of practice would be advantageous to the targeted population zip code areas where a need is clearly demonstrated. While the primary mission of an EMS system is to provide readily available, accessible and cost efficient pre-hospital care, expanded scope programs such as Community Paramedicine improve the quality of care and life for individuals and decrease the utilization of EMS transports for accessing primary care within the emergency departments without compromising the integrity of the emergency response system. Incorporating an Electronic Health Record, utilizing a screening eligibility tool and enhancing the current database capturing EMS transports, will track and monitor activities and metrics associated with this project.

Project Components

Through the Community Paramedicine, WCCHD proposes to meet all required project components.

a) *Develop a process (including a call center) that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site. Survey patients who use the nurse advice line to ensure patient satisfaction with the services received.* We will work with healthcare partners in leveraging this resource and to establish a process for surveying patients.

b) *Enhance linkages between primary care, urgent care, and Emergency Departments in order to increase communication and improve care transitions for patients.* Our goal is to have a collaborative effort by utilizing existing data from ICare and our electronic patient care records to identify the patients in need. This will improve communications between the ED, EMS, primary care and urgent care, allowing for the patient to gain education, find available resources and provide direction to the most appropriate avenue of care based on their specific needs. This will strengthen the linkage between community and healthcare in the underserved areas of Williamson County.

c) *Conduct quality improvement for project using methods such as rapid cycle improvement*-- With the addition of a quality improvement Captain, they will be able to manage the project based on a rapid cycle improvement model. First, help establish what needs to be accomplished, secondly what changes can we make to result in an improvement and thirdly, how will we know an improvement has been made. Each step is defined in the outline of the template which defines the goals, baselines and measuring improvement.

Continuous Quality Improvement: WCCHD 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 share information such as challenges, lessons learned and considerations for safety net populations. This collaboration will streamline the appropriate delivery of healthcare to the citizens who do not have access to primary healthcare or have used the 911 system or emergency departments as their primary healthcare.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Currently, a Community Paramedicine program does not exist for residents of Williamson County. Our system offers case management and patient navigation services, but these are typically only accessible to patients who call into our Healthcare Helpline and/or enrolled in the County Indigent Health Care Program. The initiative will improve access for targeted patients while diverting patients from emergency rooms to a medical home for healthcare needs.

WCCHD does not receive funding from the U.S. Department of Health and Human Services that will be used for this program.

Related Category 3 Outcome Measure(s):

- OD-9 -- Right Care, Right Setting

- IT-9.2 -- ED appropriate utilization (Standalone measure) - Reduce Emergency Department visits for target conditions including Diabetes, Cardiovascular Disease/Hypertension, and Asthma

Reasons/Rational for selecting the outcome measure:
Data relating to frequent ED utilizers (described above) identifies the need for reducing ED visits for targeted conditions. Category 3 Outcomes are aligned with the Healthy People 2020 objectives to reduce the number of persons who are unable to obtain or are delayed in accessing appropriate medical care. The Community Paramedicine team will empower, educate and link individuals to right care/right setting to increase appropriate level of care. Linking to medical services and determining eligibility through the WCCHD Patient Navigation Program (126936702.2.1), patients are more likely to be compelled in seeking services for their chronic disease. Education and health literacy introduce opportunities for health promotion and knowledge of their chronic condition in order to control and manage their disease.

Relationship to Other Projects:
This project is one in a system of DSRIP projects that will increase access to health care, improve quality of care, and improve health outcomes for rural populations including:

- 126936702.1.1 Expanded Capacity for Access
- 126936702.1.3 Implement project to enhance collection, interpretation, and/or use of REAL data;
- 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care; and
- 126936702.2.2 Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population

Relationship to Other Performing Providers' Projects in the RHP and Plan for Learning Collaborative*:*
No other providers in RHP 8 are establishing a Community Paramedicine. We have collaborated with other performing providers in the RHP to include the continuum of care necessary for targeted population served. Through the St. David's Round Rock Medical Center project (#020957901.1.1), referring and connecting uninsured individuals under the 200% FPL seeking acute care services. In addition, working with Bluebonnet Trails Community Services – Emergency Services Diversion Project (#126844305.2.2) will identify frequent utilizers of emergency services; provide early intervention or intensive wraparound services and supports for a targeted behavioral health population, including people with co-occurring disorders. By coordinating the above mentioned projects, we can contain costs by avoiding the duplication of services, and provide meaningful delivery system reform to the underserved and low-income populations. Several learning collaboratives of professionals from the areas of primary care and mental health services exist in Williamson County. These active groups, who meet monthly, strive to provide continuous quality improvements, seek new ideas and solutions to improve patient outcomes, and share with others across the State of Texas and the nation.

Project Valuation:
The valuation of each WCCHD project takes into account the degree to which the project

accomplishes the goals of the Waiver, community needs, the aggregate population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Integrated Care Collaboration has identified an estimated approximately 2,500 emergency room visits per year that could have been diverted to a more appropriate resource. With an estimated $500 per visit, this equates to an estimated valuation of $1,250,000 per year. In addition, Emergency Medical Services has identified approximately 2,000 calls for service per year in the rural areas that could have been managed by primary care or outpatient services. The cost of an average Advanced Life Support call is $1,100 or an estimated valuation of $2,200,000 per year. With the implementation of the community paramedic project, the opportunity for cost savings could offset the cost of program and provide the most appropriated healthcare resources to our citizens with the result of better patient outcomes. WCCHD considers this project as high need because it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing preventive health services. Providing timely, well-informed and appropriate level care will divert these types of needs from the urgent and emergent care facilities. Being able to access theses services at an appropriate and more affordable level of care will reduce the associated uncompensated care costs. Overall, the project seeks to accomplish delivery system reform by understanding that there is a shortage of clinics that provide preventive health services in this community; that due to this shortage, the average wait time for a new patient can be three weeks or longer; and that in order to fill in this gap in care, additional funding sources and support is needed. Moreover, the diversion of inappropriate non-emergent care services through urgent and emergent care facilities, to increase access points to timely and appropriate level of care, would improve patient care and satisfaction. Estimated costs for DYs 2-5 for hiring qualified staff, purchasing equipment, unit vehicle and necessary supplies has a cost value of $3,930,304.

Williamson County and Cities Health District 126936702.1.2 (Project 1.6.2) Category 1 Milestones and Metrics			
126936702.1.2	**1.6.2**	**1.6.2.a - 1.6.2.c**	**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.**
Williamson County and Cities Health District			**126936702**
Related Category 3 Outcome Measure (s):	**126936702.3.2**	**IT-9.2**	**Reduce Emergency Department visits for target conditions**

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)
Milestone 1 [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-8.2]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. **Baseline/Goal:** Collaborate with RHP participants to establish plan, goals and expectations of project. **Data Source:** Strategy plan, meeting minutes, correspondence and research material **Milestone 1 Estimated Incentive Payment: $503,992** **Milestone 2** [P-9]: Review project	**Milestone 3** [P-10]: 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** [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Collaborate with RHP participants to establish plan, goals and expectations of project with baseline of 2000 patients/year. **Data Source:** Strategy plan, meeting minutes, correspondence and research material **Milestone 3 Estimated Incentive Payment: $336,657** **Milestone 4** [P-2]: Collect baseline data, if medical advice line currently	**Milestone 6** [I-17]: Implement interventions to improve access to care of patients receiving urgent medical advice. The following metrics are suggested for use with an innovative project option to improve access to care of patients receiving urgent medical advice but are not required. **Metric 1** [I-17.1]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. **Baseline/Goal**: Baseline – 2,000 patients per year (DY3); Goal –Serve 200 patients in DY4. **Data Source**: ICare 2.0, Medicaider and emschart **Milestone 6 Estimated Incentive Payment: $981,360**	**Milestone 7** [I-17]: Implement interventions to improve access to care of patients receiving urgent medical advice. The following metrics are suggested for use with an innovative project option to improve access to care of patients receiving urgent medical advice but are not required. **Metric 1** [I-17.1]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. **Baseline/Goal:** Baseline – 2,000 patients per year (DY3); Goal –Serve 400 patients in DY5. **Data Source:** ICare, emsCharts and Medicaid. **Milestone 7 Estimated Incentive Payment: $930,988**

data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Metric 1** [P-9.1]: Number of new ideas, practices, tools, or solutions tested by each provider. **Baseline/Goal**: Develop plan to provide medical service outreach to underserved rural areas of county **Data Source**: Meeting minutes and implementation plans **Milestone 2 Estimated Incentive Payment: $503,992**	exists within RHP; Develop metrics specific to the medical advice line in use by the performing provider to track access to specified patient populations determined by RHP. **Metric 1** [P-2.1]: Documentation of baseline assessment. **Baseline/Goal:** Baseline **-** Develop process of tracking specified target population and provide service specific to improve access to resources specific to identified need; Goal - Establishment of baseline data will identify specific area of need. **Data Source**: ICare 2.0/emsCharts **Milestone 4 Estimated Incentive Payment: $336,657** **Milestone 5** [P-X]: Designate/hire personnel or teams to support and/or manage the project. **Metric 1** [P-X.8]: Hire specialized staff for paramedicine project. **Baseline/Goal:** Baseline **–** Currently no staff are dedicated to the paramedicine project; Goal - Fully		

	staff program to implement in rural areas of the county **Data Source**: HR records **Milestone 5 Estimated Incentive Payment: $336,658**		
Year 2 Milestone Bundle Amount: $1,007,984	**Year 3 Estimated Milestone Bundle Amount: $1,009,972**	**Year 4 Estimated Milestone Bundle Amount: $981,360**	**Year 5 Estimated Milestone Bundle Amount: $930,988**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $3,930,304			

Category 1 Project Narrative
Williamson County & Cities Health District - 126936702.1.3

Project Area, Option and Title: 1.5.3 Implement project to enhance collection, interpretation, and/or use of REAL data
Unique Project ID: 126936702.1.3

Performing Provider Name: Williamson County Cities and Health District
Performing Provider TPI #: 126936702

Project Summary:

- **Provider Description:** Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
- **Intervention:** The project will enhance and improve the quality and consistency of public health client demographic (race, ethnicity, gender, and language) data collection and interpretation to ensure health disparities are addressed appropriately.
- **Project Status:** This is a new project.
- **Project Need:** CN.3.3 – Inconsistency in data collection which identifies health disparities and populations at risk. This project will address problems with data collection, particularly for race/ethnicity. For example, WCCHD analysis of reported sexually transmitted disease cases for Round Rock shows a growing proportion of cases in the "unknown" category for race/ethnicity from 2006 to 2011 (analysis by WCCHD of data from the Texas Department of State Health Services) and case data from the 2009 – 2010 pertussis epidemic mirror national trends indicating that Hispanic infants have a higher incidence of clinically significant pertussis, which place them at greater risk for hospital admission. Factors leading to an increased risk for Hispanic infants including language/communication and cultural issues that may serve as barrier to obtaining health care services. The insignificant of poor data could misinform key policy and program decisions, leading to interventions that are counterproductive and unintentionally increasing the impact of a disparity and coordinated care for those with multiple needs.
- **Target Population:** This project will leverage existing groups and organizations such as hospitals, community clinics and community health centers. The target populations identified are individuals with Medicaid, low income uninsured and indigent with disparate health outcomes to ensure appropriate level of care is addressed and met which makes up approximately 60% of our population served.
- **Category 1 or 2 Expected Project Benefit for Patients:** This project seeks to structure a framework for reliable Race, Ethnicity and Language fields to improve the collection of data in identifying health disparities and reducing empty REAL data fields. This project will reduce empty or unknown race filed for reported cases such as Chlamydia and communicable diseases from 2,940 by DY4 and 5,880 by DY5 (see Improvement Milestone I-9.1); thus improving the information technology infrastructure resulting in few clinical errors, and improved diagnostic ability.
- **Category 3 Outcomes:** OD-11 Addressing Health Disparities in Minority Populations

- IT-11.2: 5% improvement in disparate health outcomes for target populations by DY5;
- IT-11.3: Improve utilization rates of clinical preventative services by 5% in DY5 in target population with identified disparity; and
- IT-11.4: Improve patient satisfaction and/or quality of life scores by 5% in DY5 in target population with identified disparity.

- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. WCCHD intends to develop and pilot a continuous quality improvement (CQI) based process for improving data quality, using analyses of the data to identify disparities and plans to address these gaps. WCCHD will share the results of the pilot with providers throughout the region and through existing forums (Health Data Users Group and WilCo Integrated Care Collaboration). Improved data are a vital need to help drive policy and planning decisions which have a measurable meaningful impact on residents throughout the region.

Project Description:

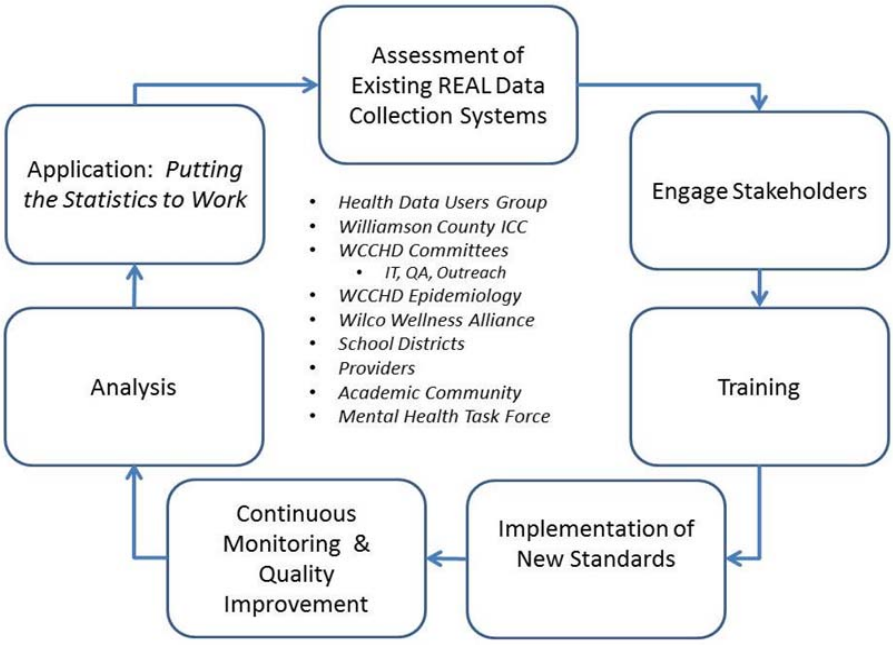
Addressing and Developing Strategies for Reducing Health Disparities through Improved Data Collection Systems and Analytics - The Williamson County and Cities Health District (WCCHD) proposes to improve the quality and consistency of public health client demographic (race, ethnicity, gender, and language) thereby improving the quality of information supplied to decision makers addressing health disparities.

This project will involve significant changes in administrative and training policies and procedures throughout WCCHD at all four public health centers (Georgetown, Cedar Park, Round Rock, and Taylor). Staff at all levels, including program navigators, case managers, social workers, customer service representatives, nutritionists, public health and prevention specialists, administrative support staff, and management would receive training as part of a Data 101 course (currently being developed) on the importance of collecting accurate demographic information on all clients served. There are clearly problems with data collection, particularly for race/ethnicity. WCCHD analysis of reported sexually transmitted disease cases for Round Rock shows a growing proportion of cases in the “unknown” category for race/ethnicity from 2006 to 2011 (analysis by WCCHD of data from the Texas Department of State Health Services). The reasons for this negative trend are unclear but needs to be addressed.

The intent of the Data 101 course is not only to improve data quality and consistency but also to raise awareness and understanding of the relationship between social disparities and community health outcomes. After being piloted at WCCHD, the Data 101 curriculum will be shared with other organizations with the ultimate goal of improving the quality of data feeding into the regional ICare system managed by the Integrated Care Collaboration (ICC). The ICC is a nonprofit alliance of health care providers in Central Texas dedicated to the collection, analysis

and sharing of health information with the goal of improving health care quality and cost efficiency across the continuum of care. One of the ICC primary functions is the operation and management of a regional Health Information Exchange called ICare. Through the analysis of clinical data in ICare, the ICC is able to identify needs in the Central Texas health care system and create programs to improve health outcomes for vulnerable populations.

The concepts of continuous quality improvement and the community health assessment (WCCHD follows the Mobilizing for Action through Planning and Partnership (MAPP) process) will also be reviewed during Data 101, introducing the concept of a community dashboard as a means to continuously monitor and share updates on community health related statistics. Examples of how data are used will be featured during the training including WCCHD Community Health Profiles, Condition/Disease Briefs, and Epidemiology Annual Reports. These documents, combined with dashboard demonstrations (http://www.healthysonoma.org/, http://www.healthyntexas.org/) will provide Data 101 participants with a clear understanding of the importance of collecting data in a systematic fashion, and that the process for appropriately targeting public health interventions starts with data collection at the client interview and data entry level.



Goals and Relationship to Regional Goals:
This project will leverage existing groups and organizations wherever possible to provide venues or forums for discussions on improving the quality of data used to make key programmatic and policy decisions related to community health assessment. The emphasis on partnership will improve the credibility of the public health system and help WCCHD to expand upon existing coalition building activities under the Wilco Care Alliance.

Goals**:**

- Increase the % of WCCHD clients with accurate race/ethnicity information recorded in their electronic health record;

- Improve the quality of data analysis based on demographic data used to inform policy decisions focused on reducing health disparities; and
- Enhance the information technology infrastructure for the public health system to improve ability to exchange data with the ICare system electronically.

Actions aimed at addressing disparities which are based on poor data will have limited impact on the problem. At worst, poor data could misinform key policy and program decisions, leading to interventions that are counterproductive, unintentionally increasing the impact of a disparity and using up critical resources. Achieving the primary goals should ultimately result in improved customer satisfaction and health outcomes for populations experiencing disparities.

This Project meets the following Regional Goals by improving the quality of data underlying planning policy development:

- increasing the proportion of residents with a regular source of care; and
- increasing coordination of prevention and care for residents, including those with behavioral or mental health needs

Challenges:
One of the greatest challenges may be in sharing the results. For some measures, improving the quality of REAL data collection may actually produce results that do not support the notion of a disparity or may point to inequities in different groups or populations. Reaching consensus on how race/ethnicity is handled may be difficult. For example, decisions about whether or not to record multiple races may impact database design and mapping fields for import/export between systems. To address differences between systems and possible problems with mapping, we anticipate (1) comparing different organizations' data collection requirements and determining whether or not there is any flexibility in these requirements, and (2) using the results of this assessment to guide negotiations on establishing standards for collecting REAL data. These negotiations would occur in existing venues such as HDUG or the Williamson County ICC.

5-year Expected Outcome for Provider and Patients:

- Improved understanding by front line employees of the importance of REAL data entry as measured by pre- and post-training and client satisfaction surveys;
- 90% of all clients with WCCHD electronic health records with race/ethnicity fields populated or "unknown" entered;
- 75% of all clients with WCCHD electronic health records with the race/ethnicity fields populated; and
- WCCHD expects to fully implement electronic reporting of notifiable conditions from the ICare system to WCCHD's Outbreak Management System.

Starting Point/Baseline:
Based on existing pertussis records a baseline of 50-60% of all records contain accurate race and ethnicity or "unknown" versus being left blank. Less than 50% of records contain both fields.

Rationale:

Community Need Addressed:

- Community Need Area: CN.3 – Lack of coordinated care for those with multiple needs.
- Specific Community Need: CN.3.3 – Inconsistency in data collection which identifies health disparities and populations at risk.

Process milestones were selected to reflect a Continuous Quality Improvement (CQI) process, serving as an indicator of whether or not an established plan is followed and incorporating stakeholder feedback throughout the process. Milestones signal a significant and sustainable change in how data is collected, processed, and analyzed. Collecting valid and reliable data fields using a uniform framework provides a process improvement tool for health care organizations to systematically collect demographic and communications data from patients or their caregivers to address the identification of disparities and address appropriately.

Although Williamson County ranks as one of the healthiest counties in Texas according to the County Health rankings, it is clear there is still room for improvement when the health of Texas is compared to other states. There are some populations in Williamson County that experience disparities in health, quality of care, health outcomes, and incidence as related to conditions such as cardiovascular disease, pertussis, Chlamydia, cancer, obesity, and diabetes. Disparities can been seen among groups based on race and ethnicity, language, economic factors, education, insurance status, geographic location (rural vs. urban, zip code), gender, sexual orientation and many other social determinants of health.

Based on analysis of vital statistics data by WCCHD in 2012 (unpublished results) both the capacity for delivering prenatal care and the prenatal care rate have increased in recent years. However, the analysis suggests that prenatal care continues to be underutilized by minority women. Case data from the 2009 – 2010 pertussis epidemic mirror national trends indicating that Hispanic infants have a higher incidence of clinically significant pertussis, putting them at greater risk for being admitted to a hospital. There are many factors leading to an increased risk for Hispanic infants including language/communication and cultural issues that may serve as barrier to obtaining health care services. The 2011 WCCHD Epidemiology Report (http://www.wcchd.org/statistics_and_reports/docs/2011_Epidemiology_Report.pdf) contains an article describing the impact of the 2009 – 2010 epidemic on communities throughout Williamson County.

Core Project Components:

a. *Redesign care pathways to collect valid and reliable data on race, ethinicity, and language at the point of care.* Key stakeholders from throughout the region will be invited to participate in discussions around the collection standardization and processing procedures for REAL data. WCCHD will facilitate meetings to discuss basic definitions for REAL data and identify any existing procedures which may need to be modified as well as any training needs for front line staff.
b. *Implement system to stratify patient outcomes and quality measures by patient REAL demographic information in order to identify, analyze, and report on potential health disparities and develop strategies to address goals for equitable health outcomes.* WCCHD will assess its current and future data needs by examining how existing systems are being

used (e.g. TWICES for immunizations and TB, CHASSIS for case management). Based on the results of this internal assessment, combined with the requirements and standards established with stakeholders (see project component 1), WCCHD will solicit proposals from vendors for a health record management system.

c. *Develop improvement plans, which include a continuous quality improvement plan, to address key root causes of disparities with the selected population.* An improvement plan, which includes a continuous quality improvement plan, will be developed by WCCHD research group in conjunction with the external stakeholders who serve on the Health Data Users Group. The plan will include a process for identifying and addressing key root causes of disparities. This includes developing a curriculum which will include guidelines and techniques for capturing quality REAL data and further developing of policy and procedures.

d. *Use data to undertake interventions aimed at reducing health and health care disparities (tackling "gap") for target patient populations through improvements in areas such as preventive care, patient experience, and/or health outcomes.* With improved data collection identifying and addressing a more defined health care disparities within the targeted population, appropriate levels of interventions will be implemented. Data is a key to ensuring suitable interventions which aim at reducing health and health care disparities specifically where there's a gap in services. Improved data will allow for assessing current interventions available for targeted population and improve or expand where necessary. Continuous quality assurance and improvement of data collection will result in higher quality health data driving the creation of activities and projects that impact patient outcomes.

Continuous Quality Improvement: The Center 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: WCCHD does not receive U.S. Department of Health and Humans Services program initiative funds that will be used for 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 the disparity gap.
  - IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.
  - IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity.

Reasons/rationale for selecting outcome measures: Improved data is necessary for building a foundation for effective policy and program development, and building the credibility necessary

to advocate for addressing disparities, justifying local spending, and obtaining grant funding. Quality data is vital for the evaluation process and an integral part of the community health assessment process. Achievement levels would be reported on two levels both focusing on client outcomes: (1) direct input from patients on improved customer service systems via client satisfaction surveys, focus groups, and in-person interviews; and (2) number and scope of initiatives undertaken to address disparities and their impact on patient satisfaction and health outcomes. In addition, the collection of quality REAL data will help providers to delineate potential categories of differences in observed health status.

Relationship to Other Projects:
This project improves the quality of data supporting the need for the other WCCHD projects, ensuring disparities are being appropriately measured and monitored:

This project relates to all other WCCHD projects, including:

- 126936702.1.1 Expanded Capacity for Access to Care
- 126936702.1.2 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;
- 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care; and
- 126936702.2.2 Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population

A robust public health information technology infrastructure, supported by trained staff, is a vital component of any system intended to identify and serve high risk populations in the county. Furthermore, the ongoing monitoring of REAL data and the analysis of these data are needed to determine if performance measures are met. This project provides a basic foundation for improving communication between public health and providers across the county by improving the integrity of information as it passes from the provider to the Health Information Exchange level. The fact that individual providers will have real-time access to a unified patient record of the highest quality will provide the platform providers need to make informed decisions toward positive outcomes for their patients. Finally, improved aggregate REAL data allows public health officials to more effectively track the progress of projects short and long term, allowing for more informed policy and decision making by leadership.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
For the WCCHD expansion of safety-net services to succeed in reducing health disparities, robust data collection systems and training are needed to ensure WCCHD and the public health system meet information technology standards and practices followed by hospitals and other providers throughout the region. By necessity, the project will require intense collaboration with providers throughout the region. Much of the learning opportunities will occur early on as WCCHD implements the Data 101 curriculum. As the project matures, there will be many opportunities to share best practices and collaborate on special projects.

Project Valuation:

This project will reduce empty or unknown race filed for reported cases such as Chlamydia and communicable diseases by 30% or 2,940 by DY4 and 60% or by DY5 (see Improvement Milestone I-9.1); thus improving the information technology infrastructure resulting in few clinical errors, and improved diagnostic ability for targeted population. The result of improving and collecting REAL data, will establish data elements to effectively link to data systems used in health care service delivery in order to tailor the delivery of appropriate level of primary care as well as data systems used in quality improvement. The valuation of this project takes into account the degree to which the value of improved data linked in health care systems requires the development of tools, protocols and training curriculum for collecting and utilization of REAL data elements. The consolidation of many different data collection systems for reporting and syndromic surveillance, as well delivery of high quality care, is essential in keeping the overall costs of health care from escalating, specifically for the targeted population. Improving the information technology infrastructure will result in fewer clinical errors, improve diagnostic ability through improved access to critical historical information maintained in a Health Information Exchange, and allow for more sophisticated analytics to focus interventions for targeted population where they are most needed. In conclusion, the valuation and impact of this project to targeted population will result in patients receiving appropriate level of care, quality of care delivered, focus on efforts to reduce health and mental health disparities and accuracy in reported cases to Department of State Health Services for syndromic surveillance purposes, such as Chlamydia and communicable disease.

Williamson County and Cities Health District 126936702.1.3 (Project 1.5.3) Category 1 Milestones and Metrics			
126936702.1.3	**1.5.3**	**1.5.3.a - 1.5.3.d**	**Implement project to enhance collection, interpretation, and / or use of REAL data. Providers may select one or more of the following project components, as appropriate for the provider's starting point in collection and use of REAL data:**
Williamson County and Cities Health District			**126936702**
Related Category 3 Outcome Measure (s):	**126936702.3.3** **126936702.3.4** **126936702.3.5**	**IT-11.2** **IT-11.3** **IT-11.4**	**IT-11.2 Improvement in disparate health outcomes for target population, including identification of the disparity gap.** **IT-11.3 Improve utilization rates of clinical preventive services in target population with identified disparity.** **IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity.**

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)
Milestone 1 [P-3]: Develop curriculum or implement an existing evidence-based curriculum that includes effective strategies to explain relevance of collecting REAL data to patients and staff **Metric 1** [P-3.1]: Number or proportion of staff trained on curriculum. **Baseline/Goal:** Baseline – minimal training specific to REAL data collection has occurred. Collection of REAL data are somewhat fragmented between data entry staff and case workers and clinical staff. Goal - 90 – 100% of front line WCCHD staff trained in REAL data	**Milestone 2** [P-4]: Implement standardized policies and procedures to ensure the consistent and accurate collection of data **Metric 1** [P-4.1]: Description of elements in the system. **Baseline/Goal:** Baseline - no formal policies and procedures; Goal - Completed WCCHD policies and procedures for REAL data collection integrated with other WCCHD policies with annual review as part of ongoing quality assurance. **Data Source:** WCCHD Policy Manual and Standard Operating Procedures/Guidelines	**Milestone 3** [I-9]: Collect valid, reliable REAL data fields as structured data, using a uniform framework. This framework provides a process improvement tool for health care organizations to systematically collect demographic and communications data from patients or their caregivers. **Metric 1** [I-9.1]: The number of patients registered with designated REAL data fields are incomplete. **Baseline/Goal:** Baseline - 9,800; Goal - Reduce empty REAL data fields by at least 30% compared to baseline. **Data Source:** WCCHD Systems:	**Milestone 4** [I-9]: Collect valid, reliable REAL data fields as structured data, using a uniform framework. This framework provides a process improvement tool for health care organizations to systematically collect demographic and communications data from patients or their caregivers. **Metric 1** [I-9.1]: The number of patients registered with designated REAL data fields are incomplete. **Baseline/Goal:** Baseline - 9,800; Goal - Reduce empty REAL data fields by at least 60% compared to baseline. **Data Source:** WCCHD Systems: National Electronic Disease Surveillance

collection. **Data Source:** WCCHD training data bases and records **Milestone 1 Estimated Incentive Payment: $245,165**	**Milestone 2 Estimated Incentive Payment: $189,116**	National Electronic Disease Surveillance System, Outbreak Management System, Electronic Medical Records, CHASSIS **Milestone 3 Estimated Incentive Payment: $189,116**	System, Outbreak Management System, Electronic Medical Records, CHASSIS **Milestone 4 Estimated Incentive Payment: $171,116**
Year 2 Milestone Bundle Amount: $245,165	**Year 3 Estimated Milestone Bundle Amount: $189,116**	**Year 4 Estimated Milestone Bundle Amount: $189,116**	**Year 5 Estimated Milestone Bundle Amount: $171,116**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $794,513			

Category 2 Innovation and Redesign - Narratives & Tables

- **Bell County Public Health District**
  - 088334001.2.1
  - 088334001.2.2 (Pass 2)

- **Bluebonnet Trails Community Services**
  - 126844305.2.1
  - 126844305.2.2
  - 126844305.2.3 (Pass 2)
  - 126844305.2.4 (Pass 2)

- **Central Counties Services**
  - 081771001.2.1
  - 081771001.2.2
  - 081771001.2.3

- **Hill Country MHDD Centers**
  - 133340307.2.1
  - 133340307.2.2
  - 133340307.2.3
  - 133340307.2.4 (Pass 2)
  - 133340307.2.5 (Pass 2)

- **Scott & White Hospital – Llano**
  - 020840701.2.1
  - 020840701.2.2 (Pass 2)

- **Scott & White Memorial Hospital**
  - 137249208.2.1

- **Seton Highland Lakes Hospital**
  - 094151004.2.1 (Pass 2)

- **Williamson County and Cities Health District**
  - 126936702.2.1
  - 126936702.2.2 (Pass 2)

Category 2 Project Narrative
Bell County Public Health District - 088334001.2.1

Project Area, Option and Title: 2.7.1 Implement Evidence-based Health Promotion & Disease Prevention Programs. Implement evidence-based strategies to increase screenings and referral for targeted populations.
RHP Project Identification Number: 088334001.2.1

Performing Provider Name: Bell County Public Health District
Performing Provider TPI #: 088334001

Project Summary:

- **Provider Description:** Bell County Public Health District (Health District), is a Local public health district, and provides public health services to the men and women of Bell County and the surrounding area. The Health District provides services in the following programs: Immunizations, Sexually Transmitted Disease (STD) testing and treatment, Pregnancy testing and counseling, Preparedness, Disease Surveillance, Environmental Health, Food Protection, and Women Infant Children (WIC) program. The Health District serves Bell County with a 1060 square mile area and a population of 284,408 (DSHS Health Facts Profile, 2009). The Health District operates two clinics in east and west Bell County in the neighborhoods of the targeted populations.
- **Intervention:** The purpose of this project is to increase the availability of STD testing at Health District clinics. Nurses will provide STD risk reduction counseling utilizing the Centers for Disease Control's (CDC's) ABC Method (practice Abstinence, Be faithful with a negative partner, use Condoms). Clinical services will be provided according to Health District STD Testing Policies and Procedures. The Health District plans to increase the times and days that STD testing is offered from ½ day to 4 days per week.
- **Project Status:** Currently, STD testing and treatment is offered one afternoon per week in each of the Health District clinics. We will expand to four 10-hour work days (Monday through Thursday) to accommodate clients and partners accessing services.
- **Project Need:** <u>CN.1.9: Increase access to testing and treatment of STDs in Bell County.</u> Bell County has some of the highest STD rates in the State of Texas. In 2011, the Chlamydia cases/rate in Bell County was 3,933 cases or 1,325.7 per 1,000, or the highest in Texas. For Gonorrhea, the 2011 cases/rate were 1,075 cases or a rate of 362.4 per 1.000. Again, this rate was also the highest in the State. Syphilis cases in 2010 were 16 with a rate of 5.5; in 2011 there were 5 syphilis cases with a rate of 1.7 (Texas STD Surveillance Report, DSHS, 2011). Statistics for the incidence of all 3 of diseases is similar for 2010. The STD Clinics at the Health District are the only low cost STD testing and treatment clinics in Bell County.
- **Target Population:** One hundred percent of the Health District clients who were provided STD services in FY2012 were uninsured or Medicaid clients. There were 586 male and female clients in FY2012, and estimates that the number of clients tested can be increased to 1,200 per year with expanded hours. Some clients only test for Gonorrhea and Chlamydia, but clients are encouraged to test also for Syphilis. In FY12, only 500 clients tested for Syphilis, compared to 586 who tested for Gonorrhea and Chlamydia. The

Health District will increase the number clients who access care by expanding availability of STD services and by providing those services on a walk-in basis, and to reduce the number of Medicaid clients who utilize the Emergency Department for routine STD testing services.

- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to increase access to routine STD testing and treatment by increasing the number of days and clinics where testing and treatment is available to clients on a walk-in basis, going from providing services ½ day per week to 4 days per week (see Improvement Milestone 1-7.2). The project will be able to test 175 additional clients in DY3, 234 in DY4, and 293 in DY5 for both Gonorrhea and Chlamydia. An additional 150 clients will be tested for Syphilis in DY3, 200 in DY4 and 250 in DY5.

Category 3 Outcomes

- OD-9 Right Care, Right Setting
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea a in Bell County Public Health District clinics
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics

Project Description:

Increase access to Sexually Transmitted Disease Testing

The purpose of this project is to increase the availability of Sexually Transmitted Disease (STD) testing at Health District clinics. The Health District plans to increase the times and days that STD testing is offered (from ½ day to 4 days per week). Currently, the STD clinics is one afternoon per week, and the Health District is considering expanding to four 10-hour work days (Monday through Thursday) to accommodate clients accessing services in the afternoons. The Health District provided STD services to 586 clients in FY2011, and will need to establish an understanding of the number of clients we can anticipate having with better access and expanded hours. It is the hope, by expanding STD service hours to accommodate 175 additional clients in DY3, 234 in DY4, and 293 additional clients in DY 5 for both Gonorrhea and Chlamydia, and accommodate an additional 150 Syphilis clients in DY3, 200 in DY4 and 250 in DY5, that the Health District can decrease the Gonorrhea, Chlamydia, and Syphilis rates in Bell County, which are some of the highest rates in the state.

Nurses will provide STD risk reduction counseling utilizing the Centers for Disease Control's (CDC's) ABC Method (practice Abstinence, Be faithful with a negative partner, use Condoms). Clinical services will be provided according to Health District STD Testing Policies and Procedures. The Health District nursing staff has 5-10 years of experience in conducting risk assessment and risk reduction STD counseling and testing. They will provide one-on-one, individualized counseling for each STD client, to include counseling regarding the need for medication compliance, medication education, partner treatment, abstinence until partner treated, and importance of future safe sex practices. Staff will provide each client with written

educational materials, as well as condoms. Nursing staff will treat symptomatic clients at the time of testing, and will encourage abstinence until partners are treated, if positive. Clients with positive results are notified regardless if they were treated at testing, so that counseling can occur with regard to abstinence and partner treatment. Clients whose partners refuse to be treated will be offered Expedited Partner Therapy (EPT) according to established procedures.

Clients who test positive for Gonorrhea and/or Chlamydia are strongly encouraged to return to the clinic in three months for a retest due to the possibility of re-infection with an untreated partner or a new infection from a new partner. Clients who test positive for syphilis are staged and treated appropriately, and will have blood redraws to retest and ensure treatment effectiveness. Partner elicitation for positive syphilis clients is done by the Texas Department of State Health Services (DSHS) Disease Intervention Specialists. Clinic staff keeps records of positive clients and send reminders of need for retest or redraws. Client numbers are kept by clinic clerical staff for completion of reports.

Community Educators provide information in the community on the expansion of services in the hopes of getting the word out about extended hours, which will happen by increasing the hours that STD testing and treatment is available. It is the expectation that with increased utilization of Health District STD clinics that there will be less use of the local Emergency Departments (ED) for routine STD testing and treatment. In 2011, the Chlamydia cases / rate in Bell County were 3,933 cases, with a rate of 1,325.7 (compared to 2010 - 4,007 cases, rate of 1,375.2). The Chlamydia rates are the highest in the state in Bell County for 2010 & 2011. For Gonorrhea, the 2011 cases / rate were 1,075 cases, with a rate of 362.4 (compared to 2010 - 1,181 cases, rate of 405.3). These rates were also the highest in the State for 2010 & 2011 (Texas STD Surveillance Report, DSHS, 2011).

Goals and Relationship to Regional Goals:

Project Goals**:**

For the past several years, Bell County has had some of the highest STD rates in Texas. The Health District would like to see the case numbers and rates come down for Gonorrhea, Chlamydia, and Syphilis in Bell County. The Health District would also like to see clients in Bell County utilize the clinics in Killeen and Temple instead of the ED for routine STD testing.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs; and
- Reducing inappropriate utilization of services.

Challenges:

Possible challenges are clients reporting inability to pay for services. Staff will work with clients on a payment plan if they report they cannot pay, and they are symptomatic. The Health District recently began accepting credit and debit cards, which may help clients pay. Another challenge is partners refusing to get treated. Extensive education is provided on the importance of partner treatment. The expanded hours will allow partners more opportunity for treatment. For those partners who refuse to come in (or go to their provider) for treatment, EPT will be

provided. EPT is done only in cases where the client's partner refuses to get treated, and the client is at high risk for re-infection. Strict procedures are followed for EPT, since medications are provided to one person for another. Another challenge is that Fort Hood, the largest military base in the world, is located in Bell County. There is a constant influx of soldiers returning from a war campaign and they often bring STD's home with them. This may affect the expected reductions in STD case numbers and rates, since the population base will have grown.

5-Year Expected Outcome for Provider and Patients:

It is expected in the first five years of the project that the number of clients accessing services will increase by 30%. In addition, STD rates in Bell County will be reduced. With the Gonorrhea and Chlamydia rates in Bell County being the highest in Texas, the Health District expects to reduce the number of cases of Gonorrhea, Chlamydia, and Syphilis. However, the Health Department needs time to understand how our intervention will impact rates. Targets will be determined in DY3.

Starting Point/Baseline:

Bell County Public Health District saw 586 Gonorrhea, 586 Chlamydia, and 500 Syphilis clients in FY 2011 (BCPHD clinic records). Bell County STD case numbers 2011: Chlamydia 3933, Gonorrhea 1075. Bell County STD case rates: Chlamydia 1,325.7, Gonorrhea 362.4 (DSHS Texas 2011 STD Surveillance Report, cases reported from January 1 to December 31, 2011. The report is available at http://www.dshs.state.tx.us/hivstd/reports/default.shtm).

Rationale:

Community Need Addressed:

- Community Need Area: CN.1 – Limited access to primary care
- Specific Community Need: CN.1.9 – Increase access to testing and treatment of sexually transmitted diseases in Bell County

This project addresses the high Chlamydia and Gonorrhea rates in Bell County for the latest statistic year available 2011. Bell County has the highest Chlamydia and Gonorrhea case rates in the entire state in 2011. Bell County also has the 6th highest Gonorrhea case number and 7th highest Chlamydia numbers in the state in 2011. Bell County has one of the highest Chlamydia infection rates in the State (DSHS, Texas 2011 STD Surveillance Report).

This project was selected in an effort to decrease the high STD rates in Bell County. Bell County is ranked 16th by population (latest census figures from 2010 from US Census Bureau, updated February 2012), but is 6th and 7th in number of STD rates, and first in numbers of cases of Gonorrhea and Chlamydia. The consistently high numbers and rates of STD infections in Bell County could be due to the close proximity of Fort Hood Army base, the largest military base in the world. Clients, who are often active duty military, frequently utilize the STD services in Bell County clinics to avoid having this information in their military record. The large number of military clients adds to the transient nature of Bell County, which can also contribute to the spread of STDs and the high STD numbers. With the expansion of availability of STD services, the Health Department's goal is to reach and test/treat this population of clients.

Continuous Quality Improvement: The Health District 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: The Health District receives funds from the U.S. Department of Health and Human Services through state agencies; however, these funds will not be used in this project.

Related Category 3 Outcome Measure(s):

- OD-9 Right Care, Right Setting
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea a in Bell County Public Health District clinics
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics

In 2011 and similar to 2010, there were 156 patients who tested positive for Chlamydia in Health District clinics (Bell County Public Health District, 2012). A high prevalence of Chlamydia infection has been observed in women and men who were treated for chlamydial infection during the preceding several months. Most post-treatment infections result from reinfection caused by failure of sex partners to receive treatment or the initiation of sexual activity with a new infected partner. Repeat infections confer an elevated risk for PID and other complications. Unlike the test-of-cure, which is not recommended, repeat *C. trachomatis* testing of recently infected women or men should be a priority for providers. Chlamydia-infected women and men should be retested approximately 3 months after treatment, regardless of whether they believe that their sex partners were treated (Fung M, Scott KC, Kent CK, et al. Chlamydial and gonococcal reinfection among men: a systematic review of data to evaluate the need for retesting. Sex Transm Infect 2007;83:304–9; Hosenfeld CB, Workowski KA, Berman S, et al. Repeat infection with chlamydia and gonorrhea among females: a systematic review of the literature. Sex Transm Dis 2009;36:478–89). If retesting at 3 months is not possible, clinicians should retest whenever persons next present for medical care in the 12 months following initial treatment (CDC, 2012). If more clients, who had been treated for positive Chlamydia, would retest at 3 months, reinfections would be caught early and appropriate retreatment provided, thereby decreasing risk of transmission to others and/or hospitalization for serious sequelae (PID). In 2011, the Chlamydia cases / rate in Bell County were 3,933 cases, rate of 1,325.7 (compared to 2010 - 4,007 cases, rate of 1,375.2). The Chlamydia rates are the highest in the state in Bell County for 2010 & 2011 (Texas STD Surveillance Report, DSHS, 2010 & 2011).

Relationship to Other Projects:
In Pass 2, the Health District will focus on a project (#088334001.2.2) on the need for more STD testing of females of child-bearing age, to find and treat asymptomatic Gonorrhea and Chlamydia infections. According to the CDC, the number of reported cases of Chlamydia and Gonorrhea is lower than the estimated total number because infected people are often unaware of, and do not seek treatment for, their infections and because screening for chlamydia is still not routine in many clinical settings (CDC, 2012). Undetected and/or untreated Chlamydia infections are one of the leading causes of sterility, ectopic pregnancy, poor pregnancy outcomes, neonatal infection and chronic pain (DSHS, Infertility Prevention Project, 2012).

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Central Counties Services (CCS) is proposing a project (#081771001.2.2) to increase testing of STD's in their clinics, as they feel their clients may not go to the Health District to access these services. CCS believes, by nature of many of their clients' disease processes, they cannot or will not seek out testing and treatment, especially if they are asymptomatic. CCS will provide STD education, testing, and treatment on site in their clinics to decrease STD infections among their target population. The Health District will work with CCS to assist them to reach their goals in their project. CCS and the Health District are also working on a project (#081771001.2.1) to assist CCS clients that are suffering the side-effects of prolonged use of psychotropic medications. Williamson County & City Health District, south of Bell County, is proposing a broader primary care project (#126936702.1.1), but it will also increase availability of STD testing in their county.

The Health District is committed to improvement of services and broad-level delivery system transformation. The Health District has an excellent working relationship with the providers in RHP 8, and is willing to participate in learning collaboratives to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Project Valuation:
The cost of the project takes into consideration the salaries and fringe benefits of the nursing staff performing services, indirect costs for administrative staff overseeing the project, and for advertising costs to increase awareness of the project. The funds for the project are for salaries and fringe benefits only, as testing supplies, lab tests, and medications are provided at no cost to the Health District.

Bell County Public Health District 088334001.2.1 - Project Area 2.7.1 Category 2 Milestones and Metrics			
088334001.2.1	**2.7.1**		**Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)**
Bell County Public Health District			**TPI: 088334001**
Related Category 3 Outcome Measure:	**088334001.3.1** **088334001.3.2** **088334001.3.3**	**IT-9.4** **IT-9.4** **IT-9.4**	• Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics • Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics • Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics

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)
Milestone 1 [P-2]: Implement evidence-based innovational project for targeted population **Metric 1** [P-2.1]: Document implementation strategy and testing outcomes. **Baseline/Goal:** Baseline – ½ day STD testing; Goal – STD testing 4 days per week to increase availability of STD services in Health District clinics. **Data Source:** Clinic records **Milestone 1 Estimated Incentive Payment: $170,243**	**Milestone 2** [P-X.10]: Develop a new methodology, or refine an existing one, based on learnings. **Metric 1** [P-X.10]: Monitor clinic numbers and times and adjust schedule accordingly **Baseline/Goal:** Consistently monitor client numbers and make necessary changes to improve program effectiveness **Data Source:** Patient record **Milestone 2 Estimated Incentive Payment: $89,174**	**Milestone 4** [P-X.11]: Incorporate patient experience surveying. **Metric 1** [P-X.11]: Select items to be included in survey, and implement patient satisfaction surveys **Baseline/Goal:** Conduct patient satisfaction survey **Data Source:** Patient charts **Milestone 4 Estimated Incentive Payment: $98,091**	**Milestone 6** [P-X.4]: Redesign the process in order to be more effective, incorporating learnings. **Metric 1** [P-X.4]: Staff to evaluate surveys and implement findings. **Baseline/Goal:** Review patient satisfaction surveys and document results of surveys. **Data Source:** Patient surveys **Milestone 6 Estimated Incentive Payment: $107,900**

	Milestone 3 [I.7]: Increase access to disease prevention programs using innovative project option. **<u>Metric 1</u>** [1.7.2]: Increase number of Gonorrhea encounters as defined by intervention (e.g. STD screenings) **Baseline/Goal:** Baseline – 586 tests for Gonorrhea; Goal – 30% increase in number of patients tested for STD's over baseline (175 for Gonorrhea) in DY3. **Data Source:** Patient records **<u>Metric 2</u>** [1.7.2]: Increase number of Chlamydia encounters as defined by intervention (e.g. STD screenings) **Baseline/Goal:** Baseline – 586 tests for chlamydia; Goal – 30% increase in number of patients tested for STD's over baseline (175 for Chlamydia) in DY3. **Data Source:** Patient records **<u>Metric 3</u>** [1.7.2]: Increase number of Syphilis encounters as defined by intervention (e.g. STD screenings) **Baseline/Goal:** Baseline – 500 for syphilis; Goal – 30% increase in number	**Milestone 5** [I.7]: Increase access to disease prevention programs using innovative project option. **<u>Metric 1</u>** [1.7.2]: Increase number of Gonorrhea encounters as defined by intervention (e.g. STD screenings) **Baseline/Goal:** Baseline – 586 tests for Gonorrhea; Goal – 40% increase in number of patients tested for STD's over baseline (234 for Gonorrhea) in DY3. **Data Source:** Patient records **<u>Metric 2</u>** [1.7.2]: Increase number of Chlamydia encounters as defined by intervention (e.g. STD screenings) **Baseline/Goal:** Baseline – 586 tests for chlamydia; Goal – 40% increase in number of patients tested for STD's over baseline (234 for Chlamydia) in DY3. **Data Source:** Patient records **<u>Metric 3</u>** [1.7.2]: Increase number of Syphilis encounters as defined by intervention (e.g. STD screenings)	**Milestone 7** [I.7]: Increase access to disease prevention programs using innovative project option. **<u>Metric 1</u>** [1.7.2]: Increase number of Gonorrhea encounters as defined by intervention (e.g. STD screenings) **Baseline/Goal:** Baseline – 586 tests for Gonorrhea; Goal – 50% increase in number of patients tested for STD's over baseline (293 for Gonorrhea) in DY3. **Data Source:** Patient records **<u>Metric 2</u>** [1.7.2]: Increase number of Chlamydia encounters as defined by intervention (e.g. STD screenings) **Baseline/Goal:** Baseline – 586 tests for chlamydia; Goal – 50% increase in number of patients tested for STD's over baseline (293 for Chlamydia) in DY3. **Data Source:** Patient records **<u>Metric 3</u>** [1.7.2]: Increase number of Syphilis encounters as defined by intervention (e.g. STD screenings) **Baseline/Goal:** Baseline – 500 for syphilis; Goal – 50% increase in number of patients tested for STD's over baseline (250 for syphilis) in DY3.

	of patients tested for STD's over baseline (150 for syphilis) in DY3. **Data Source:** Patient records **Milestone 3 Estimated Incentive Payment: $89,175**	**Baseline/Goal:** Baseline – 500 for syphilis; Goal – 40% increase in number of patients tested for STD's over baseline (200 for syphilis) in DY3. **Data Source:** Patient records **Milestone 5 Estimated Incentive Payment: $98,092**	**Data Source:** Patient records **Milestone 7 Estimated Incentive Payment: $107,901**
Year 2 Milestone Bundle Amount: $170,243	**Year 3 Estimated Milestone Bundle Amount: $178,349**	**Year 4 Estimated Milestone Bundle Amount: $196,183**	**Year 5 Estimated Milestone Bundle Amount: $215,801**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $760,576			

Category 2 Project Narrative – Pass 2
Bell County Public Health District – 088334001.2.2

Project Area, Option and Title: 2.7.1 - Implement Evidence-based Health Promotion & Disease Prevention Programs. Implement evidence-based strategies to increase screenings and referral for targeted populations.
RHP Project Identification Number: 088334001.2.2

Performing Provider Name: Bell County Public Health District
Performing Provider TPI #: 088334001

Project Summary:

- **Provider Description:** Bell County Public Health District (Health District), is a Local public health district, and provides public health services to the men and women of Bell County and the surrounding area. The Health District provides services in the following programs: Immunizations, Sexually Transmitted Disease (STD) testing and treatment, Pregnancy testing and counseling, Preparedness, Disease Surveillance, Environmental Health, Food Protection, and Women Infant Children (WIC) program. The Health District serves Bell County with a 1060 square mile area and a population of 284,408 (DSHS Health Facts Profile, 2009). The Health District operates two clinics in east and west Bell County in the neighborhoods of the targeted populations.
- **Intervention:** The purpose of this project is to increase the number of females of child bearing age tested for STDs in Health District clinics to ultimately decrease the possible sequelae from untreated infections. Nurses will provide STD risk reduction counseling utilizing the Centers for Disease Control's (CDC's) ABC Method (practice Abstinence, Be faithful with a negative partner, use Condoms). Clinical services will be provided according to Health District STD Testing Policies and Procedures.
- **Project Status:** This project is an expansion of existing STD services. We currently serve 297 female clients but intend to increase the number of females tested for STD's by 20% over baseline in DY4 and 30% over baseline in DY5.
- **Project Need:** <u>CN.1.10: Increase STD testing of females age 14-45 to reduce potential complications of untreated STDs.</u> This project addresses the need for more STD testing of females of child-bearing age, to find and treat asymptomatic Gonorrhea, Chlamydia, and Syphilis infections, to reduce the potential sequelae such as Pelvic Inflammatory Disease (PID), sterility, ectopic pregnancy, poor pregnancy outcomes, neonatal infection and chronic pain (DSHS, Infertility Prevention Project, 2012).
- **Target Population:** The target population is females who are uninsured or on Medicaid, of child bearing age who are sexually active, and who may be unaware of having a sexually transmitted infection. This project intends to increase the number of females seen for STD testing from 297 females seen in 2011 to 356 in DY4 and 386 in DY5, and decrease potential sequelae of untreated STD's such as PID, ectopic pregnancy, pregnancy complications, neonatal infections, pelvic pain.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to increase the number of females tested for STD's in Health District clinics by 20% over baseline in DY4 (59 additional clients tested) and 30% over baseline in DY5 (89 additional clients tested).

- **Category 3 Outcomes: OD-6 Patient Satisfaction**
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores; target 10% increase over baseline in DY4.
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores; target 20% increase over baseline in DY5.

Project Description:

Increase number of females aged 14-45 who are tested for Gonorrhea, Chlamydia, and Syphilis in Bell County Public Health District Clinics

The purpose of this project is to increase the number of females of child bearing age tested for Sexually Transmitted Diseases (STDs) in Health District clinics to ultimately decrease the possible sequelae from untreated infections. The Health District staff will provide STD risk reduction counseling utilizing the Centers for Disease Control's (CDC's) ABC Method (practice Abstinence, Be faithful with a negative partner, use Condoms). Outreach will be conducted in the community to inform females of the availability of services, and also the importance of finding and treating STD's prior to complications and damage occurring. Quality clinical services will be provided by licensed nurses according to Health District STD Testing Policies and Procedures. The Health District staff has 5-10 years of experience in conducting risk assessment and risk reduction STD counseling and testing. They will provide one-on-one, individualized counseling for each STD client, to include counseling regarding the need for medication compliance, medication education, partner treatment, abstinence until partner treated, and importance of future safe sex practices. Staff will provide each client with written educational materials, as well as condoms. Nursing staff will treat symptomatic clients at the time of testing, and will encourage abstinence until partners are treated, if positive. Clients with positive results are notified regardless if they were treated at testing, so that counseling can occur with regard to abstinence and partner treatment. Clients whose partners refuse to be treated will be offered Expedited Partner Therapy (EPT) according to established procedures.

Clients who test positive for Gonorrhea and/or Chlamydia are strongly encouraged to return to the clinic in three months for a retest due to the possibility of re-infection with an untreated partner or a new infection from a new partner. Clients who test positive for syphilis are staged and treated appropriately, and will have blood redraws to retest and ensure treatment effectiveness. Pregnant women who test positive for syphilis are treated and referred for prenatal care. Counseling is provided on the potential effects of untreated STD's on the pregnancy and/or baby. Partner elicitation for positive syphilis clients is done by the Texas Department of State Health Services (DSHS) Disease Intervention Specialists. Clinic staff keeps records of positive clients and send reminders of need for retest or redraws. Client numbers are kept by clinic clerical staff for completion of reports.

Community Educators provide information in the community on the Health District services and importance of STD testing and treatment for sexually active females. It is the expectation that with increased utilization of Health District STD clinics that there will be less use of the local Emergency Departments (ED) for routine STD testing and treatment, as well as decrease the hospitalizations for sequelae of untreated STD's such as PID, ectopic pregnancy, pregnancy complications, neonatal infections, pelvic pain (DSHS, Infertility Prevention Project, 2012),

miscarriages, premature births, stillbirths, or deaths of newborn babies (U.S. Department of Health and Human Services, Office on Women's Health, Syphilis Fact Sheet, July 8, 2011).

Goals and Relationship to Regional Goals:

Project Goals**:**

It is the goal of the project to increase the number of female clients in Bell County who access STD testing and treatment services in Health District clinics to decrease the potential complications associated with untreated STD's. For the past several years, Bell County has had some of the highest STD rates in Texas. The Health District would like to see the case numbers and rates come down for Gonorrhea, Chlamydia, and Syphilis in Bell County. The Health District would also like to see clients in Bell County utilize the clinics in Killeen and Temple instead of the ED for routine STD testing.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs; and
- Reducing inappropriate utilization of services.

Challenges:

Possible challenges are clients reporting inability to pay for services. Staff will work with clients on a payment plan if they report they cannot pay, and they are symptomatic. The Health District recently began accepting credit and debit cards, which may help clients to be able to pay. Another challenge is partners refusing to get treated. Extensive education is provided on the importance of partner treatment. The expanded hours will allow partners more opportunity for treatment. For those partners who refuse to come in (or go to their provider) for treatment, EPT will be provided. EPT is done only in cases where the client's partner refuses to get treated, and the client is at high risk for re-infection. Strict procedures are followed for EPT, since medications are provided to one person for another. Another challenge is that Fort Hood, the largest military base in the world, is located in Bell County. There is a constant influx of soldiers returning from a war campaign and they often bring STD's home with them.

5-Year Expected Outcome for Provider and Patients:

It is expected in the first five years of the project that the number of female clients accessing services will increase by 20% in DY4 (356 total patients – 59 over baseline) and 30% in DY5 (386 total patients – 89 over baseline). Targets based on FY 12 client numbers. It is the intent with this project, that potential complications associated with untreated STD's will be reduced with the increase in testing of female patients. In addition, ED visits and hospital admission for sequelae from untreated STD's will go down.

Starting Point/Baseline:

297 females accessed STD services in Bell County Public Health clinics in FY2012. Increase number of females seen in STD clinic by 20% over baseline in DY4 and 30% over baseline in DY5.

Rationale:

Community Need Addressed:

- Community Need Area: CN.1 - Limited access to primary care

- Specific Community Need: CN.1.10 – Increase STD testing of females age 14-45 to reduce potential complications of untreated STDs (i.e., Pelvic Inflammatory Disease)

This project addresses the need for more STD testing of females of child-bearing age, to find and treat asymptomatic Gonorrhea, Chlamydia, and Syphilis infections. According to the CDC, the number of reported cases of Chlamydia and Gonorrhea is lower than the estimated total number because infected people are often unaware of, and do not seek treatment for, their infections and because screening for chlamydia is still not routine in many clinical settings (CDC, 2012). Untreated Gonorrhea and Chlamydia have the potential to cause Pelvic Inflammatory Disease (PID), sterility, ectopic pregnancy, poor pregnancy outcomes, neonatal infection and chronic pain (DSHS, Infertility Prevention Project, 2012). Untreated syphilis can lead to severe illness and even death. Having syphilis increases the risk of acquiring or spreading HIV. Untreated syphilis also can cause problems during pregnancy such as increasing the potential for miscarriages, premature births, stillbirths, or death of newborn babies. Infected babies may be born without signs or symptoms, but may develop health problems such as developmental delays and seizures within weeks of birth (U.S. Department of Health and Human Services, Office on Women's Health, Syphilis Fact Sheet, July 8, 2011).

Bell County had the highest Chlamydia and Gonorrhea case rates in the entire state in 2010. Bell County also had the 6th highest Gonorrhea case numbers, and 7th highest Chlamydia numbers in the state in 2010. Bell County has one of the highest Chlamydia infection rates in the State (DSHS, Texas 2010 STD Surveillance Report). Bell County STD cases numbers 2010: Chlamydia 4007, Gonorrhea 1181. Bell County STD case rates: Chlamydia 1375.2, Gonorrhea 405.3 (DSHS Texas 2010 STD Surveillance Report). In 2010, Bell County had 16 cases of primary and secondary syphilis with a rate of 5.5. In 2011, there were 5 cases of primary and secondary syphilis, with a rate of 1.7 in Bell County. DSHS Region 7, in which Bell County resides, had 7 cases of congenital syphilis in 2011 (there are no figures for Bell County) (DSHS 2011 STD Surveillance Report).

Continuous Quality Improvement: The Health District 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: The Health District receives funds from the U.S. Department of Health and Human Services through state agencies; however, these funds will not be used in this project.

Related Category 3 Outcome Measure(s):

- OD-6 Patient Satisfaction
  - IT-6.1 Percent improvement over baseline of patient satisfaction scores

Baseline patient satisfaction scores will be determined in DY3 and targets will be set for DY4 and DY5 at that time. The Health District will show a TBD improvement in DY4, and TBD

improvement in DY5, over baseline of patient satisfaction scores for patients surveyed in BCPHD STD clinics to establish if patients are getting timely care, appointments, and information.

Some clients may feel embarrassed to seek STD testing and treatment with their primary provider, or may feel more comfortable accessing these services at the Health District clinics. It is important for clients to feel comfortable when being tested and/or treated for STD's. Assessing client satisfaction will enable changes to increase quality of services provided and ensure continued use of Health District clinic for these services. Additionally, there are no other low-cost STD clinics available for individuals in Bell County. There are many physicians, EDs, and acute care clinics, but the cost for STD testing and treatment can be in the hundreds of dollars. The Health District offers a single test for Gonorrhea, Chlamydia, and Syphilis – all for a single fee, and the treatment is included in the fee and provided on site. The fee for all these tests and treatment is as low as some insurance plan's co-pay.

Relationship to Other Projects:
In Pass 1, the Health District is focusing on a project (#088334001.2.1) to implement Evidence-based Health Promotion & Disease Prevention Programs. The purpose of the project is to increase the availability of STD testing at the Health District clinics. It is the hope, by expanding STD service hours, that the Health District can increase access to STD testing and treatment, and decrease the Gonorrhea, Chlamydia, and Syphilis case numbers and rates in Bell County, which are some of the highest rates in the state. The proposed Pass 2 project focuses on females only with the goal of finding and treating STD's before they can cause complications and damage; whereas the Pass 1 project focus is increasing access to services to males and females, and to decrease overall Gonorrhea, Chlamydia, and Syphilis case numbers and rates.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Central Counties Services (CCS) is proposing a project (#081771001.2.2) to increase testing of STD's in their clinics, as they feel their clients may not go to the Health District to access these services. CCS believes, by nature of many of their clients' disease processes, they cannot or will not seek out testing and treatment, especially if they are asymptomatic. CCS will provide STD education, testing, and treatment on site in their clinics to decrease STD infections among their target population. The Health District will work with CCS to assist them to reach their goals in their project. CCS and the Health District are also working on a project (#081771001.2.1) to assist CCS clients that are suffering the side-effects of prolonged use of psychotropic medications. Williamson County & City Health District, south of Bell County, is proposing a broader primary care project (#126936702.1.1), but it will also increase availability of STD testing in their county.

The Health District is committed to improvement of services and broad-level delivery system transformation. The Health District has an excellent working relationship with the providers in RHP 8, and is willing to participate in learning collaboratives to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a semi-annual basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Project Valuation:
The cost of the project takes into consideration the salaries and fringe benefits of the nursing staff performing services, indirect costs for administrative staff overseeing the project, and for advertising costs to increase awareness of the project. The funds for the project are for salaries and fringe benefits only, as testing supplies, lab tests, and medications are provided at no cost to the Health District. The value of the project also includes the potential savings from possible ED visits, hospitalizations, surgeries, medications, and long term costs of care associated with untreated STD sequelae (i.e. PID, ectopic pregnancy, pregnancy complications, neonatal infections, chronic pain, miscarriages, premature births, stillbirths, or deaths of newborn babies).

Bell County Public Health District 088334001.2.2 (Project Area 2.7.1 - Pass 2) Category 2 Milestones and Metrics				
088334001.2.2	**2.7.1**		**2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations**	
Bell County Public Health District				**TPI: 088334001**
Related Category 3 Outcome Measure (s):	**088334001.3.4**	**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)***	
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)**
Milestone 1 [P-1]: Development of innovative evidence-based project for targeted population **<u>Metric 1</u>** [P-1.1]: Document innovational strategy and plan **Baseline/Goal:** Fully developed plan ready for execution **Data Source:** Clinic records **Milestone 1 Estimated Incentive Payment: $178,200**	**Milestone 2** [P-2]: Implement evidence-based innovational project for targeted population **<u>Metric 1</u>** [P-2.1]: Document implementation strategy and testing outcomes. **Baseline/Goal**: Fully implemented project – to increase the number of females STD tested in Health District clinics. **Data Source**: Clinic records **Milestone 2 Estimated Incentive Payment: $197,856**		**Milestone 3** [I-5]: Identify X percent of patients in defined population receiving innovative intervention consistent with evidence-based model. **<u>Metric 1</u>** [I-5.1]: Increase by 20% over baseline the number 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. **Baseline/Goal**: Baseline – 297 in FY12; Goal – 20% increase over baseline (59 clients over baseline).	**Milestone 4** [I-5]: Identify percent of patients in defined population receiving innovative intervention consistent with evidence-based model. **<u>Metric 1</u>** [I-5.1]: Increase by 30% over baseline the number 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. **Baseline/Goal**: Baseline – 297 in FY12; Goal – 30% increase over baseline (89 clients over baseline). **Data Source**: Clinic records **Milestone 4 Estimated Incentive Payment: $253,255**

		Data Source: Clinic records **Milestone 3 Estimated Incentive Payment: $237,427**	
Year 2 Milestone Bundle Amount: $178,200	**Year 3 Estimated Milestone Bundle Amount: $197,856**	**Year 4 Estimated Milestone Bundle Amount: $237,427**	**Year 5 Estimated Milestone Bundle Amount: $253,255**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $866,738			

Category 2 Project Narrative
Bluebonnet Trails Community Services – 126844305.2.1

Project Area, Option, and Title: 2.13.2 In an innovative manner, 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 not described in the project options above.
RHP Project Identification Number: 126844305.2.1

Performing Provider Name: 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 Williamson and Burnet Counties in RHP 8. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. We are responsible for behavioral health planning and coordination throughout our local service area and are the sole provider of public behavioral health services in these counties.
- **Intervention:** BTCS proposes to implement a transitional housing facility. 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 and transition into independent living.
- **Project Status:** This is a new project for BTCS. No such service exists from any provider in these Counties and there are limited affordable housing options in both.
- **Project Need:** This project addresses RHP 8 Community Needs Assessment: CN.2.1 - Limited access to behavioral health services to rural, poor and under & uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; and CN.2.12 - Limited access in Williamson County to behavioral health services for adults with serious mental illnesses who are transitioning from inpatient care and crises into community living.
- **Target Population:** The target population is mentally ill individuals referred from crisis and inpatient settings. We will prioritize admissions to those with long or repeated stays in those settings or with frequent contacts with the criminal justice system. BTCS served 7,769 persons with behavioral health disorders in FY 2012. An average of 43% of adults were Medicaid-eligible; and 73% of BTCS clients are below the federal poverty level. We expect 70% of those benefitting from this project will be poor, under or uninsured. This project will serve 18 people in DY5.
- **Category 1 or 2 Expected Project Benefit for Patients:** This project seeks to provide transitional housing services for 12 people in DY4 and 18 people in DY5. Stable living gives provides an opportunity to improve life skills and functioning.
- **Category 3 Outcomes:** IT-3.8: Our goal is to reduce behavioral health /substance abuse 30 day readmission rate by a percentage TBD based on a baseline established in DY3.

- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. This project is transformative to the community because there are no affordable housing options for those who are treated and released from inpatient psychiatric settings or who have experienced a crisis event that dislocates them from community and family. Psychiatric/medical stability is impossible without housing.

Project Description:

Peer Supported Transitional Housing

BTCS is the state designated LMHA for Williamson and Burnet Counties in RHP 8. We are responsible for an array of public 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 with behavioral health issues residing in the area. We serve a variety of persons through various contracts and payors among those BTCS has 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). 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 Emergency Department (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.) and staffed in large part by peer support specialists. Based on our treatment efforts and with the consensus of community leaders, we realize that no housing now exists that can be used to help people make the transition to recovery. We will identify a suitable facility in Round Rock, Texas to rent and remodel for development as a transitional housing alternative for people who come from and might relocate back to Williamson and Burnet Counties. The program will accept referrals from our Crisis Respite Unit, State Psychiatric Inpatient Facilities, and the local Community Center. 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. We will encourage but not require individuals to live with a roommate to reduce the overall cost of their expenses once they move out of transitional housing. While in the program Peer Specialist will teach skills to improve the likelihood of a successful transition into independent living. Peer Specialist in Recovery will assist those in the program better

understand their particular recovery needs while providing hope and encouragement. 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 programs that focus on promoting recovery and self –responsibility. A starting point will be hiring state certified peer support specialists who can assist in research and assessment of the models and will spearhead the selection of interventions that they can support as peers. Peer support will be critical to the program's success. We will assess a variety of recovery programs, such as WRAP, Whole Health and Resiliency, Recovery Dialogue, Destination Recovery (Person-Centered Recovery Goals), Healthy Eating and local Support Groups (*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 ; and *Consumer Operated Services – EBP*, http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD).

The common elements they all support skills development, self- awareness and individual responsibility in the recovery process. For example, WRAP is listed on the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 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 Peer Supported 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 develop this program of transitional living based on recovery principles with an average census of around 6 persons who will stay from between one 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 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 Goal:
- Establish a Transitional Housing program based on Recovery Principles;
- Recruit, train and certify Peers to provide transitional services;
- Provide services to the target population of people who have been hospitalized or experienced a crisis event and have been in the Crisis Respite facility; and
- Assist people to regain functioning and self-manage their wellness

This Project meets the following Regional Goals:

- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

As this program is established and grows, we expect individuals will have fewer ED 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 to the broader community of persons in Williamson County with SMI who are in the process of recovery.

Challenges:
Challenges include finding adequate housing for persons who are ready to exit the transitional living program and to live independently or in a supportive living situation in the community. We 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 training and certifying peer support specialists and ensuring they have the knowledge necessary to make linkages with other programs such as crisis respite and federally qualified health clinics. During DY2 we will be actively recruiting individuals with SMI for training and certification as Peer Support Specialists. We will also begin a 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 live successfully and gives them the opportunity to be assisted by their peers as they make that transition. Community tenure will improve with these supports and readmissions will be reduced.

Starting Point/Baseline:
Currently no Transitional Housing program exists in the four Counties; therefore, the baseline is 0 in DY2. Baseline data is expected to be based on patients entering the peer supported transitional housing program DY3. The precise metrics are to be determined based on the planning and research cycle of the project. As stated, we expect to impact ED visits, arrests, utilization of crisis respite services and state hospitalizations but we must determine the baseline number during the initial phase.

Rationale:
Community Need Addressed:

- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.12 - Limited access in Williamson County to behavioral health services for adults with serious mental illnesses who are transitioning from inpatient care and crises into community living.

In Category 2 - Innovation and Redesign; Project Area and Option: 13 –" 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, ED, urgent care etc.); 2 – "Other" project option: 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 not described in the project options above." We selected the "Other" option even though it is not associated with a set of Core Components because the project incorporates at least six of the community-based interventions 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; and
- Peer support – A service that models successful health and mental health behaviors. It is provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals.

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.

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. This innovative community alternative to institutional care not only saves money through reduced hospitalizations but also provides people the opportunity for recovery with the help of their peers.

The Milestones selected for DY's 2 and 3 are:

- P-1 Milestone: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources;
- P-2 Milestone: Design community-based specialized interventions for target populations. Interventions may include (but are not limited to) Residential Assistance;

- (Foster/Companion Care, Supervised Living, Residential Support Services); and
- P-4 Milestone: Evaluate and continuously improve interventions.

We selected these because we are starting a new program that has not been implemented in this Region and must ensure that the right population is targeted with the right interventions and then continuously adjusted as we learn how to help people succeed through the use of peers, supports and transitional services. The metrics are a combination of program reports and logs and census numbers.

The Milestone for DY's 4 and 5 are:

- I-5 Functional Status: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on ANSA; we selected the target 30% in DY4 and 40% in DY5.

We selected Functional Status because we expect the period of Transition will improve functioning and our goal is to return to community life.

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.

Continuous Quality Improvement: The Center 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project provides housing services to enhance the initiatives currently funded by the U.S. Department of Health and Human Services (DHHS). BTCS receives funds to operate substance abuse Outreach Screening and Referral services in Williamson and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services in this project; however, this project enhances and extends the care currently provided with Federal funds by a providing a local option to address crisis needs. BTCS currently employs Peer Support Specialists to enhance services in all outpatient programs. Peers is a system reform initiative that we are proud to support. This system reform initiative will be enhanced by utilizing additional Peers in the vital role of promoting wellness and self-management. Also as stated above, this will create a community hub for Recovery activities.

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. 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:
The project will be intertwined with new projects proposed by BTCS and existing programs. It is anticipated that some referrals will come from individuals who have been diverted from county jails or emergency services in our Emergency Service Diversion Project (#126844305.2.2). Also we expect persons to be admitted from the Crisis Respite Project (#126844305.1.2) and to use that program in lieu of hospitalization if short term stabilization is required. We also anticipate that some high functioning individuals with Intellectual and Developmental Disabilities (IDD) who are provided wrap around services through our IDD Assertive Community Treatment project (#126844305.2.3), in Pass 2 may be eligible for and need these transitional housing services. Currently, BTCS has an active effort underway to recruit and certify peer specialists and this program will provide a great fit for the skills and commitment of those individuals.

Relationship to Other Performing Provider Projects and Plan for Learning Collaborative:
BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care.

Project Valuation:
This project seeks to provide transitional housing services for 12 people in DY4 and 18 people in DY5. Although this is a small number of people, the acuity is such that we expect 1,080 be days in DY4 and 1,620 bed days in DY5 since this is a group of people who have multiple hospitalizations and great difficulty maintaining community tenure. Stable living gives provides an opportunity to improve life skills and functioning. This represents a substantial savings when compared to bed day costs for inpatient psychiatric facilities and substantial patient benefit in that it supports a healthy life in the community. 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).

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.

Bluebonnet Trails 126844305.2.1 (Project 2.13.2) Category 2 Milestones and Metrics			
126844305.2.1	**2.13.2**		**In an innovative manner not described above, implement other evidence-based project for a targeted behavioral health population to prevent unnecessary use of services in a specified setting. Note: Providers opting to implement an innovative project under this option must propose relevant process and improvement milestones.**
Bluebonnet Trails MHMR			**126844305**
Related Category 3 Outcome Measure (s):	**126844305.3.4**	**IT-3.8**	**Behavioral Health /Substance Abuse 30 day readmission rate**

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)
Milestone 1 [P-2]: Design community-based specialized interventions for target populations; Supervised Living and Residential Support Services. **Metric 1** [P-2.1]: Project plans which are based on evidence / experience and which address the project goals **Baseline/Goal:** Produce a comprehensive report detailing development of the project plan including all elements above. **Data Source:** Program documents and community data reports and analysis. **Milestone 1 Estimated Incentive Payment: $231,563**	**Milestone 3** [P-3]: Enroll and serve individuals with targeted complex needs. **Metric 1** [P-3.1]: Number of targeted individuals enrolled / served in the project. **Baseline/Goal:** Enroll and provide services to 12 individuals. **Data Source:** Program records and EHR. **Milestone 3 Estimated Incentive Payment: $219,375** **Milestone 4** [P-4]: Evaluate and continuously improve interventions **Metric 1** [P-4.1]: Project planning	**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: $482,625**	**Milestone 6** [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 6 Estimated Incentive Payment: $471,900**

Milestone 2 [P-3]: Enroll and serve individuals with targeted complex needs. **<u>Metric 1</u>** [P-3.1]: Number of targeted individuals enrolled / served in the project. **Baseline/Goal:** Enroll and provide services to 6 individuals. **Data Source:** Program records and EHR. **Milestone 2 Estimated Incentive Payment: $231,562**	and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/Goal:** Produce QM report reflecting PDSA cycle, including real-time data for rapid-cycle improvement guiding CQI **Data Source:** QM reports and BI **Milestone 4 Estimated Incentive Payment: $219,375**		
Year 2 Milestone Bundle Amount: $463,125	**Year 3 Estimated Milestone Bundle Amount: $438,750**	**Year 4 Estimated Milestone Bundle Amount: $482,625**	**Year 5 Estimated Milestone Bundle Amount: $471,900**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,856,400			

Category 2 Project Narrative
Bluebonnet Trails Community Services – 126844305.2.2

Project Area, Option, and Title: 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
RHP Project Identification Number: 126844305.2.2

Performing Provider Name: 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 Local Mental Health Authority (LMHA) for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is the public provider of behavioral health services for the poor, under or uninsured in Williamson County and coordinates and provides crisis services.
- **Intervention:** BTCS proposes to use healthcare teams to reduce utilization of emergency services by individuals identified as a high utilizers. Those identified will be offered proactive care in settings other than emergency departments (EDs), including their homes. Services will be provided immediately in the short-term and ongoing wellness activities and behavioral health treatment will be initiated in the long-term.
- **Project Status:** This is a new project to be established in partnership with the Williamson County Emergency Medical Services (EMS).
- **Project Need:** A study revealed 144 High Utilizers of emergency, 105 had a mental health diagnosis and accounted for 2,071 ED visits during 2010. This project addresses the RHP Community Needs Assessment needs: CN.2.1 - Limited access to behavioral health services to rural, poor and under and uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; and CN.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson County.
- **Target Population:** This project will identify high utilizers of emergency services through the use of EMS records, Indigent Care Collaboration EMR statistics, and ED reporting. BTCS served 6,429 persons with behavioral health disorders in FY 2012. An average of 43% of adults were Medicaid-eligible; and 73% of BTCS clients are below the federal poverty level. We expect 70% of those benefitting from this project will be poor, under or uninsured.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide care to at least 45 people in DY4 and 60 people in DY5. Access to a broader range of services, a medical home and wellness activities will improve functioning, improve quality of life for these patients and will reduce the multiple inappropriate trips to the ED. This is a substantial benefit to these patients, to those who have improved access to ED due to reductions of inappropriate utilizers and to healthcare costs in the RHP.

- **Category 3 Outcomes:** IT-9.2: Our goal is to achieve ED appropriate utilization for this group of high utilizers, which will promote ongoing improvement in health rather than repeated access for emergency situations.
- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. This is a transformative project as indicated by the broad community support and participation by Williamson County Emergency Services and the healthcare community. This group of patients has presented a substantial challenge to the community and a drain on community resources. All healthcare providers are looking forward to reducing this inappropriate utilization.

Project Description:

Emergency Services Diversion Project/Community Health Initiative

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. BTCS proposes to use teams consisting of a project coordinator, licensed social workers (LSW), advanced Paramedic and nurse practitioner (NP) to reduce utilization of emergency services by individuals identified as a high utilizer of such services. This project will identify high utilizers of emergency services through the use of Emergency Medical Services (EMS) records, Indigent Care Collaboration Electronic Medical Record (EMR) statistics, and emergency department (ED) reporting. When individuals are identified, they will be offered the opportunity to receive proactive assistance in setting other than hospital EDs, including their homes. To participate patients must be enrolled and sign a Consent for Care form, which will also allow sharing of information in order to improve continuity of care. Enrolled participants medical records will be reviewed by a Professional Peer Review Committee (PPRC) made up of medical and mental health professionals from five local public hospitals, the Williamson County & Cities Health District (WCCHD), Mobile Outreach Team (MOT), EMS and Bluebonnet Trails Community Services. The PPRC will create unique comprehensive care plans for patients identified that often have mental illness and co-occurring disorders. The collaboration and sharing of information by professionals will allow improved coordination of community resources, continuity of care, avoidance of over prescribing, or contra-indication of numerous medications prescribed by multiple sources. Once a comprehensive plan has been created local hospitals should follow the plan which will help avoid duplication of services and unnecessary lab and medical tests. Another important component of the project is the use of non-physician health professionals to help coordinate care and connect patients with multiple and complex needs to appropriate resources. Teams of professionals including an advanced paramedic, Advanced Nurse Practitioner and Licensed Social Workers will make home visits to check vital signs, help with medication compliance, access home safety and ensure basic needs are met with appropriate resources. By providing proactive care with multidisciplinary teams, patients can learn to manage their chronic conditions, avoiding costly emergency room and hospital admissions can be avoided, while reducing costs while improving quality of care.

To initiate appropriate disposition of calls into the field, the 11 Williamson County EMS dispatchers will be trained to recognize critical primary and behavioral health issues. A centralized health information management system will be used to collect patient access information from the participating emergency and crisis services providers including the local EDs, EMS, MOT and BTCS. A data analyst will be hired to review the patient access information from each participating emergency and crisis services provider. On a monthly basis high utilizers of the emergency and crisis services will be identified by the data analyst and presented to the PPRC. The PPRC is comprised of key staff from the participating emergency and crisis services providers. A collaborative treatment plan will be developed for the individual identified as a high utilizer of emergency and crisis services. The treatment plan will be shared with each participating emergency and crisis services provider--and will drive the treatment provided in the field by the team of professionals including the advanced Paramedic, Advanced Nurse Practitioner and Licensed Social Workers. Each participating provider will be able to follow the treatment to ensure the individual receives a comprehensive approach to care--reducing the use of unnecessary ED visits; reducing readmissions into critical care; assisting the persons without a medical home to engage with a medical home; and positively impacting the overall health of each individual served.

This team has the capability to serve 30 identified patients at any given time. The PPRC may establish other comprehensive care plans that do not involve the use of the team for coordination of care purposes.

Goals and Relationship to Regional Goals:
This project proposes to use multi-disciplinary teams to reduce utilization of emergency services by individuals identified as a high utilizer of such services. Patients who have been identified as high utilizers of EMS and ED services will receive a care plan that reduces high utilization of EMS and ED services.

Project Goals:

- Establish a Professional Peer Review Committee for the purpose of establishing care plans for patients with a history of high utilization. The PPRC allows for discussion of treatment related issues in a protected environment, for the purpose of improving care at any location
- Establish a team of a LSW and NP to provide coordination of care, patient education, and linkage to needed services to prevent unnecessary use of EMS and ED services.
- Reduce inappropriate emergency transports, ED use
- Improve quality of care and access to healthcare for patients with complex medical needs
- Reduction of inpatient hospitalizations and costs associated with providing emergency services.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing the proportion of residents with a regular source of care; and

- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

We are proposing this project in Williamson County because an August, 2011 study by the WCCHD and the Integrated Care Collaboration of ED use in Williamson County zip codes found that a small cohort of individuals account for a disproportionate share of acute medical cases, and while consuming significant resources they were achieving poor health outcomes. There were 144 High Utilizers (HU) of emergency services, as defined as having 6 or more ED visits during a 3 month period. Of these HUs, 105 had a mental health diagnosis and accounted for 2,071 ED visits during 2010. Overall MH utilization had 44% growth from 2008 to 2010 while HUs of MH had a 74% increase. 50% of HUs have Medicaid as a payment source with the majority of the remainder having no payment source. Baseline data from the above referenced study shows that the 144 HUs accounted for approximately 2,100 ED visits. With an average ED visit being $3,700 this equals approximately $7.8 million dollars of medical care, which does not account for the cost of EMS transport. Assuming half of the visits were transported by EMS at a cost of $1,361/transport that would equal approximately another $1.43 million.

Challenges:
It will be a challenge to coordinate a monthly meeting of appropriate healthcare professionals in order to provide services to high users (HU) of emergency services. It will be a challenge to create an authentication system to ensure users view appropriate sensitive medical information based on assigned roles and responsibilities. It will be a challenge to develop patient consents and methods for sharing data that meets the needs of all of the partners. Finally, it will be a challenge to identify the appropriate patients to serve, as there is anticipated to be more need than there are resources to provide care.

5-Year Expected Outcome for Provider and Patients:
Over the next 5 years, we expect the outcomes to include: patients with high utilization of emergency services will be continuously identified, and served in the most appropriate and efficient setting; and that will result in a reduction of ED utilization by the targeted population.

Starting Point/Baseline:
Currently no involuntary Emergency Services Diversion project exists in Williamson County; therefore, the baseline is 0 in DY2. As presented above, we do have data reflecting the number of people identified as high utilizers, with 6 or more visits to the ED during a 3 month period, but we do not know the number who will accept the services and be enrolled in the project. A major effort is needed during DY2 to identify the extent of the resources needed and ensure that the intervention is appropriate and adequate.

Rationale:
<u>Community Need Addressed:</u>
- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Needs include:
  - CN.2.1 – Limited access to behavioral health services to rural, poor and under & un-uninsured populations (meds, case management, counseling, diagnoses) in Williamson County.

- CN.2.2 – Limited access for serious mentally ill adults to crisis services in Williamson County

A project to establish a PPRC among local hospitals, the health department, the mobile outreach team, EMS, and BTCS provides an opportunity to create comprehensive treatment plans for patients identified as high utilizers of emergency services. The plan may involve the use of teams consisting of an advanced paramedic, nurse practitioner and licensed social workers to coordinate services, improve patient compliance, monitor chronic conditions, reduce duplicative services, and link to needed services within the community. The skill set of the team will allow for assessment of medical conditions, psychiatric conditions, and substance use problems. Patients with chronic conditions will receive proactive, ongoing care keeping patients healthy and empowering patients to self-manage their conditions in order to avoid a decline in health or needing ED or inpatient care. This project provides the opportunity to improve the quality of care while reducing reliance on unneeded emergency services.

Core Project Components:

This project to provide Emergency Services Diversion will address all of the required core 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. Factors could include chronic physical health conditions; chronic or intermittent homelessness, cognitive issues resulting from severe mental illness and/or forensic involvement.* Although the initial study, cited above, revealed the number of high utilizers and some characteristics of the population, the contributing factors are not completely described. We will gather information from electronic health records and case management reports to further refine the characteristics and needs.

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.* The community team has done some literature review. The basic design of this project as well as the information sharing protocol and implementation steps originated from those reviews. We will use the PPRC to continue those reviews to expand the community based interventions to be developed in subsequent years.

c) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* We will use BTCS and hospital business intelligence and quality management staff to facilitate the development and documentation of our evaluation plan. Oversight will be provided by the PPRC who will ensure qualitative and quantitative metrics will be used to measure outcomes.

d) *Design models which include an appropriate range of community-based services and residential supports.* Using the information from stakeholders, PPRC, evaluation metrics, patient assessments and reports; we will evaluate available interventions to determine if they are sufficient in capacity and scope. We will adjust our model accordingly.

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. The impact of interventions will be assessed on an individual patient level by using the ANSA and SF 36. Aggregated data from those assessments along with number of ED visits, cost of medical care pre and post intervention, will be used to assess community impact and identify and respond to lessons learned.

Continuous Quality Improvement: The 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: As presented above, the August, 2011 study by the WCCHD and the Integrated Care Collaboration of ED use in Williamson County zip codes found that a small cohort of individuals account for a disproportionate share of acute medical cases, consuming significant resources they were achieving poor health outcomes. There were 144 high utilizers (HU) of emergency services, as defined as having 6 or more emergency department visits during a 3 month period. Of these, HU MH had a 74% increase. The high utilizer case management program implemented by the University of Washington Medicine, (The University of Washington Medicine, Harborview Medical Center in 2009 which *A High Utilizer Case Management Program* (http://www.wsha.org/files/2012 June 15 Behavioral Health Web Conf.pptx;) indicates that one common cause of frequent ED use is lack of access to primary care and another is the presence of behavioral health diagnoses. BTCS is a recipient of a grant through the Health Resources and Services Administration Division of the U.S. Department of Health and Human Services (DHHS) to develop a primary care/behavioral health care another RHP in partnership with the Federally Qualified Health Center for Guadalupe County. BTCS also receives funds from DHHS to operate substance abuse Outreach Screening and Referral services in Williamson and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services in this project; however, this project enhances and extends those by identifying and directing those in need to re care currently provided with federal funds.

Related Category 3 Outcome Measure:

- OD- 9 Right Care, Right Setting
  - IT-9.2 ED appropriate utilization

Reasons/rationale for selecting the outcome measure:

As presented above, 144 FUs accounted for approximately 2,100 ED visits and of those 105 had a mental health diagnosis and accounted for 2,071 ED, over 98%. This project proposes to implement a special high utilizer team to intervene with the high utilizers especially those with

behavioral health diagnoses. This is similar to a project implemented by the program demonstrated a dramatic reduction in ED use in the first 11 months; from an average of 15 visits per person per month to an average of slightly more than 1 visit per person per month. We believe our project will result in similar outcomes and therefore selected this measure.

Relationship to Other Projects:
This enhances additional projects that BTCS is pursuing related to Emergency Services Diversion in that it provides access to care following emergency interventions. As a part of graduation from Emergency Services Diversion, we will be able to offer:

- The Transitional Housing initiative [#126844305.2.1] will solidify success in remaining in the community and offer expertise, support and experience through a Peer Support Specialist;
- The Expansion of Services in Eastern Williamson County [#126844305.1.1] will allow for ongoing outpatient services for persons who currently do not meet the eligibility criteria through existing funding from the Community Mental Health services block grant provided through the Department of State Health Services from DHHS;
- The Crisis Stabilization plan [#126844305.1.2] for persons in behavioral health crisis will provide a safety net for those individuals who may be in need for more intensive care without requiring the restrictive level of care provided by a psychiatric hospital.
- Like the Crisis Stabilization plan, the Substance Addiction Treatment option [#126844305.1.5] will offer substance abuse treatment as a back-up for relapse and crisis events.

We expect these interrelated projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. This Emergency Services Diversion plan supports and relies upon the projects noted above in developing a strong community network of resources for people to continue their recovery.

Relationship to Other Performing Provider Projects and Plan for Learning Collaborative:
This project works in relation with Williamson County and Cities Health District project (126936702.1.2) for Community Paramedicine.

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care.

Project Valuation:
We expect to serve 45 patients in DY4 and 60 in DY5. As described above this represents over 700 ED visits and millions of dollars in trips by EMS, ED cost and hospital cost. 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).

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails 126844305.2.2 (Project 2.13.1) Category 2 Milestones and Metrics			
126844305.2.2	**2.13.1**	**2.13.1.a – 2.13.1.e**	**Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.**
Bluebonnet Trails MHMR			**126844305**
Related Category 3 Outcome Measure(s):	**126844305.3.5**	**IT-9.2**	**ED Appropriate Utilization**

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)
Milestone 1 [P-1]: Conduct needs assessment of complex behavioral health populations who are high users of community public health resources. **Metric 1** [P-1.1]: Number of frequent ED users. **Baseline/Goal:** Preliminary information available from 3 month study, but Baseline/Goal: TBD **Data Source:** Program records, EHR, EMS calls and Hospital records **Milestone 1 Estimated Incentive Payment: $340,575** **Milestone 2** [P-3]: Enroll and serve individuals with targeted complex needs. **Metric 1** [P-3.1]: Number of	**Milestone 3** [P-4]: Evaluate and continuously improve intervention. **Metric 1** [P-4.1]: Number of monthly meetings, conference calls, or webinars organized by the RHP that the provider participated in. **Baseline/Goal:** Monthly participation by Performing Provider **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. **Milestone 3 Estimated Incentive Payment: $1,110,600**	**Milestone 4** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patient in target population served by this emergency diversion service. **Baseline/Goal:** Baseline - 0 since no such service currently exists in the RHP; Goal - Serve 45 people in DY4 who are high utilizers of ED and EMS services. **Data Source:** EHR, EMS and ED records. **Milestone 4 Estimated Incentive Payment: $1,110,600**	**Milestone 5** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patient in target population served by this emergency diversion service. **Baseline/Goal:** Baseline - 0 since no such service currently exists in the RHP; Goal – Serve 60 people in DY5 who are high utilizers of ED and EMS services. **Data Source:** EHR, EMS and ED records. **Milestone 5 Estimated Incentive Payment: $987,200**

targeted individuals enrolled / served in the project. **Baseline/Goal:** Baseline **–** 0; Goal - TBD **Data Source:** Program records, EHR, EMS calls and Hospital records **Milestone 2 Estimated Incentive Payment: $340,575**			
Year 2 Milestone Bundle Amount: $681,150	**Year 3 Estimated Milestone Bundle Amount: $1,110,600**	**Year 4 Estimated Milestone Bundle Amount: $1,110,600**	**Year 5 Estimated Milestone Bundle Amount: $987,200**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $3,889,550			

Category 2 Project Narrative – Pass 2
Bluebonnet Trails Community Services – 126844305.2.3

Project Area, Option and Title: 2.13.1 – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population**.**
RHP Project Identification Number: 126844305.2.3

Performing Provider Name: 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 Authority (LA) for persons with Intellectual and Developmental Disabilities (IDD) for Burnet and Williamson Counties in RHP 8. The two Counties comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. The LA designation includes the requirement to serve as the Safety Net for individuals with IDD in the region.
- **Intervention:** BTCS proposes to provide intensive wrap around services called Assertive Community Treatment (ACT) for individuals with IDD at the point of crisis and during life transitions to prevent them from being placed in institutions or inappropriately using EDs and crisis services. These services include crisis response, assessment, behavior plans and management. We will also rain and educate health care providers on serving those with IDD.
- **Project Status:** This is a new service and an innovative application of ACT teams.
- **Project Need:** This project addresses RHP 8 Community Needs Assessment needs: CN.2 – Limited Access to Mental Health/Behavioral Health Services; and CN.2.14 - Limited access to behavioral health services and disparities in access to care and health outcomes for adults and youth who are intellectually and developmentally disabled in Williamson County.
- **Target Population:** The target population is individuals with IDD who are taken to EDs in our region or in jeopardy of losing community living placements due to behaviors that are challenging or dangerous. We anticipate serving about 50 persons annually once the program is matured. BTCS served 882 persons with IDD in these counties in FY 2012 and 50% were Medicaid eligible. We expect at least 50% of those benefitting from these services to be Medicaid beneficiaries.
- **Category 1 or 2 Expected Project Benefit for Patients:** We expect to serve 30 people in DY4 and 50 people in DY5. The behavior plan and team services will help individuals to improve regain their functioning level and return to community living. Services will continue until the individual is stable and comfortable in their setting.
- **Category 3 Outcomes:** IT-9.2: Our goal is to achieve ED appropriate utilization and thereby improve the lives of those with IDD who can retain their community living setting and the community health by eliminating unnecessary ED use and opening access to those who truly need the ED. Our goal in DY4 is to divert 10 people prior to a contact with the

ED, which will be 33% of the total served; and in DY5 to divert 20 people prior to a contact with the ED, which will be 40% of the total served.

- **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

Project Description:

Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Developmental Disabilities (IDD)

BTCS is the state designated LA for Burnet and Williamson Counties in RHP 8. That designation includes the requirement to serve as the Safety Net for individuals with Intellectual and Developmental Disabilities (IDD) in the region (TAC Title 40, Part I, Chapter 2, Subchapter G, Rule 2.303). In that capacity we are responsible for assessing the service and support needs of individuals with IDD, coordinating service planning for them and assembling a network of providers to meet those needs. In our role as LA, BTCS has identified that individuals who experience behavioral issues in foster care, group homes and Intermediate Care Facilities/Intellectual Disabilities-Related Condition (ICF/ID-RC) settings are frequently brought to Emergency Departments (EDs) in Williamson and Burnet Counties for treatment and stabilization of what is identified by the provider as a mental illness. Persons with IDD are frequently misdiagnosed and responded to improperly when they are exhibiting behavioral issues. These behavioral issues are often preceded by times of stress such as changes in care giver, changes in living situations, other life changes that might be customary but still result in a need for crisis response. Sometimes the behavior issues are a result of co-occurring mental illness. Research indicates that as many as 33% of individuals with IDD have a co-existing mental illness (*Social Work Today*, Vol. 10 No. 5; Quintero & Flick, 2010; http://www.socialworktoday.com/archive/092310p6.shtml).

BTCS has developed specialized interventions for persons diagnosed with Autism Spectrum Disorders and currently provides ACT Team services for persons who need intensive mental health services. We plan to build on these areas of expertise. BTCS proposes to provide ACT Team services for individuals with IDD at the point of crisis and during life transitions such as when individuals move from natural supports, discharge from State Supported Living Centers (SSLC) or ICF/ID-RC facilities. Through this project we will divert people with IDD from higher cost, institutional placement and into local resources. The project will also provide specialized consultation to attending physicians providing primary care and emergency medicine services, allowing them to provide proper care rather than expending resources trying to diagnose and treat outside of their area of expertise. Stakeholders in the region have provided the impetus for the project with their requests for assistance to avoid disruption of long-term residential placements. Families of individuals with IDD report an inability to address needs of their family members or to find a skilled provider to assist them to keep family members at home or be accepted into residential placement because of repeated visits to EDs and admissions to mental health facilities or jails.

ACT Teams are well documented best practice as intervention for persons with Serious Mental Illnesses (SMI) who have a difficult time maintaining community tenure. The intervention is included in the Substance Abuse and Mental Health Services Administration (SAMHSA), Evidence Based Practices registry and a Toolkit for implementation of ACT is available through

SAMHSA (http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345). We plan for the ACT Team for persons with IDD to be led by a Licensed Masters Level professional and will include a psychologist who is a behavioral expert and a psychiatric consultant, nursing, service coordinator and community skills trainers. We will locate the team in Round Rock to respond to requests for intervention from either County we serve. At the time of referral we expect to go where the individual is and provide assessment and intervention to stabilize the situation. Following that we will continue assessment that leads to the development and implementation of a behavioral plan to help the individual return to his/her current living situation and to successfully maintain that setting. Wrap around services will continue until transition to other community resources can be achieved and the person is comfortable and stable with the new resource provider. Team intervention is envisioned to be short-term and intensive with the goal of helping persons retain community placement, with referral to long term provider resources where appropriate. In addition to direct client intervention, we propose to use the resources of the team to begin educating law enforcement and emergency rooms as well as IDD group home providers to create referral paths that are well known and easy to use. For DYs 2 and 3 we selected Process Milestones, P-2, designing the intervention; P-3, enroll and serve persons in the targeted population with complex needs; and P-7, participation with other providers and the RHP to promote collaborative learning. We will document the activities associated with design in implementation plans and the adjustment of that design in the CQI notes, minutes and real time data from electronic health record (EHR) as relates to assessment of functioning, treatment participation and patient goal achievement. We will document enrollment and service in the EHR. We selected these Milestones because we are starting a new program, reflecting an innovative use of the well-known ACT team concept. This approach, as we have proposed it, has not been implemented in this RHP or anywhere else. We must ensure that the right population is targeted with the right interventions and that the program is continuously adjusted as we learn how to help people succeed. We selected the I-5 Milestone: Functional Status, for both DYs 4 and 5. We have identified preliminary research indicating that the BPI-01 and/or ICAP could be useful as a functional assessment for this project (*Research in Developmental Disabilities* 2010 Jan-Feb 31(1) 97-107 http://www.ncbi.nlm.nih.gov/pubmed/19800760#). We selected this Milestone because it is important to us that persons with IDD remain in their long-term placements. Achieving the goal of improved functioning will preserve placements and reduce ED utilization.

Goals and Relationship to Regional Goals:
This project proposes to use multi-disciplinary ACT Teams to intervene during the utilization of emergency services and reduce further ED use by persons with IDD.

Project Goals:

- Develop an ACT Team model specializing in the assessment and stabilization of persons with IDD and utilizing existing resources in the community where appropriate;
- Provide training to law enforcement, emergency room personnel, health care providers, psychiatric hospital providers, and community residential and non-residential providers regarding the project and how to access the services;
- Implement the project to target group as requests for services are received; and

- Gather data for outcome measures reflecting services utilized and effectiveness of these services to ameliorate crisis and preserve undisrupted community living for persons with IDD.

This Project meets the following Regional Goals:

- Increasing coordination of prevention and care for residents, including those with chronic illnesses and/or behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:

The biggest challenge is that there is a pervasive misunderstanding in the health care community and in broader community concerning the differences in diagnosis and treatment between behavioral issues for persons with IDD and mental health crises for persons with SMI. Another challenge will be acceptance by caregivers that the intervention will work and that services will be wrapped around the individual until the crisis is resolved. This project will address the first challenge through education by engaging emergency medical professionals, IDD consumers and advocates throughout the RHP 8 to assist us in developing a protocol to implement ACT Teams for persons with IDD. We will then widely disseminate that protocol through a communication plan that utilizes resources of community partners. This same education and communication approach will be used with caregivers in order to address the second challenge.

5-Year Expected Outcome for Provider and Patients:

Over the next five years we expect the outcome of this project to include providing training to law enforcement, ED personnel, health care providers, psychiatric hospital providers, and community residential and non-residential providers regarding how to recognize behavioral issues in persons with IDD and how to access appropriate services. The outcome for program participants will be avoidance of unnecessary inappropriate ED utilization and the resulting loss of community living arrangements and overuse of institutional care. When persons with IDD receive the proper care and interventions, then admissions to institutional care and multiple visits to EDs are avoided.

Starting Point/Baseline:

Currently no ACT Team Services for persons with IDD exists in the four Counties; therefore, the baseline is 0 in DY2. We will enroll and serve individuals in DY3; therefore, the baseline will be established during DY3.

Rationale:

Community need addressed:

- Community Need Area: CN.2 – Limited Access to Mental Health/Behavioral Health Services
- Specific Community Need: CN.2.14 – Limited access to behavioral health services and disparities in access to care and health outcomes for adults and youth who are intellectually and developmentally disabled in Williamson County.

There is no ACT team for persons with IDD currently in place in RHP 8 but there is evidence that a specialized intervention is needed for these individuals when they are taken to EDs. An ACT Team that includes specialists in IDD who can assess needs and apply behavioral plans or other IDD specific interventions will reduce time in the ED, misdiagnosis and placement in more restrictive settings. Currently available data does not accurately identify the number of persons with IDD who have been taken to EDs due to behavior problems. We can identify the number of persons in service through the LA who have been removed from placement and admitted or referred to a higher level of care. However, visits to EDs are coded as interventions for mental illness diagnoses regardless of the presence of IDD, frequently resulting in the misidentification of behavior problems as other mental illnesses. Our estimate of the number whose admission is a result of behavior problems is around 30% based on experience working with this group of persons.

BTCS participates in a pilot program through the Department of Aging and Disability Services (DADS) the aim of which is to reduce institutional placement using the team approach. There are an increased numbers of individuals that have been referred at intake that are in crisis due to the lack of appropriate resources to respond to the behavioral crisis. The persons that are at high risk display one or more of the following needs: danger or risk of losing their support system, especially those supports a person requires to continue living in their own or family home; at risk of being abused or neglected; basic health and safety needs are not being met through current supports including mental health needs; at risk for loss of the functional skills that keep them in their community; or repeated criminal behavior or dangerous behaviors or threats, but incarceration is not an option because of their low level of cognitive ability. An increase of referrals from SSLCs is expected for individuals transitioning to community living. They will need a crisis intervention plan developed to insure supports are in place prior to the move for successful community living. At this time 5 referrals from the SSLC have been made. The ACT Team will enhance this current pilot project and serve as a safety net for those individuals.

<u>Project Components:</u>

The ACT team services for persons with IDD will address all of the required core components:

a) *Assess size, characteristics and needs of target population.* Although the initial data cited above, gives a picture of the number of persons with IDD referred to EDs, all EDs are not included and the cause of referral does not differentiate for behavioral issues. We will define the data needs and then gather information from electronic health records and case management reports to further refine the characteristics and needs.

b) *Review literature / experience with populations similar to target population to determine community-based interventions that are.* The staff for the LA has done some literature review to identify basic design of this project and the application of ACT to persons with IDD. As described above, we need to engage stakeholders to develop specific protocols for the intervention. We will use that coalition to promote community understanding and response.

c) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* We will use BTCS quality management staff to facilitate the formation of learning collaboratives with the other community centers in RHP 8, all of which provide services and supports to persons with IDD. We will meet and disseminate information

among the group to ensure qualitative and quantitative metrics will be used to measure outcomes.

d) *Design models which include an appropriate range of community-based services and residential supports.* Using the information from stakeholders, community centers, evaluation metrics, functional assessments and reports; we will evaluate interventions to determine if they are sufficient in capacity and scope. We will adjust our model accordingly.

e) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* As indicated below, preliminary research leads us to consider using Behavior Problems Inventory -01(BPI-01) or the Inventory of Client and Agency Planning (ICAP) as a functional assessment. Our staff is familiar with both and we expect one of these will give us the best measure of individual improvement. However we will perform additional research prior to implementation of the tools. Aggregated data from the assessment selected along with number of ED visits will be used to assess community impact and identify and respond to lessons learned.

Continuous Quality Improvement: The 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: As above, BTCS currently participates in a team based pilot to reduce institutional care through the DADS. This project supports and enhances that system reform initiative that supports the Promoting Independence goals of DADS. BTCS is also a recipient of a grant through the Health Resources and Services Administration Division of the US Department of Health and Human Services (DHHS) to develop a primary care/behavioral health care another RHP in partnership with the Federally Qualified Health Center for Guadalupe County. BTCS also receives funds from DHHS to operate substance abuse Outreach Screening and Referral services in Williamson and several other counties, and Mental Health block grant funds for outpatient mental health services. Those DHHS funds will not be used for direct services in this project; however, this project enhances and extends those services that will be needed as the ACT Team assists in transitioning individuals back to their long-term living environment and community living.

Related Category 3 Outcome Measure:

- OD- 9 Right Care, Right Setting
  - IT-9.2 ED appropriate utilization

Reasons/rationale for selecting the outcome measure: We selected this measure because the goals stated above are to establish an ACT Team that can respond and intervene to improve functioning during a crisis event. Wrap around services, quick intervention and continuing community education should achieve the outcome of appropriate ED utilization.

Relationship to Other Projects:
This project to intervene and stabilize persons with IDD in Crisis enhances additional projects that BTCS is pursuing in that they relate to additional crisis services and supportive aftercare such as Transitional Housing. Related Projects include:

- The Transitional Housing initiative (#126844305.2.1) will solidify success in remaining in the community and offer expertise, support and experience through a Peer Support Specialist;
- The Crisis Stabilization project (#126844305.1.2) for persons in behavioral health crisis will provide a safety net for those individuals who may be in need for more intensive care without requiring the restrictive level of care provided by a psychiatric hospital; and
- Crisis Assessment for Persons in Behavioral Health Crisis (Burnet County) (#126844305.1.5) to support and enhance the ACT for persons with IDD responses in this County.

We expect these interrelated projects will demonstrate improved outcomes due to availability of outpatient and aftercare services in the communities in which people live. The plans and supports employed by ACT Teams depend on community resources. The projects noted above improve the community network of resources for people.

Relationship to Other Performing Provider Projects and Plan for Learning Collaborative:
While this project shares a number of things in common with other LMHA's, the project Central Counties is planning regarding a Coffeehouse for High Functioning IDD (#081771001.1.3) addresses the same audience.

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care.

Project Valuation:
We expect to serve 30 people in DY4 and 50 people in DY5. The behavior plan and team services will help individuals to improve regain their functioning level and return to community living. This reduces inappropriate use of inpatient hospital and is of substantial benefit to the patient who can remain in a community living setting. 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).

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails 126844305.2.3 (Project 2.13.1 - Pass 2) Category 2 Milestones and Metrics			
126844305.2.3	**2.13.1**	**2.13.1.a – 2.13.1.e**	**Design, Implement, and Evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.**
Bluebonnet Trails MHMR			**126844305**
Related Category 3 Outcome Measure (s):	**126844305.3.8**	**IT-9.2**	**ED Appropriate Utilization**

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)
Milestone 1 [P-2]: Design community-based specialized interventions for persons with IDD in crisis **Metric 1** [P-2.1]: Project plans which are based on evidence / experience and which address the project goals **Baseline/Goal:** Produce a project plan that reflects research and evidence and experience **Data Source:** Program Documents **Milestone 1 Estimated Incentive Payment: $129,675** **Milestone 2** [P-3]: Enroll and serve individuals with targeted complex needs **Metric 1** [P-3.1]: Number of	**Milestone 3** [P-3]: Enroll and serve individuals with targeted complex needs **Metric 1** [P-3.1]: Number of targeted individuals enrolled / served in the project. **Baseline/Goal:** Enroll 6 persons in DY3 **Data Source:** Project documentation and EHR **Milestone 3 Estimated Incentive Payment: $122,850** **Milestone 4** [P-7]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects	**Milestone 5** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patient in target population served by this emergency diversion service. **Baseline/Goal:** Baseline - 0 since no such service currently exists in the RHP; Goal - Serve 30 people in DY4. **Data Source:** EHR, EMS and ED records. **Milestone 5 Estimated Incentive Payment: $270,270**	**Milestone 6** [I-X]: Number of patient interventions. **Metric 1** [I-X.1]: Number of patient in target population served by this emergency diversion service. **Baseline/Goal:** Baseline - 0 since no such service currently exists in the RHP; Goal - Serve 50 people in DY5. **Data Source:** EHR, EMS and ED records. **Milestone 6 Estimated Incentive Payment: $264,264**

targeted individuals enrolled / served in the project. **Baseline/Goal:** Enroll 3 persons. **Data Source:** EHR **Milestone 2 Estimated Incentive Payment: $129,675**	**Metric 1** [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Participate in all scheduled meetings and develop improvement initiatives. **Data Source**: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Metric 2** [P-7.2]: Implement the "raise the floor" improvement initiatives established at the scheduled meetings. **Baseline/Goal:** Commit to the improvement and implement it. **Data Source**: Documentation of "raise the floor" improvement initiatives. **Milestone 4 Estimated Incentive Payment: $122,850**		
Year 2 Milestone Bundle Amount: $259,350	**Year 3 Estimated Milestone Bundle Amount: $245,700**	**Year 4 Estimated Milestone Bundle Amount: $270,270**	**Year 5 Estimated Milestone Bundle Amount: $264,264**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,039,584			

Category 2 Project Narrative – Pass 2
Bluebonnet Trails Community Services – 126844305.2.4

Project Area, Option and Title: 2.13.1 – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
RHP Project Identification Number: 126844305.2.4

Performing Provider Name: 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 Local Mental Health Authority (LMHA) for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. They comprise 25% of the land mass but 54% of the population. Williamson County has nearly 50% of the population at 422,679. BTCS is the only public behavioral health provider in these Counties.
- **Intervention:** BTCS proposes to expand the clinical capacity and eligibility criteria for youth and adults arrested or incarcerated in these two Counties. We will provide screening, assessment and diversion recommendations prior to long-term incarceration. We will ensure linkage to community behavioral health care.
- **Project Status:** This expands current services in Burnet and Williamson. We will add staff and open eligibility beyond current limitations.
- **Project Need:** This addresses RHP 8 Community Needs: CN.2.1 - Limited access to behavioral health services to rural, poor and under & un-uninsured populations (meds, case management, counseling, diagnoses) in Williamson County; CN.2.13 – Limited access to adult behavioral health services in Williamson County; and CN.2.15 – Limited access to behavioral health services for adults and youth in Williamson and Burnet Counties who are involved in the adult and youth justice system.
- **Target Population:** The target population includes those in contact with law enforcement, arrested or in the process of booking and those on probation, parole or otherwise released from detention in these Counties who are also diagnosed with behavioral health disorders. Jail match records indicate 17% of those jailed in Burnet County and 15% of those in Williamson County in 2012 had prior treatment in the state mental health system. BTCS served 7,769 with behavioral health disorders in FY 2012. An average of 43% of adults were Medicaid-eligible; 76% of youth were eligible for CHIP or Medicaid and 73% of clients are below the federal poverty level. Approximately 70% of those benefitting from this project will be poor, under or uninsured. We expect to serve 75 a year.
- **Category 1 or 2 Expected Project Benefit for Patients:** We expect to serve an additional 50 people in DY4 and 75 in DY5 achieving our Improvement Milestone I-X for Target Population Reached. Behavioral health treatment stabilizes thinking mood and behavior and thereby improves functioning of these individuals. We will measure that improvement by administration of standardized instruments, ANSA for adults and CANS

for youth on admission and at intervals during treatment. We expect 30% receiving specialized interventions will demonstrate improved functional status in DY4 and 40% in DY5 (Improvement Milestone I-5.1).

- **Category 3 Outcomes:** IT- 9.1: Our goal is to decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. Treatment improves the lives of those who are diverted from incarceration and provided behavioral health treatment and, provided treatment upon release from detention and allows the opportunity to participate fully in community life.
- **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

Project Description:

Services to Justice-Involved Youth and Adults – Burnet and Williamson Counties

BTCS is the LMHA for Burnet and Williamson Counties in RHP 8 and for six adjacent Counties in three other RHPs. The LMHA has responsibility to identify gaps in service or barriers to access for persons with behavioral health issues residing in the area. We also provide direct treatment services under contracts with a variety of payers, including the Department of State Health Services (DSHS) and the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) to provide specialty behavioral health services to the "priority population." BTCS proposes to enhance its current services in Burnet and Williamson Counties for justice-involved youth and adults by expanding the clinical capacity of those programs, expanding the eligibility criteria to include a broader range of mental illnesses including substance use disorders and to serve those who are charged, adjudicated and proposed for release within the County justice systems. The goal of the program is to provide screening, assessment and diversion recommendations prior to long-term incarceration. To carry out this project, we will hire and train licensed professional staff and additional case management support staff. The services will be located in our current offices in Burnet and Williamson Counties. These staff will work along with, enhancing and expanding treatment services provided to current TCOOMMI patients and to a new broader range of eligible program participants.

The 'priority population' includes children and adolescents with Serious Emotional Disturbance (SED) and adults, who are primarily diagnosed with Serious Mental Illnesses (SMI), (Federal Definition for SED and SMI can be found at: http://www.healthcare.uiowa.edu/icmh/documents/FederalDefinitionsofSMIandSED.doc.) These groups of patients need services and are in serious jeopardy when placed in prison and juvenile probation facilities; however, there are a large number of individuals who also need services and could benefit from treatment and potentially be diverted from incarceration. BTCS operates a service funded by TCOOMMI in Williamson County that serves this specialty population and provided care in FY 2012 to 38 adolescents. The *Texas Criminal Justice Coalition - Williamson County Juvenile Justice Data Sheet* reveals that of the 869 youth between the ages of 10 and 17 who were referred to Texas Juvenile Justice Department, 39% or 335 of them were diagnosed with mental illness http://tcjc.redglue.com/sites/default/files/youth_county_data_sheets/Williamson%20County%20Data%20Sheet%20(Sep%202012).pdf. The conclusion is that "Reducing the number of youth adjudicated to residential facilities can only be achieved if stakeholders strongly invest in 'a

consistent, county-based continuum of effective interventions, supports, and services.'" There is no youth program in Burnet County, which reports that 95% of the children in court Appointed Special Advocates program needed mental health services. They also report that only 10% of the youth in Juvenile Probation received needed mental health services (*FY 2011-2013 Burnet, Blanco and Llano Counties Community Plan for Coordination of Criminal Justice and Related Activities*, February 2011). Regarding adults, DSHS data regarding those arrested who have been treated in the state mental health system shows that for the four month period during the beginning of 2011, 383 individuals jailed in Burnet and Williamson Counties had been treated prior to incarceration. That represents 17% of those jailed in Burnet County and 15% of those in Williamson County.

There are 2 aspects to improving services for justice-involved youth and adults, first is the assessment, treatment planning and referral combined with linkage through the court of probation and parole system. The second is the treatment services required to meet the needs identified by the assessment and treatment planning. This project addresses the later by adding professional licensed staff to the current program and by increasing the case management staff, I.e., linkage and court liaison staff. The treatment availability issue is addressed through several other DSRIP projects BTCS has proposed. The project staff will provide a critical assessment, evaluation and linkage function to those new programs and services. BTCS has made excellent progress over the last several years in obtaining permission and installing telemedicine connections and equipment at County jails which will allow for screening and diversion prior to incarceration. When clinically appropriate and depending on the nature of the charges, recommendations may be made for community based service based on the condition that the appropriate judicial authority drops criminal charges. This recommendation will give judges alternatives to incarceration. If the judge agrees to release the person, BTCS case manager will arrange transportation, temporary housing and necessary services. Services and client functioning improvement are documented in court orders and in Anasazi^{tm}, the EHR for BTCS.

Goals and Relationship to Regional Goals:
The vision or overarching goal for RHP8 is to "… transform the local and regional health care delivery systems to improve access to care, efficiency, and effectiveness." Reducing inappropriate use of justice systems by adults with SMI and youth with SED will not only improve the lives of those individuals, but improve overall health and well-being in the Region. Making resources available to provide effective and efficient health care in lieu of incarceration improves quality of life, community health outcomes and criminal justice outcomes. The goals for the program are to provide early intervention and treatment to individuals in custody but **not yet incarcerated** for the long-term in county jails or in prisons and to reduce multiple arrests by providing behavioral health treatment that stabilizes behavior, improves functioning and reduces social deficits. This intervention will reduce potential psychiatric hospitalizations as well. We expect to be able to reduce the percentage of those who are incarcerated and have an exact behavioral health system match by 25% over the five years of the project.

<u>Project Goals:</u>

- Expand the scope of the services for justice-involved adults and youth by adding licensed staff;

- Expand the range of eligible participants in the services for justice-involved youth and adult; and
- Implement the project in collaboration with juvenile and adult Court systems and other components of the justice system.

This Project meets the following Regional Goals:
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:
A major challenge will be working with the Courts and other components of the criminal justice systems to identify opportunities for early intervention and diversion. Even though someone might be eligible for diversion to treatment, the judicial system must act on that recommendation by dropping charges or taking other legal steps. Judges, prosecutors and defense attorneys must feel confident that treatment will be provided and that it has a reasonable chance of success. This challenge will be addressed by providing ongoing training and continuing education for jail staff and law enforcement. Communication between BTCS and jail staff, local law enforcement, prosecutors and judges is currently part of the justice-involved intervention program, but is limited to the specialty interventions and special populations or long-range planning. BTCS will strengthen an ongoing dialogue with judges, prosecutors, attorneys, adult and juvenile probation by focusing on new services and access for new populations. We will engage in joint implementation planning, joint treatment planning and presentation of outcome data available so they can achieve confidence and fully utilize the services.

5-Year Expected Outcome for Provider and Patients:
The expected outcome over five years is that fewer adults with adults and youth with behavioral health diagnoses and who commit minor crimes stemming from the deteriorated mental state will need to be incarcerated and instead can receive needed services in a community setting where they have a greater opportunity to lead a stable life. Early intervention and diversion will reduce the number initially incarcerated and ongoing services will reduce recidivism. As a result, we expect to reduce the number of matches in the behavioral health data system to 25% of the level as determined in data extracted for DY2, during the discovery and assessment period of the project for adult jail matches and assessed youth in the juvenile probation system.

Starting Point/Baseline:
Currently some services for the priority population who are also justice-involved are provided in Williamson County and some jail diversion screening, assessment and referral services are provided in Burnet County. However, the eligibility criteria have not been expanded, nor have clinical services and oversight been added to the program. Therefore, the baseline census for the new project is 0 in DY2. Additionally, we have not begun the uniform administration of functional assessments and do not have a baseline for changes in functioning as a result of the programs. We will use the remainder of DY2 to initiate needed processes. We will enroll and

serve individuals in DY3 therefore, the baseline for census and the baseline for Functional Improvement will be established during DY3 as those assessments are completed.

Rationale:

Community Need Addressed:

- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Needs:
  - CN.2.1 – Limited access to behavioral health services to rural, poor and under & un-uninsured populations (meds, case management, counseling, diagnoses) in Williamson County.
  - CN.2.13 – Limited access to adult behavioral health services in Williamson County.
  - CN.2.15 – Limited access to behavioral health services for adults and youth in Williamson and Burnet Counties who are involved in the adult and youth justice system.

Texas has historically utilized the criminal justice system as the default provider of mental health services for adults. As a consequence, many individuals with serious and persistent mental illness spend months and years incarcerated for misdemeanors. Texas spends even less on services for youth in need of behavioral health services and in recent years juvenile probation departments have had to increase mental health services to meet the growing demand. According to the Williamson County Juvenile Services 2011 Annual Report, they conducted 1202 follow up assessment for mental health issues based on initial screenings and "…(t)he department conducted a total of 368 psychiatric appointments for youth in the Academy, Juvenile Justice Alternative Education Program (JJAEP), TRIAD, Detention, and Field Probation;" (page 45). These statistics and the jail match data presented above indicate the consequences of limited access to behavioral health services in Williamson and Burnet Counties. A second consequence is that in the absence of referral and follow-up treatment, individuals are released in the same condition or more deteriorated condition than the one that probably lead to their incarceration. The next time they are detained they are once more mentally ill and/or substance abusing and in jail. An approach based on early identification and treatment will provide more opportunity for successful assimilation into a community setting with ongoing community supports. We selected the process milestones P-1 for DY2 because we need to understand the new population and the demand of that population and we selected P-3 because there is clearly a great need to enroll individuals and initiate services. We will conduct a Plan, Do, Study, Act (PDSA) cycle as indicated by process milestone for DY3 and utilize the information concerning enrollment and demand and as we begin to track increase in service volume to this special population. Improvement milestone selected for DY4 and 5 is to measure improvement in functioning. We will measure and report reduction in criminal justice involvement for Category 3. We selected improvement in functioning because we are certain that outcome improves community tenure, reduces recidivism and will lead to a reduction in criminal justice involvement.

Core Project Components:

This project to provide Services to Justice-Involved Youth and Adults – Burnet and Williamson Counties will address all of the required core project components:

a) *Assess size, characteristics and needs of target populations (e.g., people with forensic involvement).* There is a current program and this project expands that to a broader group of eligible participants. We have experience and anecdotal information about them but more precise assessment is needed concerning the size, characteristics and needs.

b) *Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* We have familiarity with the literature concerning this program and interventions. We are adding clinical services and oversight and will conduct additional reviews. This is also an opportunity to engage community stakeholders in the justice systems to participate in the review, planning and design of the project.

c) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* We will use BTCS and hospital business intelligence and quality management staff to facilitate the development and documentation of our evaluation plan. Oversight will be provided by the community stakeholders who will ensure qualitative and quantitative metrics will be used to measure outcomes relevant to the justice systems.

d) *Design models which include an appropriate range of community-based services and residential supports.* Using the information from stakeholders, evaluation metrics, patient assessments and reports; we will evaluate available interventions to determine if they are sufficient in capacity and scope. We will adjust our model accordingly.

e) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* The impact of interventions will be assessed on an individual patient level by using the ANSA for adults, the CANS for youth and the SF 36. Aggregated data from those assessments along with number of juvenile referrals or adult incarcerations will be used to assess community impact and identify and respond to lessons learned.

Continuous Quality Improvement: The 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: BTCS receives funds from U.S. Department of Health and Human Services (DHHS) including Substance Abuse Prevention and Treatment Block Grant used to operate substance abuse Outreach Screening and Referral services in Williamson, Burnet and several other counties; and Community Mental Health services block grant used for outpatient mental health services. These DHHS funds will not be used for direct services in this project; however, participants could be referred and treated in those other programs ongoing or upon discharge. This project enhances and extends those services that will be needed as these individuals are diverted from incarceration and provided behavioral health care in the community.

Related Category 3 Outcome Measure:

- 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 measure: It is our goal to provide community care at the right time and in the right setting and reduce inappropriate arrest and incarceration for adults and youth. We believe that achieving the project goal and providing early intervention and treatment leads directly to the outcome of right care, right setting. Allowing people to languish in jail due to mental illness or substance abuse is wrong and counterproductive for them and for our society.

Relationship to Other Projects:
This enhances or supports additional projects below that BTCS has proposed by improving access to community based aftercare and outpatient services.

- The Transitional Housing initiative (#126844305.2.1) will solidify success in remaining in the community and offer expertise, support and experience through a Peer Support Specialist;
- The Crisis Stabilization plan (#126844305.1.2) for persons in behavioral health crisis will provide a safety net for those individuals who may be in need for more intensive care without requiring the restrictive level of care provided by a psychiatric hospital;
- Crisis Assessment for Persons in Behavioral Health Crisis (Burnet County) (#126844305.1.4) to support and enhance the ACT for persons with IDD responses in this County; and
- Outpatient Substance Addiction Services for Adult and Youth - Burnet and Williamson Counties (#126844305.1.5) for persons needing routine outpatient counseling and intensive outpatient services.

Relationship to Other Performing Provider Projects and Plan for Learning Collaborative:
While this project shares a number of things in common with other LMHA's, the project Central Counties is planning regarding Temple Day Services is most similar (#081771001.2.3).

BTCS will participate in all learning collaboratives organized or sponsored by Texas A&M Health Science Center that are relevant to our projects. We believe it is important to improving and adjusting the care provided. We will also participate with other community centers and behavioral health care providers as we continue to do through the Texas Council of Community Centers. This exchange of ideas is important and helps us adjust and refine our programs and approaches to behavioral health care.

Project Valuation:
We expect to serve an additional 50 people in DY4 and 75 in DY5. 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).

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails 126844305.2.4 (Project 2.13.1 – Pass 2) Category 2 Milestones and Metrics				
126844305.2.4	**2.13.1**	**2.13.1.a – 2.13.1.e**	**Design, Implement, and Evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.**	
Bluebonnet Trails MHMR				**126844305**
Related Category 3 Outcome Measure (s):	**126844305.3.9**	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons**	
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)**	
Milestone 1 [P-1]: Conduct needs assessment to identify expanded population of youth and adults who are frequently admitted to criminal justice settings **Metric 1** [P-1.1]: Provide report identifying the following: - Targeted population characteristics - Gaps in services - How program will identify, prioritize and manage target population - Ideal number of patients to enroll - Estimate of resource adequacy related to services and locations. **Baseline/Goal:** Produce a comprehensive report documenting all points above. **Data Source:** Project documentation; stakeholder surveys, criminal justice	**Milestone 3** [P-4]: Evaluate and continuously improve interventions **Metric 1** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles. **Baseline/Goal:** Meet Monthly to review data and conduct improvement assessments and set goals. **Data Source:** Project reports (including data sets,) Agendas, Minutes, sign-in logs **Milestone 3 Estimated Incentive Payment: $189,450**	**Milestone 4** [I-5]: Functional Status **Metric 1** [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments, ANSA for adults and CANS for youth. **Baseline/Goal:** Baseline- the number served in DY 4, 50 people; Goal - 30% of those served show improvement in functioning. **Data Source:** Assessment forms and aggregated report of assessment results; and EHR. **Milestone 4 Estimated Incentive Payment: $112,725** **Milestone 5** [I-X]: Number of patients served	**Milestone 6** [I-5]: Functional Status **Metric 1** [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments, ANSA for adults and CANS for youth. **Baseline/Goal:** Baseline - the number served in DY 5, 75 people; Goal - 40% of those served show improvement in functioning. **Data Source:** Assessment forms and aggregated report of assessment results; and EHR. **Milestone 6 Estimated Incentive Payment: $148,200** **Milestone 7** [I-X]: Number of patients served	

assessments and records. **Milestone 1 Estimated Incentive Payment: $97,494** **Milestone 2** [P-3]: Enroll and serve individuals with targeted complex needs, forensic involvement. **Metric 1** [P-3.1]: Number of targeted individuals enrolled / served in the project. **Baseline/Goal:** Baseline – 0; Goal - is 25 enrolled and served in DY2. **Data Source:** Project documentation; criminal justice records and EHR. **Milestone 2 Estimated Incentive Payment: $97,494**		**Metric 1** [I-X.1]: Target population reached; number of patients served who have been involved with law enforcement and the judicial system who also has a behavioral health issue. **Baseline/Goal:** Baseline for this new community based program is 0 for DY2; Goal - Expect to serve 50 in DY4 **Data Source: EHR** **Milestone 5 Estimated Incentive Payment: $112,725**	**Metric 1** [I-X.1]: Target population reached; number of patients served who have been involved with law enforcement and the judicial system who also has a behavioral health issue. **Baseline/Goal:** Baseline for this new community based program is 0 for DY2; Goal - Expect to serve 75 in DY5 **Data Source: EHR** **Milestone 7 Estimated Incentive Payment: $148,200**
Year 2 Milestone Bundle Amount: $194,988	**Year 3 Estimated Milestone Bundle Amount: $189,450**	**Year 4 Estimated Milestone Bundle Amount: $225,450**	**Year 5 Estimated Milestone Bundle Amount: $296,400**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $906,288			

Category 2 Project Narrative
Central Counties Services – 081771001.2.1

Project Area, Option and Title: 2.2.2 Apply evidenced-based care management model to patients identified as having high-risk care needs
RHP Project Identification Number: 081771001.2.1

Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012 we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations (MUP).
- **Intervention:** This project provides education, training and support by a registered nurse for persons with severe and persistent mental illness (SPMI) having chronic health conditions (hypertension, diabetes, weight gain, etc.) due to prolonged psychiatric medicine use. This project builds the patient's ability/desire to improve their self-managing of chronic health condition(s), instead of stopping psychotropic medicine that helps their psychiatric symptoms. This project has both personal training sessions and support groups for patients trying to self-manage the same type of chronic health condition.
- **Project Status:** This project is a new service.
- **Project Need:** CN.3.1: Limited coordinated care exists in Bell County for disparity groups with co-occurring behavioral health needs and chronic physical conditions due to prolonged psychiatric medicine use. Studies show people with SPMI die 25 years earlier, on average, than non-mentally ill peers. Factors that lead to the early death of people with SPMI include negative effects caused by medication needed to treat their mental illness (*Morbidity and Mortality in People with Serious Mental Illness.* http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm).
- **Target Population:** The prevalence of chronic conditions among our patients is not known at this time, but it is estimated to be around 10% of the patients served at our Killeen, Texas and Temple, Texas clinics, which would be about 140 patients. Actual number to be served is TBD in DY3. 97% of all of the Center's patients are Medicaid (41.89%), uninsured or indigent. We anticipate the same percentages of Medicaid, uninsured and indigent patients will benefit from this project
- **Category 1 or 2 Expected Project Benefit for Patients:** Increase number SPMI patients with chronic condition management plans to 75 patients in DY4 and 100 patients in DY5

(Improvement Milestone I-18.1). We are expecting to provide these services for 100 patients in DY3, 150 patients in DY4, and 200 patients in DY5 under this project (See **"Rationale"** paragraph below regarding shortened life expectancy of persons with severe and persistent mental illness).

- **Category 3 Outcomes:** IT-11.1: 45% of patients using this service are expected to gain functional improvement in their chronic health conditions over their baseline assessments by DY5. Persons with severe and persistent mental illness who gain functional improvement of their chronic health conditions are more likely to stay on their antipsychotic medicine and to add a significant number of years to their life expectancy. If such improvement in chronic health conditions could add 5-10 years to each patient's life span, that would result in a **net gain of 500 - 1,000 person years for each of the 3 full years of this project.**
- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. There are several reasons why this project is truly a transformational project and they are: 1) this is the first project to bring physical medicine resources into our behavioral health service delivery system; 2) this is the Center's first focused effort to address our patient's physical health problems that are known to shorten the life expectancy of persons with SPMI; 3) providing assistance with managing the negative side effects of strong psychiatric medications needed by our patients is viewed as a strong means to reinforce medication compliance – a major problem with the people we serve; and, 4) this project strongly reinforces the recovery model of psychiatric services promoted by our Center by empowering our patients to take charge of, and master the control of their chronic health condition's symptoms.

Project Description:

Self-management of chronic conditions resulting from prolonged psychotropic/ antidepressant medication use by adults with severe and persistent mental illness

The Center has as its priority to serve adults with severe and persistent mental illness in their own community. Antipsychotic and antidepressant medications have made it possible for severely mentally ill persons to reside in their own community as opposed to being held in the asylums of decades gone by. Antipsychotic and antidepressant medications are very strong medications that have a profound effect of being able to reduce many of the negative symptoms of these severe and persistent mental illnesses (schizophrenia, major depression, manic/depressive, schizo-affective, etc. disorders). These powerful and effective medications frequently induce one or more physical side-effects in persons who must take these medications over a prolonged period of time. These side-effects can result in chronic health conditions. Examples of some of these chronic health conditions are: hypertension, diabetes, obesity, nervous ticks, excessive dry mouth, distorted sense of balance, etc. This project is being undertaken to help our patients with severe and persistent mental illnesses to

understand how these side effects occur, how to monitor the severity of these side-effects, and how to prevent the chronic health conditions caused/aggravated by these powerful medicines from getting progressively worse, and more quality-of-life impairing.

Each patient participating in this project will be offered:

a. An assessment of the severity of their chronic health condition(s),
b. An explanation of how our bodies normally regulate these biological functions which become out of balance (written information in layman's terms will be given),
c. What common self-help remedies are used to stabilize or reduce the level of these chronic health problems,
d. A mutually developed personal plan with attainable goals for improvement will be given to the patient, documented in the patient's electronic health record, and self-management progress updated in the electronic health record after each visit, and
e. Professional coaching/feedback on how their plan is going and how to improve the outcome of their plan.

Topics available to the patients will be:

a. Increased knowledge of importance of psychotropic or antidepressant medication compliance despite the potential side effects;
b. Increased knowledge of weight change side effects, strategies for weight loss, and information to manage these effects;
c. Increased knowledge of hypertensive side effects, consequences of long term hypertension (stroke, MI), how to manage the condition, use of blood pressure measuring devices will be demonstrated, and importance of regular evaluation by a healthcare provider;
d. Increased knowledge of diabetes side effects, importance of management of blood sugars to decrease long term effects of diabetes (cardiovascular, peripheral, eye, kidney), how to check and track blood sugars will be demonstrated, and the importance of regular evaluation by a healthcare provider; and
e. Increased knowledge about the negative health effects of excessive smoking and caffeine use.

The assessment of the patient's chronic health condition level and subsequent follow-up contacts when levels are re-checked would be recorded in the patient's electronic health record, along with each person's self-management plan to manage/improve his/her chronic health condition. Assistance will be given to our patients for their obtaining a blood pressure monitoring device, and/or glucose testing equipment and supplies. As patients become involved with these efforts to strengthen their ability to self-manage their chronic health conditions, we would envision starting focused support groups among our patients with similar chronic health conditions to encourage their mutually supporting each other in their endeavors to improve their health status (attendance rosters would be kept). It is our longer term goal that some of the patients who really learn how to manage their medication induced/aggravated chronic health conditions well might become peer facilitators for new patients who are just being referred to this service. We have seen this model work very well with our patients around their acknowledgement and management of their severe and persistent mental illness.

Goals and Relationship to Regional Goals:

Project Goal:

The goal of this service is to help adult behavioral health patients learn how to stabilize or reduce their chronic health condition(s) caused/aggravated by their prolonged use of psychotropic/antidepressant medications such that their chronic health conditions do not pre-morbidly shorten the patient's life expectancy or influence the patient to discontinue their psychotropic/antidepressant medications that have helped stabilize their severe and persistent mental illness symptoms.

This Project meets the following Regional Goals:

- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:

- The patient's ability to grasp the instructional information due to their mental illness (disorganized thought patterns).
- The patient's lack of support system or encouragement to maintain healthy changes.
- Client's inability to retain information for extended length of time due to their mental illness.

This project will take these challenges into account as the nurse uses repetition of information with our patients, and reviews written materials as many times as necessary for patients to grasp the information being taught/shared. Our interaction with the patients will be transformed from educator to coach as we strive to help our patients put into practice the information they have learned about the management of their chronic health condition. We anticipate that within the first year of this project we will form chronic health condition specific support groups to assist and support our patients with the life-style changes often needed to successfully stabilize/reduce the severity of their chronic health condition.

5 Year Expected Outcome:

The severely and persistently mentally ill adults served by the Temple, TX and Killeen, TX clinics who are experiencing chronic health conditions as a result of prolonged psychotropic/ antidepressant medication use will be offered the opportunity to learn about their chronic health condition(s) and ways to manage/reduce its health impact. It is expected that those patients who effectively engage in this project for 3 or more months will make significant progress at being able to stabilize their chronic health condition and begin to reduce the severity of their chronic health condition. Those participants who are actively engaged in this project for 6 months or more should see a significant reduction in their chronic condition. While adults with severe and persistent mental illness often struggle with their sense of personal worth, improvement of their ability to proactively manage their chronic health condition should give them more sense of control over their life and personal health, thus benefiting their sense of personal worth and well-being. We envision patient support groups being formed among our patients who have similar chronic health conditions to encourage their persistence in managing the lifestyle changes often needed for successful

management/reduction of these chronic health conditions. We also will work to groom the patients who achieve the most progress so that they can become peer mentors to new patients just entering the service.

Starting Point/Baseline:
This type of service has not been previously performed at the Center. Baseline ratings for the severity of medication induced/aggravated chronic health conditions are therefore not available for this project prior to DY2. As the Center patients are referred to this project, their chronic health condition severity will be evaluated and recorded as the patient's individual baseline measurement.

Rationale:
Community Need Addressed:

- Community Need: CN.3 Lack of coordinated care for those with multiple needs
- Specific Community Need: C.N. 3.1 Limited coordinated care exists in Bell County for disparity groups having co-occurring behavioral health needs and chronic physical conditions resulting from prolonged use of psychotropic medications

Persons with severe and persistent mental illness have shorter life expectancy due to many factors. Studies have shown that people with severe and persistent mental illness die 25 years earlier, on average, than their non-mentally ill peers as shown in *Morbidity and Mortality in People with Serious Mental Illness* (authors: Joe Parks, MD, Dale Svendsen, MD, Patricia Singer, MD, Mary Ellen Foti, MD, (http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm). Several factors that influence the pre-mature death of people with severe and persistent mental illness include negative effects caused by the medications needed to control their mental illness. Some psychotropic medications can cause weight gain, diabetes, and hypertension. Education on these conditions and ways to manage the effects in a proactive manner can decrease the long term negative effects of these conditions and increase life expectancy. This project will partner nursing staff from Health District and Center patients to increase patient education about these chronic side effects of psychotropic medications and increase their ability to self-manage these conditions successfully, thus increasing their potential longevity.

While mental disorders are common in the United States, their burden of illness is particularly concentrated among those who experience disability due to serious mental illness (SMI). The National Survey on Drug Use and Health (NSDUH), which defines SMI as:

- A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders)
- Diagnosable currently or within the past year
- Of sufficient duration to meet diagnostic criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)
- Resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities

The Substance Abuse and Mental Health Services Administration (SAMHSA) examines the mental health treatment each year through the National Survey on Drug Use and Health (NSDUH). In 2008, 13.4% of adults in the United States received treatment for a mental health

problem. This includes all adults who received care in inpatient or outpatient settings and/or used prescription medication for mental or emotional problems. SAMHSA's NSDUH also found in 2008 that just over half (58.7%) of adults in the United States with a serious mental illness (SMI) received treatment for a mental health problem. Treatment for SMI differed across age groups. The most common types of treatment were outpatient services and prescription medication.

SAMHSA's NSDUH further found in 2008 that 71% of adults who had major depression used mental health services and treatment to help with their disorder.

Education is essential to managing side effects encountered with any medication, and psychotropic medications are no exception. Behavioral or lifestyle changes are also important to improve chronic health conditions and the personal plan and goal setting involved with this project will help motivate and reinforce positive behavior change among our patients.

Continuous Quality Improvement: The Center 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project does not supplant any services or funds currently provided to the Center through the U.S. Department of Health and Human Services. The services proposed to be provided under this project serve to enhance, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

Related Category 3 Outcome Measure(s):

- OD-11 Addressing Health Disparities in Minority Populations
  - IT-11.1 Improvement in Clinical Indicator in an Identified Disparity Group

Adults with severe and persistent mental illness are a population group that is widely recognized as being underserved. All of the Center's clinics are designated by the Texas Dept. of State Health Services as caring for underserved populations. Bringing chronic health condition management into our two largest behavioral health clinics is motivated out of a desire to improve the quality of life status of the patients we serve. We also recognize that while the psychotropic medications we provide to improve their mental health symptoms can be very helpful to our patients experiencing an improved quality of life; these same medications can cause chronic medical conditions which then lowers the patient's quality of life. We therefore see that we have an ethical obligation to our patients to also help them with these potential chronic health side-effects.

We know that lifestyle changes, which are often needed to manage chronic health conditions, are best achieved when a person has a clear understanding of the goal to be accomplished by the lifestyle change. Therefore we chose an evaluation approach that emphasizes the joint

development of personal change goals to improve the patient's effective management/ reduction of his/her personal chronic health condition.

Relationship to Other Projects:
This project will attempt to empower clients to manage chronic conditions brought on by the long term use of psychotropic medications. If clients can successfully manage their condition, there will be fewer ED visits from preventable sequelae, and less long term complications of the chronic conditions. This project also relates to our desire to have improved patient involvement in their behavioral and personal health care, and the patient's sense of satisfaction that our Center is trying to relate to them as a whole person whose general quality of life is of great importance to our Center and its staff (Temple Day Services Project #081771001.2.3). This project is one of our Center's first attempts to bring more physical medicine into our behavioral health clinic environment. Our patients are fairly well motivated to come to our clinic for the care they receive, and if we can combine our behavioral health services with more general health services, we are expanding our patients' experience of having a medical home.

Other Center projects include:

- 081771001.1.1 Establish more primary care clinics
- 081771001.1.2 Implement technology-assisted behavioral health services by psychologists, psychiatrists, and other qualified providers
- 081771001.1.4 Develop and implement crisis stabilization services to address the identified gaps in the current community
- 081771001.1.5 Enhance improvement capacity through technology
- 081771001.2.2 Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations
- 081771001.2.3 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population

Relationship to Other Performing Providers' projects and Plan for Learning Collaboratives:
This project works with the Health Department, who is planning a Sexually Transmitted Disease testing and treatment project (#088334001.2.1) and one to work with women of child-bearing age (#088334001.2.2).

The Center is committed to improvement of services and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Project Valuation:
The valuation of this project takes into account the value of: 1) this is the first project to bring physical medicine resources into our behavioral health service delivery system; 2) this is the Center's first focused effort to address our patient's physical health problems that are known to shorten the life expectancy of persons with SPMI; 3) providing assistance with managing the

negative side effects of strong psychiatric medications needed by our patients is viewed as a strong means to reinforce medication compliance – a major problem with the people we serve; and, 4) this project strongly reinforces the recovery model of psychiatric services promoted by our Center by empowering our patients to take charge of, and master the control of their chronic health condition's symptoms. The valuation of the project also takes into consideration the salaries and fringe benefits of the nursing staff performing these services, the informational materials that will be used with patients, the equipment and consumable supplies to assist patients in monitoring their glucose levels and blood pressure levels, as well as the administrative overhead and indirect costs to run the project. The valuation of this project also takes into account the value of extended life expectancy (see Rationale section above) when chronic medical conditions are well managed. It is expected that this project will serve 200+ persons with severe and persistent mental illness per year and that at least half (100) of these individuals will be able to accomplish significant improvement in managing their chronic medical condition.

The valuation of this project also takes into account the quality of life gains and medical cost savings achieved by successful chronic health condition management. If such improvement in chronic health conditions could add 5-10 years to each patient's life span, that would result in a **net gain of 500 - 1,000 person years for each of the 3 full years of this project.** The successful management of their chronic health conditions through these extra years of life would also reflect a significant health services cost savings by limiting or avoiding the more extreme health complications that come with the advance stages of these chronic health conditions.

Central Counties Services 081771001.2.1 (Project 2.2.2) Category 2 Milestones and Metrics			
081771001.2.1	2.2.2		Apply evidence-based care management model to patients identified as having high-risk health care needs
Central Counties Services			081771001
Related Category 3 Outcome Measure (s):	081771001.3.4	IT-11.1	Improvement in Clinical Indicator in identified disparity group

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)
Milestone 1 [P-11]: Develop and implement program to assist behavioral health patients to better self-manage their chronic conditions caused by prolonged psychotropic medication use. **Metric 1** [P-11.1]: Increase the number of behavioral health patients enrolled in a self-management program regarding the health-risk side-effects of long-term psychotropic medicine use. a. Numerator: Number of patients enrolled in a self-management program for a given chronic condition. b. Denominator: Number of patients with given chronic condition **Baseline/Goal:** Baseline - This is a new service, so our Center will not know in advance what percent of our patients have chronic health	**Milestone 3** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. **Metric 1** [I-21.2]: Documentation of increased number of unique patients participating in the program to assist behavioral health patients to better self-manage their chronic conditions caused by prolonged psychotropic medication use. Demonstrate improvement over prior reporting period. a. Total number of unique patients served in the program for the reporting period **Baseline/Goal:** Baseline – TBD in DY 3 (anticipate 75); Goal – increase to 100 patients **Data Source**: Patient electronic health record.	**Milestone 5** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. **Metric 1** [I-21.2]: Documentation of increased number of unique patients participating in the program to assist behavioral health patients to better self-manage their chronic conditions caused by prolonged psychotropic medication use. Demonstrate improvement over prior reporting period. a. Total number of unique patients served in the program for the reporting period **Baseline/Goal:** Baseline – TBD in DY 3 (anticipate 75); Goal – increase to 150 patients in DY4. **Data Source**: Patient electronic health record.	**Milestone 7** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. **Metric 1** [I-21.2]: Documentation of increased number of unique patients participating in the program to assist behavioral health patients to better self-manage their chronic conditions caused by prolonged psychotropic medication use. Demonstrate improvement over prior reporting period. a. Total number of unique patients served in the program for the reporting period **Baseline/Goal:** Baseline – TBD in DY 3 (anticipate 75); Goal – increase to 200 patients in DY5. **Data Source**: Patient electronic health record.

conditions. Goal: The Center will determine the number/% of its patients served in these two clinics who have a chronic health condition that can be affected by self-management activities. **Data Source**: Patient electronic health record and individual patient interviews. **Milestone 1 Estimated Incentive Payment: $28,860** **Milestone 2** [P-X] (See p. 7 of the Planning Protocol): Establish a baseline of number of service enrollees in order to measure improvement over self **Metric 1** [P-X.6]: Establish baseline for patients enrolled in service **Baseline/Goal:** Baseline – 0, this is a new service. Goal – Establish baseline by the number of patients enrolled in this service during the month of September, 2013 – the baseline is expected to be approximately 75 patients. **Data Source:** The Center's electronic health record system.	**Milestone 3 Estimated Incentive Payment: $35,300** **Milestone 4** [P-X] (See p. 7 of the Planning Protocol): Establish a baseline in order to measure improvement over self. **Metric 1** [P-X.6]: Determine the baseline number of patients served by this project with written chronic condition self-management goals **Baseline/Goal:** Baseline – 38 patients in DY2; Goal – 50 patients in DY3. **Data Source:** The Center's electronic health record system. **Milestone 4 Estimated Incentive Payment: $35,300**	**Milestone 5 Estimated Incentive Payment: $37,740** **Milestone 6** [I.18]: Improve the percentage of adult behavioral health patients experiencing chronic conditions as a result of their taking psychotropic medications who have written self-management goals for their conditions **Metric 1** [I-18.1]: Determine the number of patients with written chronic condition self-management goals: a. Numerator: The number of patients with the specified chronic condition with one recorded self-management goal recorded in his/her electronic health record. b. Denominator: Total number of patients with the specified chronic condition recorded in his/her electronic health record. **Baseline/Goal:** Baseline – 38 patients in DY2; Goal – 75 patients in DY4. **Data Source:** The Center's electronic health record system. **Milestone 6 Estimated Incentive Payment: $37,740**	**Milestone 7 Estimated Incentive Payment: $42,180** **Milestone 8** [I.18]: Improve the percentage of adult behavioral health patients experiencing chronic conditions as a result of their taking psychotropic medications who have written self-management goals for their conditions. **Metric 1** [I-18.1]: Determine the number of patients with written chronic condition self-management goals: a. Numerator: The number of patients with the specified chronic condition with one recorded self-management goal recorded in his/her electronic health record. b. Denominator: Total number of patients with the specified chronic condition recorded in his/her electronic health record. **Baseline/Goal:** Baseline – 38 patients in DY2; Goal – 100 patients in DY5. **Data Source:** The Center's electronic health record system. **Milestone 8 Estimated Incentive Payment: $42,180**

Milestone 2 Estimated Incentive Payment: $28,860			
Year 2 Milestone Bundle Amount: $57,720	**Year 3 Estimated Milestone Bundle Amount: $70,600**	**Year 4 Estimated Milestone Bundle Amount: $75,480**	**Year 5 Estimated Milestone Bundle Amount: $84,360**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $288,160			

Category 2 Project Narrative
Central Counties Services – 081771001.2.2

Project Area, Option, and Title: 2.7.1 Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations
RHP Project Identification Number: 081771001.2.2

Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012 we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations.
- **Intervention:** This project provides persons (adults and adolescents) with severe and persistent mental illness (SPMI) easy access to STD education, testing and treatment by a registered nurse within the Center's mental health clinics in Temple and Killeen (Bell County) where the patients are already accustomed to attending.
- **Project Status:** This is a new project.
- **Project Need:** CN 3.2 Limited coordinated care exists in Bell County for disparity groups having co-occurring behavioral health needs and sexually transmitted diseases. For the latest statistical year **Bell County had the highest Chlamydia and Gonorrhea case rates in the State of Texas**. Studies show that people with SPMI die 25 years earlier, on average, than non-mentally ill peers. **Several factors that influence the pre-mature death of people with SPMI include unsafe sexual behavior** (p.16) "Morbidity and Mortality in People with Serious Mental Illness" (http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm).
- **Target Population:** 97% of the Center's patients are Medicaid (41.89%), uninsured, or indigent. We expect the same percentages of Medicaid, uninsured and indigent patients will benefit from this project. We expect this project to serve 100+ patients per year, but the actual number of patients who will use this service is not known.
- **Category 1 or 2 Expected Project Benefit for Patients:** This project will increase access of approximately 1,000 behavioral health patients (combined census of the Center's Killeen and Temple Clinics) to STD education, assessments and treatment in the familiar setting of our Killeen and Temple TX Clinics (Improvement Milestone I-7.2) which they already arrange to attend. Expected encounters for this project are: DY3 = 240, DY4 =288, DY5 = 360.

- **Category 3 Outcomes:** IT-11.1: Improvement in STD education, assessment and treatment (clinical indicator) for people with SPMI (disparity group) who visit Center clinics. The expected improvement in delivery of STD services will be 30% in DY4 and 40% in DY5 compared with baseline. **Bell County had the highest Chlamydia and Gonorrhea case rates in the State of Texas**. **Several factors that influence the pre-mature death of people with SPMI include unsafe sexual behavior.** Early detection and treatment avoids the personal health risks and costs of treating these same diseases at their advanced stages and avoids passing these STDs on to their newborn infants, thus avoiding personal and financial costs of coping with potential birth defects and physical condition complications for their newborn child. If such improvement in patient health conditions could add 5-10 years to each patient's life span, that would result in a **net gain of 500 - 1,000 person years for each of the 3 full years of this project.**
- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. There are several reasons why this project is truly a transformational project and they are: 1) this is the first project to bring physical medicine resources into our behavioral health service delivery system; 2) this is the Center's first focused effort to address our patient's physical health problems that are known to shorten the life expectancy of persons with SPMI; 3) this project strongly reinforces the recovery model of psychiatric services promoted by our Center by empowering our patients to take charge of, treating an STD and to take charge of their lifestyle choices to avoid future STD infections; 4) this project is forward looking in helping our patients avoid STD complications for their newborn children.; and, 5) the successful treatment of persons with one or multiple STDs reduces the personal and financial costs of treating advanced disease symptoms and helps avoid the personal and financial costs of treating future potential STDs.

Project Description:

Provide increased access to STD screenings for behavioral health patients in their behavioral health clinic settings.

Persons with severe and persistent mental illness have shorter life expectancy due to many factors. Studies have shown that people with severe and persistent mental illness (SMI) die 25 years earlier, on average, than their non-mentally ill peers as shown in *Morbidity and Mortality in People with Serious Mental Illness* (Parks, Svendsen, Singer and Foti authors). On page 16 of this research document, the authors identify Patient, Provider and System Factors Contributing to Morbidity and Mortality to Persons with SMI – "unsafe sexual behavior". *Morbidity and Mortality in People with Serious Mental Illness*, (http://usatoday30.usatoday.com/news/health/2007-05-03-mental-illness_N.htm).

This project will provide nursing staff from Bell County Public Health District (Health District), under contract arrangements with the Center to conduct Sexually Transmitted Disease (STD)

testing, treatment and educational counseling at Central Counties Services offices in Killeen, TX and Temple, TX. Both clinics are designated by the Texas Dept. of State Health Services as serving Medically Underserved Populations (MUP). Bell County has one of the highest Chlamydia and Gonorrhea rates in the State of Texas. This project will partner nursing staff from the Health District and Center clients to increase availability of STD services in an effort to increase testing for Chlamydia, Gonorrhea, Syphilis, and HIV. The Health District nursing staff will be available at the Center's offices in Temple and Killeen to provide STD testing, treatment, and education. One day of these services will be offered each week in each clinic. Clients with chronic and persistent mental illness may not otherwise seek out STD testing and treatment services due to the disorganizing effects of their mental illness. Persons with severe and persistent mental illness most often do not have a medical home, and consequently obtain most of their physical health services from local hospital emergency departments (EDs). When receiving medical care in the ED, medical attention is usually given only to the patient's presenting health crisis, and not to the patients' general health status. This project intends to bring the STD testing, treatment and educational counseling services to the behavioral health patients when they are in the Centers' clinics for their mental health visit. The outcome of these screening, educational, treatment services, and condition improvement/progress made by each patient will be recorded in each patient's electronic health record and aggregated into monthly and quarterly reports to both document the activity of this project, but also to serve as the basis for continual process improvement of this service. Patients participating in this service will be randomly surveyed regarding their satisfaction level with the services they received and how these services might be improved.

Goals and Relationship to Regional Goals

Project Goal:

The goal of this project is to decrease the incidence, prevalence and long term health effects of sexually transmitted diseases among persons with severe and persistent mental illness served in our Temple, TX and Killeen, TX clinics. This goal will be accomplished through increasing behavioral health patients' access to sexually transmitted disease education, testing and treatment services in the same clinic that each patient receives his/her behavioral health services.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs; and
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs.

Challenges:

- Overcoming the stigma associated with potentially having a sexually transmitted disease;
- Incorporation of a new service into the clinic patient flow;
- Increasing patient awareness regarding the availability of STD services; and
- Maintaining the discreetness of this service in the clinic setting so that other patients will not be made aware that a particular patient is seeking/receiving these services.

Our Center will thoroughly plan the initiation of these services with the Bell County Health District nurse to resolve any potential logistic issues that might impact on the above. Educational information about these services will be placed in our waiting areas and in our staff offices. We will make this information available in the various languages of our patient group. Our Center has Spanish-speaking staff in both the Killeen and Temple clinics to assist the nurse, if needed.

5-year Expected Outcome for Provider and Patients:

- Increased screening for Chlamydia, Gonorrhea, Syphilis, and HIV among adolescent and adult behavioral health patients;
- Decreased Chlamydia and Gonorrhea case rates among the behavioral health patients served in the Temple, TX and Killeen, TX clinics, and in general, among the citizens of Bell County;
- Increased knowledge of STD risk factors and reduction strategies among adolescent and adult behavioral health patients; and
- Avoidance or minimalizing the occurrence of the newly identified drug-resistance strains of gonorrhea and the potential threat of an untreatable strain of gonorrhea emerging.

Starting Point/Baseline:

This type of service has not been offered at the Center in the past, so baseline numbers for this project in DY1 and the beginning of DY2 is zero. The baseline for the number of behavioral health patients seeking STD education and testing will be set by the level of such sessions during the month of September 2013. In subsequent years, the project will strive to increase the numbers of patients tested for STDs over the previous year.

Rationale:

<u>Community Need Addressed:</u>

- Community Need Area: CN.3 - Lack of coordinated care for those with multiple needs
- Specific Community Need: CN 3.2 - Limited coordinated care exists in Bell County for disparity groups having co-occurring behavioral health needs and sexually transmitted diseases.

See also Addendum #1E Bell County Health Facts Profile 2009 – Communicable Diseases – Reported Cases
See also Addendum #1J Homeless Count and Characteristics Survey Results for Temple and Killeen, TX
See also Addendum #1 (Supplementary Web Links) – Bell County Community Needs Assessment, 2010
See also p. 16 of Patient, *Provider and System Factors Contributing to Morbidity and Mortality to Persons with SMI – "unsafe" sexual behavior* (*Morbidity and Mortality in People with Serious Mental Illness*, Parks, Svendsen, Singer and Foti authors).

This project addresses the high Chlamydia and Gonorrhea rates in Bell County for the latest statistic year available 2010. Bell County had the highest Chlamydia and Gonorrhea case rates in the entire state in 2010 (DSHS, Texas 2010 STD Surveillance Report). Bell County also had the

6th highest Gonorrhea case numbers and 7th highest Chlamydia numbers in the state in 2010. In an October 18, 2012 Houston Chronicle newspaper article (Falkenberg: *Sex-Ed Program is Effective* by Lisa Falkenberg) statistics were given that 11% of sixth graders are sexually active, 35% of ninth graders are sexually active, and nearly 70% of twelfth-graders were sexually active. These startling statistics are probably even higher among adolescents with behavioral health problems who engage in risk-taking behaviors.

According to the Centers for Disease Control (CDC), the number of reported cases of Chlamydia and Gonorrhea is lower than the estimated total number because infected people are often unaware of, and do not seek treatment for, their infections and because screening for Chlamydia is still not routine in many clinical settings (CDC, 2012). Undetected and/or untreated Chlamydia infections are one of the leading causes of sterility, ectopic pregnancy, poor pregnancy outcomes, neonatal infection and chronic pain (DSHS, Infertility Prevention Project, 2012).

The Center's behavioral health patients are both medically underserved and have a higher than normal likelihood of engaging in risk-taking behaviors, such as sexual promiscuity, etc. This project brings a needed service to a group of people who likely have higher than average need for this service.

Continuous Quality Improvement: The Center 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project does not supplant any services or funds currently provided to Central Counties Service through the U.S. Department of Health and Human Services. The services proposed to be provided under this project serve to enhance, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

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

Our Center realizes that, unfortunately, society often sees a stigma attached to pursuing STD education and testing services, similar to the stigma attached to seeking behavioral health services. By offering STD education/testing services within our clinics, we are both seeking to diminish the stigma attached to seeking these services and to increase access to these services by a medically underserved and disparate population. We therefore chose to measure/monitor the number of patient-specific sessions held within the two days per week that they are offered. We have every expectation that through the ease of access to these services, general education among our behavioral health patients about sexually transmitted diseases, informal

support for these services among the patient group by patients who have had positive results from treatments for sexually transmitted diseases, and the supportive encouragement of our behavioral health staff, that the number of behavioral health patients seeking these services will increase over time to fill the nurses service schedule. We are also hopeful of achieving over time a much lower incidence rate of sexually transmitted diseases among our patient population than the average rate in Bell County.

Relationship to Other Projects:
This project is focused on increasing access to health and behavioral health services and is similar to our telemedicine (#081771001.1.2) and performance improvement and reporting capacity (#081771001.1.5) project which have a similar goal of increasing patient access to behavioral health services. Therefore we judge that increasing the number of STD education/testing sessions will be a strong indicator that this project is successful. The number of education sessions leading to STD testing; the number of tests which identify the presence of a sexually transmitted disease; and the number of patients with confirmed sexually transmitted disease who receive successful treatment will also be monitored. These statistics will be aggregated on a monthly and quarterly basis to demonstrate the progress and success of this most beneficial project.

Other Center projects include:

- 081771001.1.1 Establish more primary care clinics
- 081771001.1.3 Expand the number of community based setting where behavioral health services may be delivered in underserved areas
- 081771001.1.4 Develop and implement crisis stabilization services to address the identified gaps in the current community
- 081771001.2.1 Apply evidenced-based care management model to patients identified as having high-risk care needs
- 081771001.2.3 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
This project also correlates with two Health District projects: STD Testing (#088334001.2.1) and Prevent Potentially Preventable Conditions for Women of Child bearing age (#088334001.2.2).

There are several projects in Region 8 that seek to integrate behavioral health services with general health, or primary care services. There also are projects that seek to encourage persons to establish a medical home so that their care can be better coordinated and that health conditions can be identified in their earlier and more treatable stages. This project is in harmony with these regional efforts and is seen as one of the first steps to ultimately achieve integrated health and behavioral health services in our area.

Project Valuation:
The valuation of the project takes into consideration the salaries and travel costs, and fringe benefits of the nursing staff performing services, the educational and consumable supplies needed for this project, as well as the administrative overhead and indirect costs to run the

project. The valuation of this project also takes into account the monetary and personal quality of life costs saved by early detection and treatment of STDs.

The valuation of this project also takes into account the quality of life gains and medical cost savings achieved by successful early treatment of sexually transmitted diseases and the prevention/education services which assist the patients in avoiding future sexually transmitted diseases. Part of this project's valuation is based on how it strongly reinforces the recovery model of psychiatric services promoted by our Center by empowering our patients to take charge of, treating an STD(s) and to take charge of their lifestyle choices to avoid future STD infections. Early detection and treatment avoids the personal health risks and costs of treating these same diseases at their advanced stages and avoids passing these STDs on to their newborn infants, thus avoiding personal and financial costs of coping with potential birth defects and physical condition complications for their newborn child. If such improvement in patient health conditions could add 5-10 years to each patient's life span, that would result in a **net gain of 500 - 1,000 person years for each of the 3 full years of this project.** The successful treatment of STDs and avoidance of future STD episodes by improved management of their life styles through these extra years of life would also reflect a significant health services cost savings by limiting or avoiding the more extreme health complications that come with the advance stages of STD infections.

Central Counties Services 081771001.2.2 (Project 2.7.1) Category 2 Milestones and Metrics			
081771001.2.2	**2.7.1**		**Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screen s, colonoscopies, prenatal alcohol use, etc.)**
Central Counties Services			**081771001**
Related Category 3 Outcome Measure (s):	**081771001.3.5**	**IT-11.1**	**Improvement in Clinical Indicator in identified disparity group**

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)
Milestone 1 [P-2]: Implement evidence-based innovational project for targeted population – Sexually transmitted disease education and screenings of medically under-served, mental health patients served by our Center. **Metric 1** [P-2.1.]: Document implementation strategy and testing outcomes. **Baseline/Goal:** STD education and testing has not been provided previously in our Killeen, TX and Temple, TX clinics, so we do not have an estimate of how many patients will avail themselves of this service. The goal of this project is to provide these services to all clinic patients who have an interest in these services. **Data Source:** Patient electronic health records	**Milestone 3** [I-7]: Increase access to disease prevention (STD education/ testing) programs using innovative project option (behavioral health clinic outreach). **Metric 1** [I-7.2]: Increased number of encounters as defined by intervention (e.g. STD screenings, education, outreach, etc.) per month among mental health patients at our Killeen, TX and Temple, TX clinics. **Baseline/Goal:** Baseline – Estimated to be 192 annual encounters. Increase encounters to 240 total encounters in DY3. **Data Source:** Patient electronic health records and scheduling software data **Milestone 3 Estimated Incentive Payment: $70,600**	**Milestone 4** [I-7]: Increase access to disease prevention (STD education/ testing) programs using innovative project option (behavioral health clinic outreach). **Metric 1** [I-7.2]: Increase number of encounters as defined by intervention (e.g. STD screenings, education, outreach, etc.) per month among mental health patients at our Killeen, TX and Temple, TX clinics. **Baseline/Goal:** Baseline – Estimated to be 192 annual encounters. Increase encounters to 288 total encounters in DY4. **Data Source:** Patient electronic health records and scheduling software data **Milestone 4 Estimated Incentive Payment: $75,480**	**Milestone 5** [I-7]: Increase access to disease prevention (STD education/ testing) programs using innovative project option (behavioral health clinic outreach). **Metric 1** [I-7.2]: Increase number of encounters as defined by intervention (e.g. STD screenings, education, outreach, etc.) per month among mental health patients at our Killeen, TX and Temple, TX clinics. **Baseline/Goal:** Baseline - Estimated to be 192 annual encounters. Goal – Increase encounters to 360 total encounters in DY5. **Data Source:** Patient electronic health records and scheduling software data **Milestone 5 Estimated Incentive Payment: $84,360**

Milestone 1 Estimated Incentive Payment: $28,860 **Milestone 2** [P-X] (See p. 7 of Planning Protocol): Establish a baseline, in order to measure improvement over self. **<u>Metric 1</u>** [P-X.6.]: Establish a baseline number of STD screening, education, outreach, etc. encounters among mental health patients at our Killeen, TX and Temple, TX during the month of September 2013 in order to measure improvement over self **Baseline/Goal:** Baseline – 0, this is a new service; Goal – Determine baseline, (this number is estimated to be 192 annual encounters). **Data Source:** Center Scheduling Program, and Patient Electronic Health Records **Milestone 2 Estimated Incentive Payment: $28,860**			
Year 2 Milestone Bundle Amount: $57,720	**Year 3 Estimated Milestone Bundle Amount: $70,600**	**Year 4 Estimated Milestone Bundle Amount: $75,480**	**Year 5 Estimated Milestone Bundle Amount: $84,360**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $288,160			

Category 2 Project Narrative
Central Counties Services – 081771001.2.3

Project Area, Option and Title: 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.
RHP Project Identification Number: 081771001.2.3

Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Project Summary:

- **Provider Description:** Central Counties Services (Center) is an agency of the state providing publicly-funded adult/ child mental health, intellectual and developmental disability (IDD), and early childhood intervention services for 3 RHP 8 Counties (Bell, Lampasas, Milam = 2,789 square miles/352,218 population) and 2 RHP 16 Counties (Coryell, Hamilton = 1,8878 square miles/91,250 population). The Center as the Single Portal Authority authorizes state psychiatric hospital and IDD state living Center admissions. In FY2012 we helped 8,000 people with 240,000+ units of service. The Texas Department of State Health Services (DSHS) deemed all Center clinics as serving Medically Underserved Populations (MUP).
- **Intervention:** This project provides supportive day services for adults with severe and persistent mental health problems, who were recently discharged from a psychiatric hospital or jail, or have recently experienced a crisis that put them at risk for hospitalization/incarceration. Services include work skills training, medicine management, daily living skills training to support patients' ability to live on their own. It will use a recovery service model and have at least one peer counselor to assist patients.
- **Project Status:** This is a new project.
- **Project Need:** CN.2.17 Lack of community support services for persons with severe and persistent mental health diagnosis in Bell County. Addendum 1G Overuse of state psychiatric hospital bed days by this service area. Addendum 1 Supplemental Web Links – Bell County Human Services Needs Assessment pp. 79, 88, 103, 236.
- **Target Population:** The target population for these services are adults with severe and persistent mental illness, most of whom are indigent since their mental illness severity is a major barrier to regular employment. We intend to serve 20 adults in DY4 (average monthly enrollment), and 25 adults by DY5. We anticipate most clients will be from Temple, TX. 97% of the Center's patients are Medicaid (41.89%), uninsured, or indigent. We expect the same percentages of Medicaid, uninsured and indigent patients will benefit from this project.
- **Category 1 or 2 Expected Project Benefit for Patients:** The improvement goal of this project is to increase the average enrollment in these supportive day services to 20 in DY4 and 25 in DY5.
- **Category 3 Outcomes:** IT-9.1: Decrease in mental health admissions and readmissions to institutional psychiatric hospitals or criminal justice settings such as jails or prisons by 30% in DY4 and 40% in DY5.

- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. This project is transformational in that there are currently no supportive behavioral health day services in this service region. This project will educate and support the participants in the recovery model of mental health care in which the patient is empowered to take control over his/her recovery process. This project will offer daily support to encourage medication compliance and lifestyle changes that are more conducive to living independently in the Temple community. This project will also provide a safe/supportive place to practice those new lifestyle choices.

Project Description:

Supportive Behavioral Health Day Services For persons with Severe and Persistent Mental Illness - Temple

This project would be organized on a recovery model which holds out the expectation that every patient, no matter how impaired they are at the time, can improve their condition. The recovery model emphasizes the patient's personal responsibility to accept his/her illness and take personal responsibility to work to improve their level of personal functioning and their quality of life. This project would be staffed to provide supportive day services for up to 20 adults at a time who have a severe and persistent mental illness and reside in the Temple/Belton, TX area. The project participant would be chosen from among patients who have experienced frequent psychiatric hospitalizations or incarcerations, or who are imminently at risk of psychiatric hospitalization or incarceration. Patients involved with these services would receive skills training on how to manage: a) their medications, b) their negative symptoms of their mental illness, c) to improve their ability to manage their own living environment and d) to improve their ability to utilize the public transportation system in the Temple/Belton, TX area. The program would provide lunch for those attending and would use the shopping for food and meal preparation process as skill-building activities to better equip the patients to live independently. Many of the skill training sessions and social skill building activities would be done as a group to assist the participants in forming mutually supportive relationships with the other program participants.

This project would also provide transportation for the patients to assist their getting settled in the community, and would also work on the patient's use of the public transportation system (bus-stop is one block from the service site). The services would include computers on which to train the patients on how to use them and the internet as a personal resource in their mental health recovery and stabilization. This computer/internet literacy will become more personally available to participating patients by the program staff educating the patients about the computer/internet resources available at the Temple Public Library, as well. This project would include helping the patients to learn more about community resources that are available to them (parks, city wellness/recreation facilities, etc.). This project would also include the

recruitment, training, and employment of peer specialists (Menu Category 2.8). The supportive counseling of the peer specialist would both increase the patient's buy-in with the program, and patient's sense of support from someone who has managed their severe and persistent mental illness symptoms sufficiently well to be able to support others in their recovery.

Each patient participating in this project would have a detailed personal history written up by the staff regarding the patient's past use of state psychiatric hospital services, local emergency medicine department usage, and criminal/incarceration events in their life. Center staff would help patients explore these events and what led up to them occurring so that alternate choices/behaviors could be identified for the patient. Center staff would work with each patient to develop a practical recovery plan that would strive to put supports in place to assist the patient's ability to deal with problems without needing institutional support/intervention. All of the above information would be entered into the patient's electronic health record system of the Center. A medication support group would be formed as part of the services to encourage each patient to comply with their medications, and the follow-up appointments necessary to maintain their medication access/supply. Center staff would also assist the participants to apply for any disability support, housing support, or vocational training support for which they may be eligible, and will also assist the participants in applying for pharmaceutical assistance programs to offset the costs of their medications. A daily attendance roster would also be maintained. If an enrolled patient is absent from the services on a day that he/she was supposed to attend, staff will contact the patient to determine why he/she is not attending. If the patient cannot be contacted, staff will contact local hospitals and jails to determine if the patient has been admitted.

Goals and Relationship to Regional Goals:

Project Goals:

This service has as its goal to reduce the "revolving-door" hospitalizations/incarcerations of the chronically and persistently mentally ill persons in the Temple/Belton, TX area. This is to be accomplished by the skills training activities available to the patients in this program. It is expected that the longer a patient participates in this service, the greater the length of time will be before further hospitalization/incarceration caused by a mental health crisis occurs. During this stable time it is the service goal to enroll each patient in whatever benefit programs he/she might be eligible for, to include Section-8 housing, Medicaid, Social Security Disability, etc. Accessing these support services will assist the patient in re-structuring his/her community living supports and add to the options for the patient to use to effectively avoid hospitalization or incarceration in the future.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:
One of the challenges of this project will be finding an appropriate facility in which to offer these services. The facility will need to be close to the local public transportation stops, and convenient to downtown Temple. It will also be a challenge to find a living arrangement for those patients who are coming out of the hospital/jail, or have been living on the street. Ideally the facility used for this service would have shower facilities to facilitate personal hygiene of the patients, a simple kitchen/food storage area in which to teach simple food handling and preparation skills, and sufficient space to have a small computer lab with 6-10 places for patients to practice their computer literacy skills and do simple internet searches. Our Center is exploring a neighborhood just northeast of our downtown Temple area to find a suitable building. This neighborhood is in the vicinity of our Child/Adolescent Behavioral Health Clinic and the Temple main post office. The Center is hesitant to secure a building for this project prior to knowing the approval of this project proposal.

5-Year Expected Outcome for Provider and Patients:
It is expected that these services will engage those persons being released from psychiatric hospitalization, those diverted from a psychiatric hospitalization, and those diverted from incarceration into participating in skills training-based, supportive day services. The expected outcome would be improved medication compliance, longer periods of staying in the community without hospitalization, arrest, or involvement with emergency department services. Another expected outcome will be in the improvement of the patient's daily living skills needed for independent living, to include the ability to utilize the local public transportation system, preparing simple one-person menus, shopping for groceries, simple meal preparation, food storage knowledge, and how to put together a simple personal budgeting system.

The longer term goals (5+ years) for this project would be to have it evolve into a peer support/drop-in Center that could be used as a support system by person's who have made major progress in reconstituting their lives – much like the very effective social support system of Alcoholics Anonymous groups.

Starting Point/Baseline:
This is a new service for the Center so there is no baseline regarding how many days this program will help a person with severe and persistent mental illness stay out of an institutional setting (psychiatric hospital or incarceration). The baseline for each patient will be obtained within two weeks of their becoming involved with these services and will be documented in the patient's electronic health record. We are optimistic that these services will make a significant difference in the length of time the patients can stay out of an institution.

Rationale:
<u>Community Need Addressed:</u>
- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.17 - Lack of community support services for persons with severe and persistent mental health diagnoses in Bell County

Addendum 1G of the RHP 8 Plan illustrates our service region using more than its assigned level of access to the state psychiatric hospital system due to the lack of local alternatives to provide structured support services in our Temple community.

Persons with severe and persistent mental illness often become more and more isolated from their families and their personal support network. The more their illness progresses, the more withdrawn and isolated they become. We are convinced that bringing a severely and persistently mentally ill person into a supportive environment will make a significant difference in their ability to reverse their isolation and feelings of low self-worth. It is our belief that being able to daily reinforce the tenants of this recovery-model approach to helping patients manage their symptoms and build their personal skills through this day service program will have high impact results in the lives of those served by this program.

Core Project Components:

a) *Assess size, characteristics and needs of target populations (e.g., people with SPMI).* This component is addressed in Milestone 1. Central Counties will research different models of day services, interview staff from other programs where this service is offered, conduct an internet search for reference materials/ service models, etc. to be used as the basis for developing our Center's Implementation plan.

b) *Review literature / experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes such as forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life.* This component is also addressed in Milestone 1. This component is also addressed in Milestones 6 and 8 below. Examples of source documents for service design are: "Effectiveness of peer support in reducing readmissions of persons with multiple hospitalizations" W. H. Sledge, et al, Psychiatric Services, 62(5), 541-544; "Planning and creating successful adult day services" Marilyn Martle, LaDonna Jensen, NADSA-AAHSA Whitepaper; "Report of the Mental Health Day Support Work Group, Recovery, Employment, and Rehabilitation Services" Renee Alberts, et al, Falls Church Community Services Board Report, "Peer Support, Whole Health & Resiliency" ; Appalachian Consulting Group, Inc. Cleveland Ga.

c) *Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.* This the qualitative aspect of this component is also addressed in Milestones 6 and 8 below which are the continuous quality improvement components of this project that strive to continuously improve the quality and effectiveness of the services delivered to each patient under this project. Based on the reports, determine what factors can improve appointment attendance and participation by patients, what procedural activities can be re-organized or streamline to improve the efficiency of documenting services provided by telemedicine technology. Revise the items to be tracked and reported upon for future improvement. The quantitative aspects of this component are addressed under Milestones 3 and 5 in which we which seek to increase the number of patients served by this project.

d) *Design models which include an appropriate range of community-based services and residential supports.* This component will be addressed in Milestone 1 and will be a part of the continuous improvement efforts of Milestones 6 and 8. Also see the Project

Description paragraph above which describes the service components to be offered under this project.

e) *Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.* This component will be addressed in our Category 3 Milestone which evaluates the reduction of admissions and readmissions into psychiatric hospitals and into criminal justice settings by the severe and persistently mentally ill group of patients served by this project. This component will also be addressed every time the patients' personal treatment plan is updated through a re-assessment of the patient's functioning level and recorded in the patient's electronic health record.

Continuous Quality Improvement: The Center 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project does not supplant any services or funds currently provided to Central Counties Service from the U.S. Department of Health and Human Services. The services proposed to be provided under this project serve to enhance, but not duplicate, the services provided by our Center to persons with severe and persistent behavioral health problems.

Related Category 3 Outcome Measure(s):

- OD-9 Right Care, Right Setting
  - IT-9.1 Decrease in mental health admissions and readmissions to institutional psychiatric hospitals or criminal justice settings such as jails or prisons

The goal of this project is to reduce the number of days people with severe and persistent mental illness spend in state psychiatric hospital services, or incarcerated in local jails due to minor crimes committed in the midst of a mental health crisis. The outcome we will be measuring is the number of days a person with severe and persistent mental illness is able to be in the community rather in one of these more restrictive and costly institutional settings. We will use the number of days each person was able to stay in the community between their last two admissions, or mental health crisis episodes in which they were at risk of institutionalization as the baseline measure. We will then periodically measure how many days a patient has been able to stay out of an institutional setting with the support of the services offered in this project, and compare that number of days with their personally established baseline. We expect that the longer a patient actively participates in these supportive day services, the more likely that the length of time between institutional episodes will likewise increase significantly.

Relationship to Other Projects:

This project would provide supportive day services for up to 20 adults with severe and persistent mental illness residing in the Temple/Belton, TX area, and who have experienced

frequent psychiatric hospitalizations, or who are imminently at risk of psychiatric re-hospitalization. This project relates to our proposed Crisis Respite Project (#081771001.1.4), as both are aimed at decreasing the use of the state psychiatric hospital system and the criminal justice system in Texas. This project could eventually provide "step-down" services to patients who are just getting out of our proposed crisis respite services

The Center has the following projects:

- 081771001.1.1 Establish more primary care clinics
- 081771001.1.2 Implement technology-assisted behavioral health services by psychologists, psychiatrists, and other qualified providers
- 081771001.1.3 Expand the number of community based setting where behavioral health services may be delivered in underserved areas
- 081771001.1.5 Enhance improvement capacity through technology
- 081771001.2.1 Apply evidenced-based care management model to patients identified as having high-risk care needs
- 081771001.2.2 Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations

Relationship to Other Performing Provider's Projects and Plan for Learning Collaborative:
Bluebonnet Trails Community Center is proposing several services that are similar to this supportive day service, and which are aimed at reducing the cyclical use of the state psychiatric hospital system and local jails.

Heart of Texas Regional Center has crisis residential services in place already, as well as a supportive day services site in a large, historic home in Waco, in RHP 16.

The Center is committed to improvement of services and broad-level delivery system transformation. We are willing to participate in learning collaboratives with providers in RHP 8 to share successes, challenges, and lessons learned in order to better serve our target population and meet our community needs. Sharing this information at least on a yearly basis will allow providers to strengthen their partnerships and to continue providing services efficiently so there is maximum positive impact on the healthcare delivery system in RHP 8.

Project Valuation:
The valuation of the project for DY2 includes the purchase of a mini-van, office and program furniture, equipment for a computer lab, audio-video presentation equipment, cooking utensils and equipment, food processing and storage equipment, the hiring and training of staff, supervision of staff, the cost of patient training materials and consumable supplies. The valuation also includes community orientation and recreation activities that promote personal physical wellness. The valuation includes mental health indirect services costs, and administrative costs for this project. Valuation of DYs 3-5 will include increases in staff salaries, and other inflationary cost adjustments. Valuation of this project also takes into account the psychiatric hospitalization and incarceration costs that can be avoided by good, supportive, skill building day services and improved medication compliance. If this project can keep half of its patients (10-15) out of psychiatric hospitals (15 days/admission) or jails (30 days per

incarceration event) , it will save our state and communities close to the entire value of this project, not to mention the personal and social costs/tolls these experiences take on the patient's sense of well-being and physical health.

Central Counties Services 081771001.2.3 (Project 2.13.1) Category 2 Milestones and Metrics			
081771001.2.3	**2.13.1**	**2.13.1.a - 2.13.1.e**	**Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.**
Central Counties Services			**081771001**
Related Category 3 Outcome Measure (s):	**081771001.3.6**	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice setting such as jails or prisons.**

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)
Milestone 1 [P-2]: Design a community-based specialized intervention (psychosocial rehabilitation services) for target populations (adults with severe and persistent mental illness). **Metric 1** [P-2.1]: Project plans which are based on evidence/ experience and which address the project goals **Baseline/Goal:** Baseline - Service does not currently exist in our system, so no implementation plan is available. Goal - Write a detailed Behavioral Health Day Services Implementation Manual that includes the staffing patterns to be used, services to be delivered, and a staffing pattern to deliver the proposed services. **Data Source:** Research different models of day services, interview	**Milestone 3** [I-X]: Increase the enrollment of individuals with targeted complex needs. (Severe and persistent mental illness who have recently (within the last 30 days) at risk of psychiatric hospitalization or incarceration due to being in a mental health crisis). **Metric 1** [I-X.1]: Increase the number of targeted individual enrolled/served in the project. (Supportive day services) **Baseline/Goal:** Baseline - 10 participants; Goal - Maintain an annual average service census of 15 participants. **Data Source:** Project documentation/rosters and patient electronic health records. **Milestone 3 Estimated Incentive**	**Milestone 5** [I-X]: Increase the enrollment of individuals with targeted complex needs (Severe and persistent mental illness who have recently (within the last 30 days) at risk of psychiatric hospitalization or incarceration due to being in a mental health crisis). **Metric 1** [I-X.1]: Increase the number of targeted individual enrolled/ served in the project (Supportive day services) **Baseline/Goal:** Baseline - 10 participants. Goal - Maintain an annual average service census at 20 participants enrolled in this service **Data Source:** Project documentation/rosters and patient electronic health records. **Milestone 5 Estimated Incentive**	**Milestone 7** [I-X]: Increase the enrollment of individuals with targeted complex needs (Severe and persistent mental illness who have recently (within the last 30 days) at risk of psychiatric hospitalization or incarceration due to being in a mental health crisis). **Metric 1** [I-X.1]: Increase the number of targeted individual enrolled/served in the project. (Supportive day services) **Baseline/Goal:** Baseline - 10 participants. Goal - Maintain an annual average service census at 25 participants enrolled in this service **Data Source:** Project documentation/rosters and patient electronic health records. **Milestone 7 Estimated Incentive Payment: $219,095**

staff from other programs where this service is offered, conduct an internet search for reference materials/ service models, etc. to be used as the basis for developing our Center's Implementation plan. Examples of source documents for service design are: "Effectiveness of peer support in reducing readmis-sions of persons with multiple hospitalizations" W. H. Sledge, et al, Psychiatric Services, 62(5), 541-544; "Planning and creating successful adult day services" Marilyn Martle, LaDonna Jensen, NADSA-AAHSA Whitepaper; "Report of the Mental Health Day Support Work Group, Recovery, Employment, and Rehabilitation Services" Renee Alberts, et al, Falls Church Community Services Board Report, "Peer Support, Whole Health & Resiliency" ; Appalachian Consulting Group, Inc. Cleveland Ga. **Milestone 1 Estimated Incentive Payment: $178,730** **Milestone 2** [P-3]: Enroll and serve individuals with targeted complex needs (Severe and persistent mental illness who have recently (within the last 30 days) at risk of psychiatric	**Payment: $189,399** **Milestone 4** [P-X.6] (see page 7 of the Planning Protocol): Establish a baseline measure in order to measure improvement over self **Metric 1** [P-X.6]: Establish a baseline measure in order to measure improvement over self – recent frequency of institutionalization (psychiatric hospital or jail) due to a behavioral health crisis **Baseline/Goal:** Baseline – TBD. Goal - Establish the baseline of for each participant on how many days have passed between the participant's last two institutionalizations. **Data Source:** Patient interviews, local MH authority and state MH (CARE) data records, state hospital records, local criminal justice system records, and collateral interviews. **Milestone 4 estimated incentive payment: $189,398**	**Payment: $202,871** **Milestone 6** [P-4]: Evaluate and continuously improve interventions. **Metric 1** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study, act method of quality improvement cycles. a. Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. **Baseline/Goal:** Baseline - Review the reports regarding the items chosen for tracking in DY3. Goal - Based on the reports, determine what factors can improve appointment attendance and participation by patients, what procedural activities can be re-organized or streamline to improve the efficiency of documenting services provided by telemedicine technology. Revise the items to be tracked and reported upon for future improvement **Data Source:** Attendance records, punctuality records, level of participation in skills training	**Milestone 8 [**P-4]: Evaluate and continuously improve interventions. **Metric 1** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study, act method of quality improvement cycles. a. Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. **Baseline/Goal:** Baseline - Review the reports regarding the items chosen for tracking in DY4. Goal - Based on the reports, determine what factors can improve appointment attendance and participation by patients, what procedural activities can be re-organized or streamline to improve the efficiency of documenting services provided by telemedicine technology. Revise the items to be tracked and reported upon for future improvement **Data Source:** Attendance records, punctuality records, level of participation in skills training sessions/ activities, medication compliance, follow-through with benefits enrollment paperwork/procedures, level of personal improvement plan investment/ adherence, etc. Focused discussions

hospitalization or incarceration due to being in a mental health crisis.) **<u>Metric 1</u>** [P-3.1]: Number of targeted individual enrolled/served in the project (Supportive day services). **Baseline/Goal:** Baseline - Since this will be a new service, no one is enrolled in this type of services at this time. Goal - By the last month of DY2 have an enrollment of 10 persons fitting the criteria for the service within the first 45 days of service operation **Data Source:** Project documentation/rosters. **Milestone 2 Estimated Incentive Payment: $178,730**		sessions/ activities, medication compliance, follow-through with benefits enrollment paperwork/procedures, level of personal improvement plan investment/adherence, etc. Focused discussions with participants on suggested service improvement. **Milestone 6 Estimated Incentive Payment: $202,872**	with participants on suggested service improvement. **Milestone 8 Estimated Incentive Payment: $219,095**
Year 2 Milestone Bundle Amount: $357,460	**Year 3 Estimated Milestone Bundle Amount: $378,797**	**Year 4 Estimated Milestone Bundle Amount: $405,743**	**Year 5 Estimated Milestone Bundle Amount: $438,190**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,580,190			

Category 2 Project Narrative
Hill Country MHDD – 133340307.2.1

Project Area, Option, and 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
RHP Project Identification Number: 133340307.2.1

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers
Performing Provider TPI #: 133340307

Project Summary:

- **Provider Description:** Hill Country Community MHMR Center (Hill Country) 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 RHP 8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP 8 with a population of approximately 30,582 in 2012.
- **Intervention:** This project will implement Co-occurring Psychiatric and Substance Use Disorder Services (COPSD) within the 2 counties served by Hill Country in RHP 8 in order to meet the needs of individuals with psychiatric and substance use issues within the community setting. Our goal is to reduce emergency department (ED) utilization, inpatient utilization, and incarceration.
- **Project Status:** This is a new project for Blanco and Llano counties.
- **Project Need:** Of the 283 individuals receiving mental health services through Hill Country in RHP 8 in November 2012, 71.7% report substance use while 14.5% report substance use at a level that interferes with their daily lives and/or medications (CN.2.20). In meeting with area hospitals, they have indicated that individuals with psychiatric disorders who also abuse substances end up in their EDs.
- **Target Population:** The target population includes individuals within Blanco and Llano counties who have a psychiatric diagnosis and abuse substances. According to the SAMHSA's National Survey on Drug Use and Health this is 1.84% of the population or 563 individuals for the two counties. Based on the population served in Hill Country's existing behavioral health program in RHP 8, it is anticipated that approximately 27% of our patients within RHP 8 have Medicaid and approximately 81% have income below $15,000 per year. We expect the target population will be similar to this.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project aims to establish COPSD services in a community setting within the 2 counties served by Hill Country in RHP 8 which will reduce inappropriate ED use and incarceration. The project seeks to provide services to a minimum of 30 individuals from the 2 counties served by Hill Country in RHP 8 by the end of DY5 (new enrollees 8 in DY3; 10 in DY4 (18 total); and 12 in DY5 (30 total).
- **Category 3 Outcomes:** IT-10.2: Activities of Daily Living (DLA-20). Our goal is to have, at a minimum, TBD% of the individuals served by the COPSD 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, inappropriate ED use and incarceration.

- **Collaboration:** TAMHSC's Pass 1 allocation was not used for this project.

Project Description:

Intervention for Co-occurring Psychiatric and Substance Use Disorders

According to Substance Abuse and Mental Health Services Administration (SAMHSA) statistics on co-occurring disorders, 25.7% of all adults with serious mental illness also suffer from substance use dependence and 19.7% of adults with any mental illness also suffer from substance use dependence. Hill Country currently serves over 283 adults with Severe and Persistent Mental Illness on an annual basis within two counties of RHP 8 (Blanco and Llano). According to the Substance Use Dimension Rating Scale on the latest Texas Recommended Assessment Guidelines, of the 283 individuals served, 71.7% report substance use while 14.5% 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, there is one individual dedicated to Co-occurring service delivery who serves Kerr and Gillespie counties in RHP 6. By expanding this service, Hill Country can better address the need of individuals with co-occurring psychiatric and substance use disorder.

Hill Country is planning to add Co-occurring Psychiatric and Substance Use Disorder services throughout the two county area served by Hill Country in RHP 8. In establishing the project, Hill Country will review literature and experiences regarding Co-occurring Psychiatric and Substance Use Disorder (COPSD) services to establish appropriate training for staff on the most effective interventions for COPSD services. Upon identifying needed training, Hill Country will recruit appropriate staff and provide targeted training for COPSD services. As a means to determine the success of the interventions, a functional assessment (DLA-20) determining what impact psychiatric illness and substance use have on the individuals daily lives will be completed upon entry into the program 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 COPSD services delivered within the program as well as by location within the program.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to establish COPSD services throughout Llano and Blanco counties in order to reduce emergency department (ED) 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 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 goals of:

- Increasing coordination of prevention and care for residents, including those with behavioral and mental health needs and
- Reducing inappropriate utilization of services.

Challenges:
The primary challenge for implementation of the project is recruiting licensed staff. Hill Country will address the challenge by offering incentives as necessary.

5-Year Expected Outcome for Provider and Patients:
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 20 consumers within the community over the life of the project.

Starting Point/Baseline:
Hill Country currently has one individual specializing in delivering COPSD services who serves forty individuals on an annual basis in RHP 6. This project will expand the service to the residents in the two counties served by Hill Country in RHP 8. The DLA-20 assessment will be performed on each individual entering the program as their baseline and the percentage of individuals who have improved DLA-20 scores on a subsequent assessment after treatment will be utilized to show improvement.

Rationale:
Community Need Addressed:

- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.20 - Limited access to behavioral health services for individuals with both psychiatric issues and substance use disorders in Blanco and Llano counties

Based on the data provided in the project description, need for additional services for co-occurring psychiatric and substance use disorders is necessary in these areas. 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:

Core Components:
Through the COPSD 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 (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 COPSD 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 (DLA-20) to determine progression of individuals receiving COPSD 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.

Continuous Quality Improvement: Hill Country 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 share information such as challenges, lessons learned and considerations for safety net populations.

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 in Kerr and Gillespie counties. This individual is funded through the Texas Department of State Health Services contract which includes federal and state funds, including SAMHSA Block Grant funds. This project will expand the service beyond the two counties served in RHP 6 to the two counties served by Hill Country in RHP 8 (Llano and Blanco Counties).

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:
COPSD 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, evaluate interventions and monitor progress and 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 COPSD 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 8 by providing specialized services addressing COPSD 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).

Hill Country has several other projects in RHP 8. These include:

- 133340307.2.2 Trauma Informed Care
- 133340307.2.3 Virtual Psychiatric and Clinical Guidance
- 133340307.2.4 Whole Health Peer Support
- 133340307.2.5 Veteran Mental Health Services

Relationship to Other Performing Providers' Projects in RHP and Plan for Learning Collaborative:
Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of RHP 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 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 learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may

arise. Hill Country MHDD Centers will participate in learning collaboratives that meet at least 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 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. The valuation on this project is based on 230 consumers over the life of the project.

Hill Country MHDD 133340307.2.1 (Project 2.13.1) Category 2 Milestones and Metrics			
133340307.2.1	**2.13.1**	**2.13.1.a – 2.13.1.e**	**Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.**
Hill Country MHDD			**133340307**
Related Category 3 Outcome Measure (s):	**133340307.3.1**	**IT-10.2**	**Activities of Daily Living**

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)
Milestone 1 [P-2]: Design community-based specialized intervention for target population **<u>Metric 1</u>** [P-2.1]: Project plans which are based on evidence/ experience and which address the project goals. **Baseline/Goal**: Baseline - No intervention currently available; Goal - Submission of project plan **Data Source:** Project documentation **Milestone 1 Estimated Incentive Payment: $52,976**	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Co-occurring Psychiatric and Substance Use Disorder) **Baseline/Goal**: Baseline - 0 individuals served; Goal - 8 individuals beginning service during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $55,266**	**Milestone 3** [P-4]: Evaluate and continuously improve interventions **<u>Metric 1</u>** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/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 3 Estimated Incentive Payment: $27,919** **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted	**Milestone 5** [P-4]: Evaluate and continuously improve interventions **<u>Metric 1</u>** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/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: $28,562** **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **<u>Metric 1</u>** [I-X.1]: Number of targeted

		individuals beginning services during demonstration year (Co-occurring Psychiatric and Substance Use Disorder) **Baseline/Goal**: Baseline - 0 individuals beginning service in DY2; Goal – 10 new individuals beginning services during DY4 (for an estimated cumulative total of 18); **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $27,918**	individuals beginning services during demonstration year (Co-occurring Psychiatric and Substance Use Disorder) **Baseline/Goal**: Baseline - 0 individuals beginning service in DY2; Goal – 12 individuals beginning services during DY5 (for an estimated cumulative total of 30); **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $28,561**
Year 2 Milestone Bundle Amount: $52,976	**Year 3 Estimated Milestone Bundle Amount: $55,266**	**Year 4 Estimated Milestone Bundle Amount: $55,837**	**Year 5 Estimated Milestone Bundle Amount: $57,123**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $221,202			

Category 2 Project Narrative
Hill Country MHDD – 133340307.2.2

Project Area, Option, and 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
RHP Project Identification Number: 133340307.2.2

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Project Summary:

- **Provider Description:** Hill Country Community MHMR Center (Hill Country) 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 RHP 8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP 8 with a population of approximately 30,582 in 2012.
- **Intervention:** This project will implement Trauma Informed Care Services within the 2 counties served by Hill Country in RHP 8 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 provide trauma services through interventions such as Seeking Safety, Trust Based Relational Intervention and Cognitive Processing Therapy to help individuals deal with trauma they have experienced.
- **Project Status:** This is a new project in Blanco and Llano Counties.
- **Project Need:** Studies have shown that the majority of individuals who are incarcerated have suffered traumatic experiences and that individuals who suffer traumatic experiences are Kaiser's Adverse Childhood Experiences Study shows that individuals 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 or inappropriate emergency department (ED) use. The 2011 Department of Family and Protective Services statistics, Llano County has 18.3 confirmed cases of child abuse per 1,000 children and Blanco County has 5.4 confirmed cases of child abuse per 1,000 children. This equates to 65 confirmed cases of trauma caused by child abuse or neglect each year.
- **Target Population:** The target population is individuals within Blanco and Llano counties who have suffered trauma. This project will target a minimum of 25 individuals who have suffered trauma to the degree that the trauma is impacting their daily life. Based on the population served in Hill Country's behavioral health program in RHP 8, it is anticipated that approximately 27% of our patients in RHP 8 have Medicaid and approximately 81% have income below $15,000 per year.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide services to a minimum of 25 individuals from the 2 counties served by Hill Country in RHP 8 by the end of DY5 (number anticipated beginning service by year, 6 in DY3; 8 in DY4; and 11 in DY5).

- **Category 3 Outcomes:** IT-10.2: Activities of Daily Living (DLA-20). Our goal is to have, at a minimum, TBD% 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, inappropriate ED use and incarceration.
- **Collaboration:** TAMHSC's Pass 1 allocation was not used for this project.

Project Description:

Trauma Informed Care

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 affects their mental health. Further research indicates that many children diagnosed with Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) are actually suffering from trauma and Post-Traumatic Stress Disorder (PTSD). In the article *Diagnosis: ADHD – 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 was conducted, 93.2% 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.

In establishing the project, Hill Country will review literature and experiences regarding Trauma Informed Care to establish appropriate training for staff on the most effective interventions for trauma. Upon identifying needed training, Hill Country will recruit appropriate staff and provide targeted training for Trauma Informed services. As a means to determine the success of the interventions, a functional assessment (DLA-20) determining what impact trauma has on the individuals daily lives will be completed upon entry into the program 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 Trauma Services delivered within the program as well as by location within the program.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to establish Trauma Informed Care throughout the two counties served by Hill Country in RHP 8. 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.

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 goals of:

- Increasing coordination of prevention and care for residents, including those with behavioral and mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:

The primary challenge for implementation of the project is recruiting behavioral health staff. Hill Country will address the challenge by offering incentives as necessary.

5-Year Expected Outcome for Provider and Patients:

By the end of five years, Hill Country's goal is to have trained at least 50 individuals in Mental Health First Aid and/or Trauma Informed Care and will have established Trauma Informed Care throughout Llano and Blanco counties and provided services to at least of 25 consumers within the community over the life of the project with 20% showing improvement on Activities of Daily Living (DLA-20) assessments.

Starting Point/Baseline:
Hill Country 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 PTSD. During fiscal year 2011, Hill Country 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 (ED), potential psychiatric hospitalizations and utilization of the criminal justice system. Activities of Daily Living (DLA-20) assessments will be completed when individuals enter the program as a baseline and subsequent DLA-20s will be conducted to show progress throughout treatment.

Rationale:
Community Need Addressed:

- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.19 - Limited access to behavioral health services for individuals who have suffered trauma in Blanco and Llano counties

Based on the data provided in the project description, need for additional services for Trauma Informed Care is necessary in these areas. Hill Country will educate the community through Mental Health First Aid and Trauma Informed Care Training and identify and train clinical staff in the provision of Trauma Informed Care services such as Seeking Safety, Trust Based Relational Intervention and Cognitive Processing Therapy.

Core 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 (DLA-20) 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 (DLA-20) 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.

Continuous Quality Improvement: Hill Country 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 share information such as challenges, lessons learned and considerations for safety net populations.

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 RHP 8. 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.

Hill Country receives funding through the U.S. Department of Health and Human Services; however, none of those funds will be used for this project.

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, evaluate interventions and monitor progress and 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 RHP 8 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).

In addition, Hill Country has several projects in RHP 8. These include:

- 133340307.2.1 Co-occurring Psychiatric and Substance Use
- 133340307.2.3 Virtual Psychiatric and Clinical Guidance
- 133340307.2.4 Whole Health Peer Support
- 133340307.2.5 Veteran Mental Health Services

Relationship to Other Performing Providers' Projects in RHP and Plan for Learning Collaborative:
Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of RHP 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 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 learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Hill Country MHDD Centers will participate in learning collaboratives that meet at least

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 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. The valuation on this project is based on 25 consumers over the life of the project.

Hill Country MHDD 133340307.2.2 (Project 2.13.1) Category 2 Milestones and Metrics			
133340307.2.2	**2.13.1**	**2.13.1.a – 2.13.1.e**	**Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.**
Hill Country MHDD			**133340307**
Related Category 3 Outcome Measure (s):	**133340307.3.2**	**IT-10.2**	**Activities of Daily Living**

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)
Milestone 1 [P-2]: Design community-based specialized intervention for target population **Metric 1** [P-2.1]: Project plans which are based on evidence/ experience and which address the project goals. **Baseline/Goal**: Baseline - No intervention currently available; Goal - Submission of project plan **Data Source:** Project documentation **Milestone 1 Estimated Incentive Payment: $86,902**	**Milestone 2** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Trauma Informed Care) **Baseline/Goal**: Baseline - 0 individuals beginning services; Goal 6 individuals beginning services during DY3 **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $90,548**	**Milestone 3** [P-4]: Evaluate and continuously improve interventions **Metric 1** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/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 3 Estimated Incentive Payment: $45,791** **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during demonstration year (Trauma	**Milestone 5** [P-4]: Evaluate and continuously improve interventions **Metric 1** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/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: $46,842** **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning services during

		Informed Care) **Baseline/Goal**: Baseline - 0 individuals beginning services in DY2; Goal - 8 individuals beginning services during DY4 (Estimated cumulative total of 14). **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $45,791**	demonstration year (Trauma Informed Care) **Baseline/Goal**: Baseline - 0 individuals beginning services in DY2; Goal - 11 individuals beginning services during DY5 (Estimated cumulative total of 25). **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $46,842**
Year 2 Milestone Bundle Amount: $86,902	**Year 3 Estimated Milestone Bundle Amount: $90,548**	**Year 4 Estimated Milestone Bundle Amount: $91,582**	**Year 5 Estimated Milestone Bundle Amount: $93,684**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $362,716			

Category 2 Project Narrative
Hill Country MHDD – 133340307.2.3

Project Area, Option and Title: 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
RHP Project Identification Number: 133340307.2.3

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Project Summary

- **Provider Description:** Hill Country Community MHMR Center (Hill Country) 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 RHP 8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP 8 with a population of approximately 30,582 in 2012.
- **Intervention:** This project will implement psychiatric and clinical guidance 24 hour a day, 7 day a week for primary care physicians and hospitals within the 2 counties served by Hill Country in RHP 8 to help physicians identify and treat behavioral health symptoms earlier to avoid exacerbation of symptoms into a behavioral health crisis.
- **Project Status:** This is a new project for Blanco and Llano counties.
- **Project Need:** Both counties served by Hill Country are designated as Entire County Healthcare Provider Shortage Areas for Mental Health (http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm). 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 this area (CN.2.18).
- **Target Population:** The target population is individuals within Blanco and Llano counties who demonstrate behavioral health symptoms and seek treatment at area hospitals or with their primary care physician. Based on a 12-month mental illness prevalence of 26.2% as reported by the National Institute of Mental Health, the target population consists of approximately 7,900 individuals. Based on the population served in Hill Country's behavioral health program in RHP 8, it is anticipated that approximately 27% of patients within RHP 8 have Medicaid and approximately 81% have income below $15,000 per year.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide 400 psychiatric consultations by the end of DY5 (50 during DY3; 150 during DY4; and 200 during DY5) for the 2 counties served by Hill Country in RHP 8 and that at least 20% of primary care physicians report improved satisfaction with psychiatric consultation over the life of the project (I-9.1).
- **Category 3 Outcomes:** 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 Blanco and Llano counties as determined by DSHS' 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 Blanco and Llano counties as determined by DSHS' 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 Blanco and Llano counties as determined by DSHS' population estimates.
- **Collaboration:** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. This project will work collaboratively with all Primary Care Physicians and Hospitals within Llano and Blanco counties in order to transform the system of care by identifying behavioral health issues early and beginning treatment before symptoms exacerbate into crisis episodes.

Project Description:

Virtual Psychiatric and Clinical Guidance

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 both of the counties served by Hill Country MHDD Centers (Hill Country) 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.

In establishing the project, Hill Country will identify primary care physicians and hospitals where patients would receive the greatest benefit, determine needed telecommunication equipment based on anticipated volume of service, and recruit and hire appropriate clinical staff with the

expertise to provide remote psychiatric consultative services. After reviewing models for deployment that have been successful in other areas, Hill Country will work with primary care physicians and hospitals to determine the most appropriate method for consultative service delivery (telephonic, video, etc.) to determine needed improvements to telecommunication equipment for 24 hour a day 7 day a week consultation.

Appropriate legal and clinical expertise will be utilized to develop necessary agreements for sharing of patient information. In addition, participating primary care physicians and area hospital will be requested to complete screenings for depression substance use disorder as a means to identify individuals who would benefit from early treatment. The screening tools to be utilized include the PHQ-9 (depression screening for adults), the PHQ-A/BDI-PC (depression screenings for adolescents, and the CAGE/AUDIT (screening tools for substance use disorder). The screenings would be performed at the primary care physician's office or local hospital and the number of individuals receiving each assessment would be reported to Hill Country. All consultative services will be recorded in Hill Country's electronic database (Anasazi) within units and subunits that will keep track of the number of services performed and the location of the services.

Goals and Relationship to Regional Goals:

Goals:

The goal of this project is to provide Primary Care Providers (PCPs) and hospitals within Blanco and Llano counties with the necessary resources and guidance to adequately treat patients who present with behavioral health conditions through Psychiatric Consultation. The goal of this project is to establish Virtual Psychiatric and Clinical Guidance to PCPs and Hospitals.

This Project meets the following Regional Goal:

- Increasing coordination of prevention and care for residents, including those with behavioral health 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.

5-Year Expected Outcome for Provider and Patients:

By the end of five years, Hill Country will have an established psychiatric consultation service available for all primary care providers and hospitals within the two counties with at least eight providers enrolled and a minimum of twenty percent of PCPs 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. To demonstrate the progress of identifying behavioral health issues, Hill Country anticipates that 5% of the respective populations will have the following assessments completed:

- PHQ-A/BDI-PC for identifying depression in adolescents;
- PHQ-9 for identifying depression in adults; and

- CAGE/AUDIT for identifying substance use disorder in adults.

Starting Point/Baseline:
There are currently no dedicated resources for behavioral health consultation available to hospitals and PCPs within Blanco and Llano counties. No formal structure currently exists for PCPs and hospitals to obtain clinical guidance regarding patients presenting with behavioral health issues.

Rationale:
Community Need Addressed:
- Community Need Area: CN.2 - Limited access to mental health/behavioral health services
- Specific Community Needs:
  - CN.2.18 - Limited access to behavioral health crisis services and delayed responses to early signs of behavioral health issues in Llano County
  - CN.2.16 - Lack of behavioral health professionals in Llano and Blanco counties

Hill Country serves two counties (Blanco and Llano) within Regional Healthcare Partnership 8 (RHP 8). Both counties served by Hill Country are designated as Entire County Healthcare Provider Shortage Areas for Mental Health. 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.

According to population estimates by the Texas Department of State Health Services (DSHS), the counties served by Hill Country within RHP 8 have a total population of 30,582 in 2012. Within the two counties, there is one general hospital and thirty-two physicians with their primary practice location listed in the area. Of these thirty-two physicians, fourteen 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 two 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 PCPs 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.

Continuous Quality Improvement: Hill Country 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 share information such as challenges, lessons learned and considerations for safety net populations.

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 8.

Hill Country receives funding from the U.S. Department of Health and Human Services; however, none of the funds will be used for this project.

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 patient/individuals enrolled to receive behavioral health consultation will be divided by the 12 to 18 year population of Blanco and Llano counties as determined by DSHS' 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 Blanco and Llano counties as determined by DSHS' 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 Blanco and Llano counties as determined by DSHS' population estimates.

Reasons/rationale for selecting the outcome measure:
The screening instruments were selected as a method for PCPs to identify issues that may require virtual psychiatric consultation. The determination to track depression screenings for adults, depression screening for adolescents, and substance use disorder screening were chosen due to the prevalence of depression and substance use disorder. 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 8 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.

In addition, Hill Country has several other projects in RHP 8:

- 133340307.2.1 Co-Occurring Psychiatric and Substance Use Disorder
- 133340307.2.2 Trauma Informed Care
- 133340307.2.4 Whole Health Peer Support
- 133340307.2.5 Veteran Mental Health Services

Relationship to Other Performing Providers' Projects in RHP and Plan for Learning Collaborative:

Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of Regional Healthcare Partnership 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 and service areas do not overlap. Two of the authorities are proposing telemedicine projects: Center for Life Resources (#133339505.1.1) and Central Counties (#081771001.1.2).

Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise. Hill Country 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 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. The valuation on this project is based on an estimated 400 consultations for individual patients over the life of the project.

Hill Country MHDD 133340307.2.3 (Project 2.16.1) Category 2 Milestones and Metrics			
133340307.2.3	**2.16.1**	**2.16.1.a – 2.16.1.j**	**Design, implement, and evaluate a program to provide remote psychiatric consultative services to all participating primary care providers delivering services to patients with mental illness or substance abuse disorders**
Hill Country MHDD			**133340307**
Related Category 3 Outcome Measure (s):	**133340307.3.3** **133340307.3.4** **133340307.3.5**	**IT-12.5** **IT-12.5** **IT-12.5**	**Other USPSTF endorsed screening (PHQ-A and BDI-PC)** **Other USPSTF endorsed screening (PHQ-9)** **Other USPSTF endorsed screening (CAGE and AUDIT)**

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)
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]: Establish project plans which are based on evidence/experience and which address the project goals **Baseline/Goal:** Baseline - No intervention has been designed; Goal - Submission of project plan **Data Source:** Project documentation **Milestone 1 Estimated Incentive**	**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/Goal:** Baseline - 0 providers enrolled; Goal - Enroll at least eight care physicians as recipients of psychiatric consultative services **Data Source:** Signed enrollment agreements **Milestone 2 Estimated Incentive Payment: $78,242** **Milestone 3** [P-4]: Determine the	**Milestone 4** [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/Goal:** Baseline - 0 providers enrolled; Goal - Increase enrollment to at least twelve primary care physicians as recipients of psychiatric consultative services **Data Source:** Signed enrollment agreements **Milestone 4 Estimated Incentive Payment: $52,700** **Milestone 5** [P-5]: Evaluate and	**Milestone 7** [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/Goal:** 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 7 Estimated Incentive Payment: $80,870**

Payment*:* $150,000	impact of the project **<u>Metric 1</u>** [P-4.1]: Evaluation plan including metrics, operation and evaluation protocols **Baseline/Goal:** 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 **Milestone 3 Estimated Incentive Payment: $78,241**	continuously improve psychiatric consultative services **<u>Metric 1</u>** [P-5.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/Goal:** 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: $52,700** **Milestone 6** [I-X]: Number of patients/individuals receiving psychiatric consultation **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals receiving psychiatric consultation **Baseline/Goal**: Baseline - 0 individuals receiving psychiatric	**Milestone 8** [I-X]: Number of patients/individuals receiving psychiatric consultation **<u>Metric 1</u>** [I-X.1]: Number of targeted individuals receiving psychiatric consultation **Baseline/Goal**: Baseline - 0 individuals receiving psychiatric consultation in DY3; Goal – 200 individuals/patients receiving psychiatric consultation during DY5 **Data Source**: Hill Country MHDD records/EHR **Milestone 8 Estimated Incentive Payment: $80,869**

		consultation in DY3; Goal – 150 individuals/patients receiving psychiatric consultation during DY4; **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $52,700**	
Year 2 Milestone Bundle Amount: $150,000	**Year 3 Estimated Milestone Bundle Amount: $156,483**	**Year 4 Estimated Milestone Bundle Amount: $158,100**	**Year 5 Estimated Milestone Bundle Amount: $161,739**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $626,322			

Category 2 Project Narrative – Pass 2
Hill Country MHDD – 133340307.2.4

Title of Project Area, Option and Title: 2.18.1 Recruit, train and support consumers of mental health services to provide peer support services
RHP Project Identification Number: 133340307.2.4

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Project Summary:

- **Provider Description:** Hill Country Community MHMR Center (Hill Country) 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 RHP 8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP8 with a population of approximately 30,582 in 2012.
- **Intervention:** This project will implement Whole Health Peer Support services within the 2 counties served by Hill Country in RHP 8 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 to treat symptoms prior to the need for utilization of emergency departments (EDs) or inpatient hospitalization.
- **Project Status:** This is a new project for Blanco and Llano counties.
- **Project Need:** According to SAMHSA, 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 Blanco and Llano counties who have severe and persistent mental illness and other health risk factors. There are currently 283 individuals identified that meet target population. Based on the population served in Hill Country's behavioral health program in RHP 8, it is anticipated that approximately 27% of our behavioral health patients within RHP8 have Medicaid and approximately 81% have income below $15,000 per year.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide services to a minimum of 60 individuals from the 2 counties served by Hill Country in RHP 8 by the end of DY5 (10 in DY3; 20 in DY4 and 30 in DY5)
- **Category 3 Outcomes:** IT-10.2: Activities of Daily Living (DLA-20). Our goal is to have, at a minimum, a TBD % 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 department utilization.

- **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

Project Description:

Whole Health Peer Support

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 are supportive in nature. By expanding peer services as an integral portion of the seven mental health clinics operated by Hill Country 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 (EDs).

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.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to establish Whole Health Peer Support throughout the two counties served by Hill Country in RHP 8. The project will consist of identifying and training peers of mental health services in the delivery of Whole Health Peer Support and integrating their work into the recovery oriented treatment plan of the individual being served. The primary challenge of the project will be recruitment, training and retention of peers for implementation of Whole Health Peer Support.

This Project meets the following 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 goals of:

- Increasing coordination of prevention and care for residents, including those with behavioral and mental health needs; and
- Reducing inappropriate utilization of 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.

5-Year Expected Outcome for Provider and Patients:
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 1.0 and to have 20% of the consumers who participate in whole health peer support experiencing improvement in standardized health measures. Currently, Hill Country has 0.07 full time equivalency for peer support services at the Llano Mental Health Clinic within RHP 8.

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 has ten peer specialists with only four having certifications through the state training program. The Llano Mental Health Clinic within RHP 8 currently has 0.07 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 Llano Mental Health Clinic operated by Hill Country within RHP 8 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:
Community Need Addressed:

- Community Need Area: CN.2 – Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.22 – Limited access to whole health peer behavioral health services for individuals in Llano and Blanco counties

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 are supportive in nature. By expanding peer services as an integral portion of the Llano Mental Health Clinic operated by Hill Country 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 1.0 full time equivalency at the Llano Mental Health Clinic operated by Hill Country.

Project Components:

Through the Whole Health Peer Support, Hill Country 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 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 each of the seven mental health clinics within RHP 8 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 other 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 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 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.

Continuous Quality Improvement: Hill Country 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Hill Country 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 Llano Mental Health Clinic currently has 0.07 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 the Llano Mental Health Clinic operated by Hill Country MHDD Centers with RHP 8 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.

Hill Country receives funding from the U.S. Department of Health and Human Services; however, none of the funds will be used for this project.

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 ED services reinforces objectives for all other behavioral health services provided by Hill Country through RHP 8 (#133340307.2.1 Co-occurring Psychiatric and Substance Use Disorder, #1333340307.2.2 Trauma Informed Care, and #133340307.2.3 Virtual Psychiatric and Clinical Guidance, and #133340307.2.5 Veteran Services) by providing specialized services addressing Whole Health Peer Support for an individual that if not addressed in the community may result in needing inpatient psychiatric services or inpatient medical 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 ED utilization and potentially preventable hospital admissions (RD-1-3).

Relationship to Other Performing Providers' Projects in RHP and Plan for Learning Collaborative:
Hill Country MHDD Centers is the local mental health authority that provides services within the following counties of RHP 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 and service areas do not overlap. However, some of the projects proposed by these authorities are similar in nature. One such project (#081771001.2.1) is proposed by Central Counties, which addresses chronic diseases that result from prolonged use of psychotropic medications.

Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

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 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, resulting in an average cost of $15,573 per patient served.

Hill Country MHDD 133340307.2.4 (Project 2.18.1 - Pass 2) Category 2 Milestones and Metrics				
133340307.2.4	**2.18.1**	**2.18.1.a – 2.18.1.i**	**Design, Implement, and evaluate whole health peer support for individuals with mental health and/or substance use disorders.**	
Hill Country MHDD				**133340307**
Related Category 3 Outcome Measure (s):	**133340307.3.6**	**IT-10.2**	**Activities of Daily Living**	
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)**	
Milestone 1 [P-3]: Identify and train peer specialists to conduct whole health classes **Metric 1** [P-3.1]: Number of peers trained in whole health planning **Baseline/Goal**: 4 peers trained in whole health planning during DY2 **Data Source**: Training records **Milestone 1 Estimated Incentive Payment: $188,810**	**Milestone 2** [P-6]: Implement peer specialist services that produce person-centered wellness plans targeting individuals with specific chronic disorders or identified health risk factors **Metric 1** [P-6.2]: Number and quality of person centered wellness plans **Baseline/Goal**: Person centered wellness plans have been developed with 10 individuals **Data Source**: Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $202,824**	**Milestone 3** [P-7]: Evaluate and continuously improve peer support services **Metric 1** [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/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 3 Estimated Incentive Payment: $104,627** **Milestone 4** [I-X]: Number of individuals beginning service during demonstration year	**Milestone 5** [P-7]: Evaluate and continuously improve interventions **Metric 1** [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/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: $109,619** **Milestone 6** [I-X]: Number of individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted	

		Metric 1 [I-X.1]: Number of targeted individuals beginning services during demonstration year (Whole Health Peer Support) **Baseline/Goal**: Baseline - 10 individuals beginning service in DY3; Goal – 20 additional individuals beginning services during DY4 (for an estimated cumulative total of 30); **Data Source**: Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $104,627**	individuals beginning services during demonstration year (Whole Health Peer Support) **Baseline/Goal**: Baseline - 10 individuals beginning service in DY3; Goal – 30 additional individuals beginning services during DY5 (for an estimated cumulative total of 60); **Data Source**: Hill Country MHDD records/EHR **Milestone 6 Estimated Incentive Payment: $109,619**
Year 2 Milestone Bundle Amount: $188,810	**Year 3 Estimated Milestone Bundle Amount: $202,824**	**Year 4 Estimated Milestone Bundle Amount: $209,254**	**Year 5 Estimated Milestone Bundle Amount: $219,238**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $820,126			

Category 2 Project Narrative – Pass 2
Hill Country MHDD – 133340307.2.5

Project Area, Option and Title: 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Veteran Mental Health and Support Services
RHP Project Identification Number: 133340307.2.5

Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Project Summary:

- **Provider Description:** Hill Country Community MHMR Center (Hill Country) 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 RHP8: Blanco and Llano. Hill Country serves a 2,607 square mile area of RHP8 with a population of approximately 30,582 in 2012.
- **Intervention:** This project will implement Veteran Mental Health Services within the 2 counties served by Hill Country in RHP 8 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 and their family members to treat symptoms prior to the need for utilization of emergency departments, inpatient hospitalization or incarceration.
- **Project Status:** The project will expand Veteran Peer Support and implement community based wrap around behavioral health services for Veterans and their families within Blanco and Llano counties.
- **Project Need:** Hill Country's service area within RHP 8 has a veteran population of 4,251 and veterans seeking behavioral health services currently have to travel and take a full day off of work to receive behavioral health services (CN.2.21). Based on an average family size for Blanco and Llano counties of 2.25, the veterans and their families are a total target population base for the project of 9,564. 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 within Blanco and Llano counties who have behavioral health issues. The target population consists of the 9,564 veterans and their families in Blanco and Llano counties, 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 RHP 8, it is estimated that

approximately 27% of our behavioral health patients within RHP 8 have Medicaid and approximately 81% have income below $15,000 per year.

- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide services to a minimum of 60 veterans and/or their family members from the 2 counties served by Hill Country in RHP 8 by the end of DY5 and 20% of the veterans served show improved functional status (I-5.1) based on the Adult Needs and Strengths Assessment (ANSA). The cumulative anticipated number of veterans or their family members served by demonstration year is as follows: DY3 12; DY4 30; DY5 60. The anticipated number of individuals served is shown as an unduplicated number since services will carry over between demonstration years. The anticipated number of veterans or their family members beginning the program in each demonstration year is as follows: DY3 12; DY4 18; DY5 30.
- **Category 3 Outcomes:** IT-10.2: Activities of Daily Living (DLA-20). Our goal is to have, at a minimum, a 30% 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.
- **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

Project Description:

Veteran Mental Health Services

Studies conducted by the Veterans Administration state that nearly 20% of the suicides that occur in the U.S. are committed by veterans. According to a study of death certificates completed by the Austin American Statesman, 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. According to population estimates from the Texas Department of State Health Services (DSHS) 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 2007, Llano and Blanco Counties within Hill Country's service area has a total population of 28,807 with a veteran population of 4,251 and estimated veteran family population of 9,564, or 33.20% of the total population. During discussions with County Veteran Service Officers, 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 will acquire an additional Veteran Peer Coordinator who can actively work to recruit and train veteran peer support providers in a concentrated area such as Blanco and Llano Counties. The Veteran Coordinator acquired through this project will be committed to serving Blanco and Llano Counties and 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 will expand Veteran Peer Services and Veteran Mental Health services throughout the two county area served by Hill Country in RHP 8. 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) will identify what impact the various stressors have on the individual's daily life. The DLA-20 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.

Goals and Relationship to Regional Goals:

Project Goal:

The goal of this project is to establish Veteran Peer and Mental Health services throughout Llano and Blanco counties in order to reduce emergency department utilization, inpatient utilization, and incarceration by developing wrap around services within the community for the targeted population.

This Project meets the following 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 goals of:

- Increasing coordination of prevention and care for residents, including those with behavioral and mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:
The primary challenge for implementation of the project is recruiting licensed staff. Hill Country will address the challenge by offering incentives as necessary.

5-Year Expected Outcome for Provider and Patients:
By the end of five years, Hill Country will have established concentrated Veteran Peer and Mental Health services within Llano and Blanco Counties which will have provided services to a minimum of 60 consumers within the community over the life of the project.

Starting Point/Baseline:
Hill Country currently has two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the number of Veteran Peer Coordinators and provide a dedicated Veteran Peer Coordinator to serve Blanco and Llano Counties served by Hill Country in RHP 8 in order to recruit and train veteran peer service providers. In addition, Hill Country will increase behavioral health services in Blanco and Llano counties to meet the behavioral health needs of the veterans needing more than peer services and for their family members. The DLA-20 assessment will be performed on each individual entering the program as their baseline and the percentage of individuals who have improved DLA-20 scores on a subsequent assessment after treatment will be utilized to show improvement.

Rationale:
Community Need Addressed:

- Community Need Area: CN.2 – Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.21 – Limited access to behavioral health services for veterans in Blanco and Llano counties

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 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 to determine appropriate staffing and skill sets necessary for service provision and identify 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 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 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.

Continuous Quality Improvement: Hill Country 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Hill Country currently has two Veteran Peer Coordinators serving a 19 county, 22,000 square mile service area. This project will expand the number of Veteran Peer Coordinators and provide a dedicated Veteran Peer Coordinator to serve Blanco and Llano Counties served by Hill Country in RHP 8 in order to recruit and train veteran peer service providers. In addition, Hill Country will increase behavioral health services in Blanco and Llano counties to meet the therapy and psychiatric needs of the veterans needing more than peer services.

Hill Country receives funding from the U.S. Department of Health and Human Services; however, none of the funds will be used for this project.

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, 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 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 RHP 8 (#133340307.2.1 Co-occurring Psychiatric and Substance Use Disorder, #133340307.2.2 Trauma Informed Care, and #133340307.2.3 Virtual Psychiatric and Clinical Guidance, and #133340307.2.4 Whole Health Peer Support) by providing specialized services for veterans 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 is reduced resulting in a reduction of Emergency Department utilization and potentially preventable hospital admissions (RD-1-3).

Relationship to Other Performing Providers' Projects in RHP and Plan for Learning Collaborative:
Hill Country is the local mental health authority that provides services within the following counties of RHP 8: Blanco and Llano. The other three local mental health authorities (Bluebonnet Trails, Center for Life Resources and Central Counties) provides mental health services to the remaining counties within RHP 8 and service areas do not overlap. No other provider in RHP 8 is specifically seeking to assist veterans; however, a number of the providers are targeting specific populations. These include Central Counties Temple Day Service project (#081771001.2.3), Bluebonnet Trails ACT Team Services project (#126844305.2.3) and Bluebonnet Trails' Transitional Housing project (#126844305.2.1).

Hill Country is committed to ongoing advancement of services for the individuals we serve and is willing to participate in learning collaboratives with other providers within the region to continually improve services and data collection and to identify how to address additional needs that may arise.

Hill Country will participate in learning collaboratives that meets semi-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 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. The valuation on this project is based on 60 consumers over the life of the project.

Hill Country MHDD 133340307.2.5 (Project 2.13.1 – Pass 2) Category 2 Milestones and Metrics				
133340307.2.5	**2.13.1**	**2.13.1.a – 2.13.1.e**	**Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.**	
Hill Country MHDD				**133340307**
Related Category 3 Outcome Measure (s):	**133340307.3.7**	**IT-10.2**	**Activities of Daily Living**	
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)**	
Milestone 1 [P-2]: Design community-based specialized intervention for target population (Veteran Mental Health) **Metric 1** [P-2.1]: Project plans which are based on evidence/experience and which address the project goal. **Baseline/Goal:** Baseline - No intervention has been designed; Goal - Submission of veteran mental health project plan **Data Source**: Project documentation **Milestone 1 Estimated Incentive Payment: $142,152**	**Milestone 2** [I-X]: Number of targeted individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted individuals beginning service during demonstration year (Veteran Mental Health) **Baseline/Goal**: Baseline - 0 individuals in DY2; Goal - 12 individuals beginning services during DY3. We anticipate a slow start given where we are in DY2, but will grow over time. **Data Source:** Hill Country MHDD records/EHR **Milestone 2 Estimated Incentive Payment: $152,704**	**Milestone 3** [P-4]: Evaluate and continuously improve interventions **Metric 1** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/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 3 Estimated Incentive Payment: $78,773** **Milestone 4** [I-X]: Number of targeted individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted	**Milestone 5** [P-4]: Evaluate and continuously improve interventions **Metric 1** [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Baseline/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: $82,531** **Milestone 6** [I-X]: Number of targeted individuals beginning service during demonstration year **Metric 1** [I-X.1]: Number of targeted	

		individuals beginning service during demonstration year (Veteran Mental Health) **Baseline/Goal**: Baseline - 0 during DY2; Goal – 18 total individuals beginning services in DY4 (for an estimated cumulative total of 30). **Data Source:** Hill Country MHDD records/EHR **Milestone 4 Estimated Incentive Payment: $78,772**	individuals beginning service during demonstration year (Veteran Mental Health) **Baseline/Goal**: Baseline - 0 during DY2; Goal – 30 individuals beginning services in DY5 (for an estimated cumulative total of 60). **Data Source:** Hill Country MHDD records/EHR **Milestone 8 Estimated Incentive Payment: $82,531**
Year 2 Milestone Bundle Amount: $142,152	**Year 3 Estimated Milestone Bundle Amount: $152,704**	**Year 4 Estimated Milestone Bundle Amount: $157,545**	**Year 5 Estimated Milestone Bundle Amount: $165,062**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $617,463			

Category 2 Project Narrative
Scott & White Hospital – Llano – 020840701.2.1
(formerly Llano Memorial Hospital)

Project Area, Option and Title: 2.8.1. Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency
RHP Project Identification Number: 020840701.2.1

Performing Provider Name: Scott & White Hospital—Llano
Performing Provider TPI #: 020840701 (New TPI: 220798701)

Project Summary:

- **Provider Description:** Scott & White Hospital – Llano is a 30-bed hospital in Llano, TX, serving a 934 square mile area and a population of approximately 19,301. It is part of Scott & White Healthcare, a large integrated system in Central Texas.
- **Intervention:** This project will apply continuous process improvement strategies, guided by the Institute for Healthcare Improvement (IHI) Model, to identify causes of avoidable Emergency Medical System (EMS) and Emergency Department (ED) utilization, prioritize potential solutions, and launch PDSA cycles on chosen improvements.
- **Project Status:** This is a new project. At the start of this project, no team is dedicated to reducing avoidable EMS and ED visits at the hospital.
- **Project Need:** Llano County and the hospital identified a need for increased capacity in EMS services in the county. The group chose to work on rapid process improvement to improve the appropriate utilization of EMS and associated ED visits to address this need. This project addresses the following community need: CN.1.5 - Limited access to emergent care and limited awareness of which levels of care are appropriate for different health needs places undue burden on the Emergency Department and Emergency Medical System in Llano County.
- **Target Population:** The target population within Llano County will be determined in DY2. A review of ED and EMS revenue and volume reports indicate 7,005 ED visits were completed in FY 2012; 1,981 EMS transports occurred. Approximately 16% of ED visits and 9% EMS transports were for Medicaid, uninsured and/or indigent populations. We expect to impact the majority of persons using EMS transport who are also Medicaid beneficiaries, uninsured patients and indigent care program members with process changes to improve the appropriateness of utilization for this group. Process changes introduced by the project will reach a cumulative total of 400 individuals in DY2-5, including 150 in DY4 and 200 in DY5. While some will necessarily still utilize EMS and ED services, the process improvement work should improve decision-making and utilization choices for the full population considering use of EMS services.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project is designed to improve the appropriateness of EMS service utilization and the resulting ED utilization that comes from EMS utilization. Process improvements will work to better address unmet needs leading to inappropriate EMS and ED utilization for County residents (Improvement

Milestone I-13.1). Reducing inappropriate ED visits will help maintain timely and effective use of EMS and ED services for patients experiencing a true emergency.

- **Category 3 Outcomes:** IT-9.2: Our goal is to reduce all-cause ED visits by 6% over baseline by the end of DY4 and 10% over baseline by the end of DY5. Although baseline rates have not yet been established, we estimate (based on historical data) that a 6% reduction will translate to approximately 420 fewer ED visits in DY4 (compared to baseline) and a 10% reduction will translate to approximately 700 fewer ED visits in DY5 (compared to baseline).

Project Description:

Continuous Rapid Process Improvement for Emergent Services

This project will apply continuous process improvement strategies, guided by the Institute for Healthcare Improvement (IHI) Model, to identify causes of avoidable Emergency Medical System (EMS) and Emergency Department (ED) utilization, prioritize potential solutions, and launch Plan, Do, Study, Act (PDSA) cycles to implement iterations of chosen improvements. The core project components include:

a) *Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.* Staff members and other stakeholders on our quality improvement team will be trained in the IHI Model to establish common language and basic competency for group participation. Teams will be facilitated by system personnel trained and experienced in quality improvement, implementation and evaluation methodology.

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.* Solicitation of employee suggestions will be systematic and purposeful. It will be important to capture the suggestions of EMS personnel in particular. Quality improvement teams will be made up of local champions for change and staff members involved in key process steps (as identified by process mapping exercises). Informal discussions, surveys, and existing employee or patient feedback mechanisms will be utilized as appropriate to the teams' work.

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).* Frequency of data feedback to the quality improvement team(s) and broader audiences will be determined by the nature of changes tested—some will require more frequent feedback than others. In all cases, we intend to measure for improvement *and* for unintended consequences (e.g., adding unintended barriers to care, adding unnecessary steps to processes) of all changes. A project manager will be responsible for documenting key actions in our PDSA cycles and collating data gathered to test each change. The nature of those data will depend on the change being tested. Data on the improvement target of ED utilization can be extracted from the hospital's billing data. Data on volume of EMS calls will come from the EMS records, the format and frequency of which needs to be determined by teams to match their planned PDSA cycles.

d) *Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.*

Implementation guides will be customized to each process improvement iteration, as appropriate.

e) *Implement software to integrate workflows and provide real-time performance feedback*. Software will be integrated only if determined to be necessary for process improvement but not for the sake of adding software alone.

f) Evaluate the impact of the process improvement programs and assess opportunities to expand, refine, or change processes based on the results of key performance indicators. Key performance indicators must be selected for each test of change. This will largely be indicators of implementation—for example, number of people reached with the change, and potential unintended impacts of the change.

Goals and Relationship to Regional Goals:
The primary goals of this project are to reduce inappropriate utilization of EMS and reduce inappropriate utilization of ED services such that those services are more readily available for responding to emergencies and transferring patients to higher levels of care outside the county quickly when needed. Our goal is to reduce inappropriate utilization of these specific services. This fits within the regional goal of reducing inappropriate service utilization is a regional goal.

Project Goals:

- Reduce avoidable utilization of EMS services (e.g., for conditions that are not urgent); and
- Decrease ED utilization by reducing use of the ED for concerns that do not require urgent or emergency services.

This Project meets the following Regional Goal:

- Reducing inappropriate utilization of services.

Challenges:
We expect our biggest challenge to be collaboration across stakeholder groups. While appropriate utilization of services is a shared goal, definitions of current problems and ideas for how to address those problems are likely to differ across groups. These differences are essential for choosing effective changes that can be sustained long-term, but differences also require effective and mutually-respectful strategies for collaboration. The team's work will be facilitated by someone from Scott & White Healthcare's System Quality & Safety team. This person is trained and experienced in facilitating the QI process and will use facilitation strategies designed to engender trust and foster effective communication across stakeholder groups.

5-Year Expected Outcome for Provider and Patients:
In five years, we expect to increase the availability of EMS services for timely patient transfers out of the County for higher levels of service when necessary because community members' needs will be met in more appropriate ways that do not require EMS transfer to the ED. We also expect increased capacity in the ED because of a reduction in visits for conditions that are not urgent or do not require emergency care. Reduction in inappropriate ED use should represent a shift in the community's ability to meet individuals' needs at the right place and right time.

Starting Point/Baseline:
Baseline will be established in DY2 after the quality improvement team specifies the program targets and project-specific metrics.

Rationale:
Community Need Addressed:
- Community Need Area: CN.1 - Limited access to primary care
- Specific Community Need: CN.1.5 - Limited access to emergent care and limited awareness of which levels of care are appropriate for different health needs places undue burden on the Emergency Department and Emergency Medical System in Llano County.

The project will address RHP 8 community need listed above.

At the start of this project, no team is dedicated to reducing avoidable EMS and ED visits at the hospital. Locally, there is a belief that additional ambulance services would be useful for helping alleviate burdens on existing EMS teams, especially when transfers to sites of care out of the county require significant time for one or more teams at a time. Rather than adding capacity, the Performing Provider and Llano County have agreed to partner to try to reduce avoidable EMS utilization, freeing up existing EMS crews for out-of-county transfers and reducing avoidable ED utilization.

We selected continuous, rapid cycle improvement processes to address the problem because no solution is obvious. The iterative work of stakeholders will be required to identify key leverage points and launch tests of change to address the problem. All required project components will be employed (see Core Components in "Project Description"). The milestones chosen represent key steps in the Model for Improvement, the model to be deployed by the team. Before launching our first test of change, we need to identify the target metrics that would indicate a change is an improvement (P-2). We then need to identify current processes and generate a list of potential changes to those processes that may lead to improvement. Once that list is generated, the team can prioritize the potential changes and select at least one to launch [P-1] [P-1.1]. This pre-work is planned for DY2. Completion of the pre-work will position the team to launch its first test of change (PDSA cycle) in DY3 [P-7]. Consistent with the Model for Improvement, the first test of change will lead to iterations of tests of change, informed by data gathered during PDSA cycles and by the pre-work in DY2. We expect that iterations of test of change should have impact on the chosen metrics by DY4 and increasing impact by DY 5 [I-13] [I-13.1]. Progress toward the targeted process-related metrics should be an indicator of progress toward achieving our Category 3 Outcome Measure—IT-9.2 Right Care, Right Setting/ED Appropriate Utilization, the indicator of impact on the community need for reduced inappropriate ED utilization.

How the project represents a new initiative or significantly enhances an existing delivery reform initiative: The project does not overlap with other initiatives funded by the U.S. Department of Health and Human Services.

Related Category 3 Outcome Measure(s):
- OD-9 Right Care, Right Setting

- IT-9.2 ED Appropriate Utilization

The project is designed to improve the appropriateness of EMS service utilization and the resulting ED utilization that comes from EMS utilization. Appropriate ED utilization is a priority because we need to maintain timely, effective ED services for individuals with urgent or emergency conditions but want to reduce use of EMS and ED services for other types of concerns. Doing so should free-up EMS and ED provider time for meeting the needs each service was designed to address. The measure was chosen because it directly reflects the project goals, described above. We will meet our improvement targets by launching iterative rapid process improvement initiatives and monitoring their impact on our targets. Ineffective changes will be dropped or adjusted to better impact our targets.

Relationship to Other Projects:
The proposed Pass 2 project (#020840701.2.2 and #020840701.3.2) at Scott & White Hospital—Llano will also use rapid cycle improvement cycles to address the related problem of ED utilization as part of behavioral health transports. Both projects will follow the Model for Improvement and some of the same stakeholders will be represented on both projects. Depending on target populations selected by the teams and identified potential tests of changes, there may be opportunities to leverage the two improvement initiatives to more broadly address utilization of ED and transport services by serving the underlying community needs proactively.

The project is also related to our Category 4 for project #020840701.2.1 in that it has the potential to reduce potentially avoidable hospital admissions following ED visits for the same conditions even though hospital admissions are not the target of the project. As of November 1, ED utilization is not a listed metric for Category 4; this project is not expected to impact time to transfer in the ED.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaboratives:
This project is related to the Category 2 project (#137249208.2.1, #137249208.3.1, and #137249208.3.2) submitted by Scott & White Memorial Hospital for a patient navigator program in Bell County with one of its goals also being reduction of inappropriate ED utilization. The strategies in the two counties will be different, but each was selected in collaboration with the IGT partners and each is expected to best meet the local needs of residents in ways that reduce need or perceived need for ED services. This project is also related to a patient navigation project (#126936702.2.1 and #126936702.3.6) proposed by Williamson County and Cities Health Department.

Scott & White Memorial Hospital will participate in a RHP 8 learning collaborative that meets semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects.

Project Valuation:
The scope of this project was determined by the availability of funds from IGT entities to serve the residents of Llano County, who used local EMS services for 1,981 transports from Sept 2011 through August 2012. By the end of DY5, the process changes introduced through this project

will reach at least 400 individuals in the target population in Llano County (Cat 2 Milestones 4 and 5). The value is the sum of a) direct costs of program implementation, measurement, and management to affect at least the processes for Medicaid beneficiaries, charity care program members, and indigent care program members (approximately 178 transports/year), and b) indirect costs of participation in this waiver and of administering the program (e.g., hiring, communication, offices, personnel management, and information technology). Because data collection and reporting is inextricably tied to process improvement, the project valuation was done across all four categories and four years then divided by 4 to estimate the per-year value or divided by the minimum required percent allocation to each category to estimate the per-category value.

When all activities are considered, the average per-year direct program cost is expected to be $252,212. This value includes a process improvement "allowance" for the quality improvement team of $24,948 per year to implement selected changes.

An indirect cost of 19% was applied to average annual direct program costs to account for cost of communication, printing, personnel time for meeting, and other incidental costs of gathering the quality improvement team and conducting program activities. Estimated per-year indirect costs are $40,269.

Scott & White Llano Memorial Hospital 020840701.2.1 (Project 2.2.1) Category 2 Milestones and Metrics			
020840701.2.1	**2.8.1.**	**2.8.1a; 2.8.1b; 2.8.1c; 2.8.1d; 2.8.1e; 2.8.1f**	**Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality and efficiency**
Scott & White Llano Memorial Hospital			**020840701**
Related Category 3 Outcome Measure (s):	**020840701.3.1**	**IT-9.2**	**IT-9.2: ED Appropriate Utilization**

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)
Milestone 1 [P-1]: Target specific workflows, processes and/or clinical areas to improve **Metric 1** [P-1.1]: Performing Provider review and prioritization of areas or processes to improve upon. a. Submission of Performing Provider report **Baseline/Goal:** Baseline - No process has been selected; Goal - Select one process to either initiate (i.e., new) or change (i.e., existing) from among the possible process changes identified by the quality improvement team **Data Source:** QI team meeting notes, report **Milestone 1 Estimated Incentive Payment: $84,509** **Milestone 2** [P-2]: Identify/target	**Milestone 3** [P-7]: Implement a rapid improvement project using a proven methodology (the IHI Model) for Improvement **Metric 1** [P-7.1]: Rapid improvement cycle Documentation that all of the steps included in the cycle methodology were performed: e.g. (1) Standardized an operation; (2) Measured the standardized operation (cycle time and amount of in-process inventory); (3) Gauged measurements against requirements; (4) Innovated to meet requirements and increase productivity; (5) Standardized the new, improved operations; (6) Continued the cycle **Baseline/Goal:** Baseline - 0 enrollees; Goal - Serve a minimum of 150 unique patients with at least one contact	**Milestone 4** [I-X]: Increase the total number of individuals in target population reached with process improvements. **Metric 1** [I-X.1]: Reach a cumulative total of 200 individuals with education or services related to the selected process changes. **Baseline/Goal:** Baseline - 0 individuals; Goal - Reach 150 individuals in DY4. **Data Source:** Program records, EMS records **Milestone 4 Estimated Incentive Payment: $202,500**	**Milestone 5** [I-X]: Increase the total number of individuals in target population reached with process improvements. **Metric 1** [I-X.1]: Reach a cumulative total of 400 individuals (DYs 2-5) with education or services related to the selected process changes. **Baseline/Goal:** Baseline - 0 individuals; Goal: Reach 200 individuals in DY5 (Cumulative total DY2-5 will be approximately 400) **Data Source:** Program records, EMS records **Milestone 5 Estimated Incentive Payment: $153,900**

metric to measure impact of process improvement methodology and establish baseline **Metric 1** [P-2.1]: Performing Provider identification of impact metrics and baseline. Submission of Performing Provider report **Baseline/Goal:** Baseline - No metrics have been selected at baseline; Goal - Select at least one metric of improvement and one of potential unintended negative consequences of changes to be implemented (e.g., adding unnecessary time, reducing access) **Data Source:** QI team meeting notes, report **Milestone 2 Estimated Incentive Payment**: **$84,509**	**Data Source:** Documentation of rapid improvement project such as notes from QI team meetings, attendance sheets, data evaluating initial implementation/impact, final report out. Or documentation of materials produced by the improvement event such as new standard workflows. **Milestone 3 Estimated Incentive Payment**: **$216,000**		
Year 2 Estimated Milestone Bundle Amount: $169,018	**Year 3 Estimated Milestone Bundle Amount: $216,000**	**Year 4 Estimated Milestone Bundle Amount: $202,500**	**Year 5 Estimated Milestone Bundle Amount: $153,900**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $741,418			

Category 2 Project Narrative – Pass 2
Scott & White Hospital – Llano – 020840701.2.2
(formerly Llano Memorial Hospital)

Project Area, Option and Title: 2.8.1. Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency
RHP Project Identification Number: 020840701.2.2

Performing Provider Name: Scott & White Hospital--Llano
Performing Provider TPI #: 020840701 (New TPI: 220798701)

Project Summary:

- **Provider Description:** Scott & White Hospital – Llano is a 30-bed hospital in Llano, TX, serving a 934 square mile area and a population of approximately 19,301. The hospital is part of Scott & White Healthcare, a large integrated system in Central Texas.
- **Intervention:** This project will apply continuous process improvement strategies, guided by the Institute for Healthcare Improvement (IHI) Model for Improvement, to identify causes of avoidable Sheriff Department Transport of behavioral health patients in crisis, prioritize potential solutions, and launch Plan, Do, Study, Act (PDSA) cycles on chosen improvements.
- **Project Status:** The project represents a new activity in the County and does not overlap with other U.S. Department of Health and Human Services initiatives.
- **Project Need:** The County identified the need for this project because the Sheriff's Department is conducting multiple transfers each month to an out-of-county facility for persons who are a danger to themselves or others due to behavioral health challenges. These transfers represent potentially avoidable costs for the county, emergency department (ED) visits to determine safety for transport, and disruption of families and individuals. This project addresses the following Community Need: CN.2.18 – Limited access to behavioral health crisis services and delayed responses to early signs of behavioral health issues in Llano County.
- **Target Population:** The target subpopulation of persons with behavioral health needs who are at risk of being a danger to themselves or others because of their condition will be determined in DY2 of the project. This target population must be broad enough to reach individuals at risk for sheriff transports. Currently, the approximate number of sheriff transports is 60 per year; an estimated 16% of this population (10 individuals per year) is uninsured or are beneficiaries of Medicaid or the Llano County Indigent Care Program. We expect process changes to reach 100 individuals in DY4 and 150 in DY5, for a cumulative total of 300 individuals in DYs 2-5. This estimate will be adjusted based on DY2 planning work and individual process changes selected.
- **Category 1 or 2 Expected Project Benefit for Patients:** At the end of the five-year demonstration, we expect to have developed new processes in Llano County for connecting individuals and families to behavioral health resources that will reduce the number of crises they experience, thereby reducing the need for forced transfers of individuals to behavioral health care by the Sheriff's Department (Improvement Milestone

I-13.1). We also expect that this reduction of behavioral health crises will reduce avoidable ED visits.

- **Category 3 Outcomes:** IT-9.2: Our goal is to reduce ED visits by 3% over baseline in DY4 (approximately 34 ED visits averted in DY4) and 5% over baseline in DY5 (approximately 56 ED visits averted in DY5).

Project Description:

Partnership to Reduce Avoidable Sheriff Deputy Transport of Persons with Behavioral Health Needs in Llano County

This project will apply continuous process improvement strategies, guided by the Institute for Healthcare Improvement (IHI) Model for Improvement, to identify causes of avoidable Sheriff Department Transport of behavioral health patients in crisis, prioritize potential solutions, and launch Plan, Do, Study, Act (PDSA) cycles to implement iterations of chosen improvements. A trained quality improvement team facilitator from Scott & White's System Quality & Safety division will guide a team of community stakeholders through the model to a) identify the problem, b) define metrics of desired change (if any are needed in addition to those outlined in Categories 2 and 3), and c) describe potential changes that may lead to improvement. The team will prioritize these potential changes then launch iterative tests of change to move the community toward reduction of behavioral health transports and related Emergency Department (ED) visits. Initial stakeholders will include representatives Scott & White Hospital—Llano (e.g., ED, mental health), Llano County government (IGT), and Llano County Sheriff's department. The group will identify additional stakeholders based on their knowledge of the community and scope of identified changes to be tested. These may include, for example, community members with experience in behavioral health, other community-based community health providers, and organizations with whom families of persons with behavioral health needs may have contact (e.g., churches, workplaces). For each test of change, the group will plan the launch of the change for a specified period. They will measure, with the assistance of a project manager as needed, both implementation and impact of each change. They will use data on both to review progress and plan future PDSA cycles.

Goals and Relationship to Regional Goals:

The primary goals of this project are to reduce inappropriate utilization of EMS and reduce inappropriate utilization of ED services by identifying and addressing behavioral health needs before crises occur that require Sheriff Department deputies to forcibly transfer individuals to behavioral health facilities. These transfers require medical clearance through EDs, usually the Performing Provider ED. Our goal to reduce inappropriate utilization of these specific services fits within the regional goal of reducing inappropriate service utilization.

Project Goal:

- Decrease ED utilization by reducing Sheriff Department transfers of individuals to behavioral health facilities.

This Project meets the following Regional Goal:

- Reducing inappropriate utilization of services.

Challenges:
The two strongest anticipated challenges are a) facilitating the team's systematic use of the Model for Improvement, and b) fidelity of implementation of tests of change. Stakeholders will vary dramatically in their experience with quality improvement and may find group work around problem definition and brainstorming possible solutions to be unlike their usual processes. We will mitigate this challenge by setting expectations for use of the model in team meetings and utilizing a trained facilitator who works for Scott & White Healthcare but on a different campus. Using an outside facilitator will allow the model to come from an outside source and allow the team leader (local to Llano County) to avoid the perception of trying to influence the team's work by facilitating toward a particular solution. We have also chosen metrics that will require systematic work by the team. For the second challenge, the team will include measures of implementation in its iterative tests of change. For example, they may choose to audit the degree to which new protocols are being fully implemented or the number of personnel using new processes. Information on implementation will help the team design new iterations of process change with both our Category 3 outcomes and full implementation as goals.

5-Year Expected Outcome for Provider and Patients:
At the end of the five-year demonstration, we expect to have developed new processes in Llano County for connecting individuals and families to behavioral health resources that will reduce the need for forced transfers of individuals to behavioral health care by the Sheriff's Department. We also expect that this reduction of behavioral health crises will reduce avoidable ED visits.

Starting Point/Baseline:
Baseline will be established in DY2 after the quality improvement team specifies the program targets.

Rationale:
<u>Community Need Addressed</u>:
- Community Need Area: CN.2 – Limited access to mental health/behavioral health services
- Specific Community Need: CN.2.18 – Limited access to behavioral health crisis services and delayed responses to early signs of behavioral health issues in Llano County.

<u>Project Components:</u>
The core project components include:
a) *Provide training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture.* Staff members and other stakeholders on our quality improvement team will be trained in the Model of Improvement to establish common language and basic competency for group participation. Teams will be facilitated by Scott & White system personnel trained and experienced in quality improvement, implementation and evaluation methodology.
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.* Solicitation of employee suggestions will

be systematic and purposeful. It will be important to capture the suggestions of deputies who carry out transfers, ED personnel who conduct exams to provide health clearance for transports, and hospital/clinic personnel who care for persons with poorly controlled behavioral health symptoms. Quality improvement teams will be made up of local champions for change and staff members involved in key process steps (as identified by process mapping exercises). Informal discussions, surveys, and existing feedback mechanisms will be utilized as appropriate to the teams' work.

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).* Frequency of data feedback to the quality improvement team(s) and broader audiences will be determined by the nature of changes tested—some will require more frequent feedback than others. In all cases, we intend to measure for improvement and for unintended consequences (e.g., adding unintended barriers to care, adding unnecessary steps to processes) of all changes.

d) *Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement.* Implementation guides will be customized to each process improvement iteration.

e) *Implement software to integrate workflows and provide real-time performance feedback.* Software will be integrated only if determined to be necessary for process improvement but not for the sake of adding software alone.

f) *Evaluate the impact of the process improvement programs and assess opportunities to expand, refine, or change processes based on the results of key performance indicators.* Beyond the indicators of Sheriff Department transfers to behavioral health and ED visits, key performance indicators must be selected for each test of change. This will largely be indicators of implementation—for example, number of people reached with the change, and potential unintended impacts of the change.

At the start of this project, the Sheriff's Department in Llano County is carrying out multiple transfers to an out-of-county facility each month for persons who are a danger to themselves or others due to behavioral health challenges. These transfers represent potentially avoidable costs for the county, ED visits to determine safety for transport, and disruption of families and individuals. Partners on this project believe these transfers could be avoided in many cases by addressing the needs of behavioral health patients before crises occur. Doing so would reduce burden on the Sheriff's Department, reduce ED visits (including those required as part of protocols for these transfers), and improve care for behavioral health needs. The solution to the problem is not obvious. By conducting collaborative process improvement work with stakeholders, we will have the opportunity to conduct rapid tests of change to find better ways to meet the needs of behavioral health patients before crises occur.

<u>How the project represents a new initiative or significantly enhances an existing delivery reform initiative</u>: The project does not overlap with other Scott & White Healthcare initiatives funded by the U.S. Department of Health and Human Services, none of which include inpatient services in Llano County.

Related Category 3 Outcome Measure(s):
Selected Category 3 measures include:

- OD-9 Right Care, Right Setting
  - IT-9.2 ED Appropriate Utilization

ED appropriate utilization was chosen because County stakeholders have indicated that a) some portion of behavioral health transfers are avoidable, possibly with improved access to services before challenges become crises, and b) all such transfers require ED visits for medical clearance of individuals for transfer to behavioral health settings.

Relationship to Other Projects:
This project is related to the Pass 1 Category 2 project (#020840701.2.1) submitted by Scott & White Hospital – Llano to undertake continuous quality improvement to address appropriate utilization of EMS services and associated ED utilization in the same County. Efforts on these two projects will be coordinated to leverage the work of teams in ways that makes work on both projects more efficient. For example, we may be able to coordinate solicitation of input from personnel and other stakeholders regarding these two problems in the County. The processes targeted for improvement will be different, but the processes for conducting rapid-cycle improvements will be the same—both are based on the IHI Model for Improvement.

The project is also related to our Pass 2 Category 4 project in that hospital-level reporting will be conducted; however, ED utilization is not among the measures currently included in Category 4.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaboratives:
This project is related to the Category 2 project (#137249208.2.1, #137249208.3.1, and #137249208.3.2) submitted by Scott & White Memorial Hospital for a patient navigator program in Bell County with one of its goals also being reduction of inappropriate ED utilization. The strategies in the two counties will be different, but each was selected in collaboration with the IGT partners and each is expected to best meet the local needs of residents in ways that reduce need or perceived need for ED services. This project is also related to two projects proposed by Williamson County and Cities Health Department. One is for a patient navigation project (#126936702.2.1 and #126936702.3.6). The other is a paramedicine project (#126936702.1.2). Bluebonnet Trails is also proposing an Emergency Services Diversion project (#126844305.2.2). There are several local mental health authorities proposing projects to reduce the number of behavioral health clients from jails.

Scott & White Hospital - Llano will participate in a RHP 8 learning collaborative that meets semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects.

Project Valuation:
The scope of this project was determined by the availability of funds from IGT entity and the available allotments in Pass 1 and 2, the known history of approximately 60 transports per year in the County, and the estimated need to touch 300 individuals in DY2-5 (100 in DY4, 150 in DY5) with process changes in order to reduce transports and related ED visits. The value is the sum of a) direct posts of program implementation, measurement, and management and b) indirect costs of participation in this waiver and of administering the program (e.g., hiring,

communication, offices, personnel management, and information technology). Because data collection and reporting is inextricably tied to process improvement, the project valuation was done across all four categories and four years then divided by 4 to estimate the per-year value or divided by the minimum required percent allocation to each category to estimate the per-category value.

When all activities are considered, the average per-year direct program cost is expected to be $98,901. This value includes a process improvement "allowance" for the quality improvement team of $59,555 per year to implement selected changes.

An indirect cost of 19% was applied to average annual direct program costs to account for cost of communication, printing, personnel time for meeting, and other incidental costs of gathering the quality improvement team and conducting program activities. Estimated per-year indirect cost is $18,791.

Scott & White Hospital - Llano - 020840701.2.2 (Project 2.8.1 – Pass 2) Category 2 Milestones and Metrics			
020840701.2.2	**2.8.1**	**2.8.1a; 2.8.1b; 2.8.1c; 2.8.1d; 2.8.1e; 2.8.1f**	**Design, develop and implement a program of continuous, rapid process improvement that will address issues of safety, quality and efficiency**
Scott & White Llano Memorial Hospital			**020840701**
Related Category 3 Outcome Measure:	**020840701.3.2**	**IT-9.2**	**IT-9.2: ED Appropriate Utilization**

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)
Milestone 1 [P-2]: Identify/target metric to measure impact of process improvement methodology and establish baseline **Metric 1** [P-2.1]: Performing Provider identification of impact metrics and baseline. Submission of Performing Provider report **Baseline/Goal:** Baseline - No metrics have been selected; Goal - Select at least one metric of improvement and one of potential unintended negative consequences of changes to be implemented (e.g., adding unnecessary time, reducing access) **Data Source:** QI team meeting notes, report **Milestone 1 Estimated Incentive Payment: $11,688**	**Milestone 2** [P-7]: Implement a rapid improvement project using a proven methodology (the IHI Model) for Improvement **Metric 1** [P-7.1]: Rapid improvement cycle **Baseline/Goal:** Baseline – 0; Goal - Complete at least one PDSA cycle **Data Source:** Documentation of rapid improvement project such as notes from QI team meetings, attendance sheets, data evaluating initial implementation/impact, final report out. Or documentation of materials produced by the improvement event such as new standard workflows. **Milestone 2 Estimated Incentive Payment: $121,747**	**Milestone 3** [I-X]: Increase the total number of individuals in target population reached with process improvements. **Metric 1** [I-X.1]: Reach a cumulative total of 200 individuals with education or services related to the selected process changes. **Baseline/Goal:** Baseline - 0 individuals; Goal - Reach 100 individuals in DY4 (cumulative total of 150 DY2-4. **Data Source**: Sherriff Department records, ED records, project files (e.g., metrics established for project) **Milestone 3 Estimated Incentive Payment**: **$112,410**	**Milestone 4** [I-X]: Increase the total number of individuals in target population reached with process improvements. **Metric 1** [I-X.1]: Reach a cumulative total of 300 individuals with education or services related to the selected process changes. **Baseline/Goal:** Baseline - 0 individuals; Goal - Reach 150 individuals in DY5 (cumulative total of 300 DY2-5). **Data Source**: Sherriff Department records, ED records, project files (e.g., metrics established for project) **Milestone 4 Estimated Incentive Payment**: **$85,432**

Year 2 Milestone Bundle Amount: $11,688	Year 3 Estimated Milestone Bundle Amount: $121,747	Year 4 Estimated Milestone Bundle Amount: $112,410	Year 5 Estimated Milestone Bundle Amount: $85,432
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $331,277			

Category 2 Project Narrative
Scott & White Memorial Hospital – 137249208.2.1

Project Area, Option, and Title: 2.9.1 Patient Navigation and Chronic Illness Support for Patients with Limited Resources
RHP Project Identification Number: 137249208.2.1

Performing Provider Name: Scott & White Memorial Hospital
Performing Provider TPI #: 137249208

Project Summary:

- **Provider Description:** Scott & White Memorial Hospital (SWMH) is a 636-bed hospital in Temple, TX, and the only Level 1 Trauma Center between Dallas and Austin. SWMH serves a 29,000 square mile area and a population of approximately 3 million people. The hospital is part of Scott & White Healthcare, a large integrated system in Texas.
- **Intervention:** This project will provide patient navigation and selected chronic illness supports for a target group of patients who are members/beneficiaries of the Bell County Indigent Care Program, Medicaid, and/or participating hospitals' charity care programs. Project components include patient navigators, chronic disease self-management workshops, additional mental health practitioners at a free clinic, and an improved network of coordinated support for program participants.
- **Project Status:** This is a new initiative for all partners, including Scott & White Healthcare.
- **Project Need:** The impetus for this project was stakeholders' call for improved supports for low income patients that would ultimately reduce unnecessary utilization of high cost ED and hospital services. The project addresses three main areas: 1) inappropriate utilization of the ED; 2) substantial resources consumed by potentially preventable hospitalizations; 3) fragmentation of the health care system; difficulty navigating services. This project ties to the following community need: CN.1.4 - Limited access to primary health care for indigent and uninsured populations in Burnet County.
- **Target Population:** In DY2, the team will select a subpopulation for which patient navigation services will be available from among the estimated 20,000+ Bell County population of Medicaid beneficiaries and members of indigent care or charity care programs. Subpopulation selection will be based on risk for potentially avoidable ED and hospital utilization and will capture approximately 6% of the target population to allow manageable caseloads for patient navigators. The project will deliver at least one patient navigator service (e.g., screening, chronic illness self-management workshop, mental health appointment, referrals) to 2,400 individuals across all project years. In DY4, 1,000 will be served. In DY5, 1,200 will be served.
- **Category 2 Expected Project Benefit for Patients:** Patient navigation and the planned increase in capacity for self-management education and mental health services will connect individuals in the patient navigator program to the right care and right community resources to meet their needs. In DYs 2-5 the program is expected to provide at least one type of service (e.g., screening, workshops, referrals) to 2,400 individuals. The program will

help participants meet a variety of types of needs affecting their health by connecting them to available resources. Improved connections with community and health service combined with improved self-management ability are expected to reduce utilization of ED services for concerns that can be more appropriately addressed in other settings (e.g., primary care). It is also expected to reduce exacerbation of health conditions sensitive to outpatient care and self-care.

- **Category 3 Outcomes:** Our goals are to:
  - IT-9.2: Reduce ED utilization among program members by at least 5% by end of DY4 and 15% by end of DY5, and
  - IT-2.11: Reduce ambulatory care sensitive condition hospitalizations by at least 5% over baseline by end of DY4 and 15% over baseline by the end of DY5.

Project Description:

Patient Navigation

This project will provide patient navigation and selected chronic illness supports for a target group among those with financial limitations, including those on the Bell County Indigent Care Program, Medicaid, and/or participating hospitals' charity care programs. The specific target audience will be chosen part of DY2 activities (Milestone P-1). Core program components will be launched before or during DY3 (Milestone 3: P-2) and will include 1) patient navigators embedded at Bell County Indigent Care Program office and at three hospitals in the county, 2) Chronic Disease-Self Management Program (Lorig/Stanford model) workshops for program participants, 3) mental health practitioners added at one free clinic to increase accessibility of services for participants with chronic mental health needs, and 4) shared protocols and communication across sites and program components to maintain a network of coordinated support for program participants.

Scott & White Memorial Hospital, the performing provider, will subcontract with Bell County Indigent Care Program, Cedar Crest Hospital & RTC, Metroplex Health System, and the Central Texas Area Agency on Aging (AAA) for the cost of embedded services at those sites and for chronic disease self-management workshops. Cedar Crest Hospital and Metroplex Hospital will also receive funds through subcontracts for .5FTE psychiatric nurse practitioner and .5FTE Licensed Clinical Social Worker or other qualified therapist to deliver care for program participants (and other patients at local free clinics if capacity allows). The team, led by a Patient Navigator Manager, will collaborate to determine the target population, develop patient navigation protocols, and create protocols for referrals and cross-site communication. Ongoing iterations of protocols are expected as the partners recognize and respond to challenges.

The anticipated long-term outcomes of this program are a) improved access to and utilization of appropriate levels of care, and b) reduced utilization and need for ED and hospital services among program members.

Goals and Relationship to Regional Goals:
The project goal is meet the health needs of program participants in ways that reduce unnecessary ED and hospital utilization. Patient navigation and the planned increase in capacity for self-management education and mental health services will connect persons with resource limitations and health needs to the right care and right community resources to meet their needs. The program will help participants meet a variety of types of needs affecting their health by connecting them to available resources. Improved connections with community and health service combined with improved self-management ability are expected to reduce utilization of ED services for concerns that can be more appropriately addressed in other settings (e.g., primary care). It is also expected to reduce exacerbation of health conditions sensitive to outpatient care and self-care.

Project Goals:
- Reduce avoidable ED visits in the target population; and
- Reduce potentially preventable hospital admissions in the target population.

This Project meets the following Regional Goals:
- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:
The two primary challenges anticipated by the partners are 1) creating and maintaining an efficient and secure data system for sharing information about program participants and navigator actions across sites, and 2) identifying timely sources of healthcare and social services to meet participants' needs in the community. The hospitals, AAA, and County have collaborated closely on the development of this plan and will leverage our effective working relationships to address these and other challenges throughout the project. Regular program calls/meetings will use standard agendas to review program data and day-to-day challenges, develop action plans, and agree on how best to disperse program funds to meet program challenges. We expect protocols to go through iterations as we try processes, identify opportunities to improve, and adjust to better meet program participant needs.

5-Year Expected Outcome for Provider and Patients:
In five years, we expect to reduce overall ED visits and hospital admits for all Indigent Care Program members, Medicaid beneficiaries, and hospital charity care program members by impacting both metrics in the selected subgroups of this low-income population. The patient navigator program will be developed and improved over time to meet the needs of this population such that they perceptions of need and medical need for high-intensity services are reduced because needs are met in other ways through outpatient services and community services.

Starting Point/Baseline:
No patient navigation exists for the target population in Bell County. Therefore, no baseline exists. Baseline will be established in DY2 (Milestone 1: P-1) after the project team reviews administrative billing data from the participating hospitals and claims data from the County Indigent Health Care Program (CIHCP) as part of its work to identify the target population for the program (among individuals who are part of the CIHCP, Medicaid, or hospital charity care programs). Once the target population for the patient navigation program has been established, we will use the same data sources to establish baseline ED utilization and hospital admissions for potentially avoidable conditions within the target group. Our intention is to establish baseline rates based on data from July 2011 – June 2012 because this period best represents the most accurate estimates of utilization for Bell County Indigent Care Program. Claims payment was temporarily suspended for that program later in the summer of 2012 through the end of the County's fiscal year and is therefore not an accurate representation of utilization for Indigent Care Program members, one important group to be represented in the target population.

Rationale:
Community Needs Addressed:

- Community Need Areas: C.3 – Lack of coordinated care for those with multiple needs
- Specific Community Need: C.3.5 - Discontinuity of care and limited awareness of available resources and services among indigent, uninsured and Medicaid populations in Bell County leads to potentially avoidable ED and hospital utilization.

The impetus for this project was the expressed need for improved support for Indigent Care Program members. This need was identified by the program director and county officials. The identification of that need resonated with the hospital partners on this application. While health services are generally available in Bell County, Texas, connecting citizens to the right care at the right time is a challenge, especially for citizens with limited financial and other resources (e.g., transportation, health literacy). Multiple studies are underway at Scott & White Healthcare to understand the experiences of members of medical aid programs (e.g., Medicaid, our internal charity care program) when they return home from the hospital and to understand how primary care utilization is associated with ED utilization among Medicaid beneficiaries nationally. Preliminary, unpublished data point to the complexity of needs affecting where and when persons with resource limitations seek care. At the same time, the demand for Bell County Indigent Care Program reimbursement for members' care exceeded that program's capacity in Fiscal Year 2011. That is, the cost of care for at least one program in our County is beyond our resources.

Patient navigation was chosen as the intervention to address complex patient needs and the growing economic burden of healthcare in our County because 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.[21] Tying inpatient and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost and quality of care. The intent of this patient navigator program is to empower citizens with resource limitations to access the medical and human services they need when those services are most needed to prevent exacerbation of health conditions leading ED and hospital services. Preventing ED and hospital services is expected to also reduce the cost of care for this population while more appropriately meeting persons' needs.

This project is a unique partnership among hospitals, the county, and a community-based organization. We recognize that the needs of persons with resource limitations cannot be met from any of our locations alone. We will therefore form a network of support for the target population to better meet their needs at the times and places program participants want and need support. No similar network exists currently. This is a new initiative for all partners, including Scott & White Healthcare.

Core Components:

Shared protocols will include the core components for this Category 2.9.1 project in the following ways:

a. *Identify frequent Emergency Department (ED) users among the target population and use navigators as part of a preventable ED reduction program.* The details of the program's efforts to prevent avoidable ED utilization will be determined by the program partners in Demonstration Year 2 (Milestone 1: P-1) after looking at patterns of use and gathering information from partners about potential causes in our region. One improvement expected from the program's efforts is an increase in referrals to PCPs for program participants who use the ED. Cultural competency will be among the topics of required patient navigator training.
b. *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* In this project, the team of navigators—embedded in and employed by various partners, will be trained in multiple disciplines such that the shared expertise of the navigator group can address the varied needs of program participants. For example, we expect to need nursing, social work, and social services training represented among the navigators. We also expect to need expertise working with Hispanic/Latino patients, with military families, and with medical aid programs.
c. *Connect patients to primary and preventive care.* One of several advantages of embedding navigators in local healthcare systems is the opportunity to optimize referral processes to each setting by partnering with a patient navigator form within each system. Sufficient primary and preventive care services are available in the County through multiple community-based clinics affiliated with two of the participating hospitals and

21 As an example, see "Limited English Proficiency Patient Family Advocate," available at AHRQ's Innovations Exchange, http://www.innovations.ahrq.gov/content.aspx?id=2726

three free clinics. Protocols will address proactive evaluation of participants' needs for recommended preventive services (e.g., vaccinations) and protocols for coaching patients to choose where to access services and then to make/attend appointments for those services. In DY5, we intend to increase the percent of navigator program patients with a primary care provider who are given a scheduled primary care provider appointment by 20% over the rate in DY3 (Milestone 5).

d. *Increase access to care management and/or chronic care management, including education in chronic disease self-management.* Protocols will include referrals to self-management education programs offered through this program to participants and to other area self-management education (e.g., diabetes education). Self-management education will be launched in DY2 (Milestone 2: P-4) to help increase patient engagement, and will continue through DY5. The addition of mental health services at one local free clinic will give navigators and participants improved access to mental health services to address chronic mental health issues.

e. *Conduct quality improvement for project using methods such as rapid cycle improvement.* Regularly-scheduled program meetings/calls will have the primary purpose of continuous quality improvement. The Model of Improvement will be among the content areas in patient navigator training. The partners will use PDSA cycles to create iterations of protocols throughout the project. Data on program implementation (e.g., types of navigation services provided to patients) will be employed by the team to help monitor quality and test the impact of program changes (Milestone 4: P-5).

Related Category 3 Outcome Measure(s):

- OD-9 Right Care, Right Setting
  - IT-9.2 ED Appropriate Utilization
- OD-2 Potentially Preventable Admissions
  - IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate

Patient navigation services will address needs identified by the team as influences on inappropriate ED utilization and Ambulatory Care Sensitive Conditions admissions for individuals with resource limitations in Bell County. These measures were chosen because both represent the consequences of gaps in services or patient engagement that lead to unnecessary utilization of high-cost, high intensity services. In some cases, services are needed because steps to prevent illness or exacerbations of conditions were not taken. In other cases, utilization of these services may represent a lack of access to or lack of awareness of access to other services designed to meet individuals' non-urgent and non-emergent needs. The multidisciplinary network of patient navigators that will be deployed for this project will be embedded across the county in both healthcare and community locations to help ensure that program members have easy and continued access to coaches, educators, and clinicians to connect them to the services that best match their needs. We will meet our improvement targets by reviewing data on processes (e.g., fidelity of implementation of program protocols) and outcomes over time. When problems with processes or lack of progress toward targets are identified, we will launch changes to address identified problems. Navigators will meet regularly to discuss challenges and progress. A project manager will help gather and report on program to allow the navigator team to monitor progress and make appropriate adjustments.

Relationship to Other Projects:
This project is related to the Pass 1 and Pass 2 projects proposed for Scott & White Hospital—Llano. All three projects will address avoidable utilization of services. The Llano hospital projects will work with stakeholders in the county to identify areas for reducing unnecessary use of EMS services and avoiding court orders to transfer persons with behavioral health crises. The demand for both types of emergent services are believed to be higher than necessary in that county and both may be leading to unnecessary ED utilization. All three projects will be monitored by personnel on Scott & White's System Quality & Safety team to identify opportunities to exchange lessons learned in the two counties for addressing needs proactively in ways that reduce avoidable utilization of services.

Category 4 reporting for this project may show changes in hospital-wide rates of potentially avoidable hospital admissions and 30-day hospital readmissions if the impact on the program-population is strong enough to show in the rates for the entire hospital population.

Relationship to Other Performing Provider's Projects and Plan for Learning Collaboratives:
Scott and White Hospital – Llano has two projects that are related to this one:

- #020840701.2.1 Patient Navigation
- #020840701.2.2 Sheriff Transport

Williamson County and Citied Health District also has a navigation project (#126936702.2.1).

Scott & White Memorial Hospital will participate in a RHP 8 learning collaborative that meets semi-annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects.

Project Valuation:
The scope of this project was determined by the available IGT and number of hospitals and community organizations that indicated a willingness to partner. The project value is based on two categories of cost and a hospital incentive for participation. The incentive is intended to cover cost of program planning, unanticipated program costs or new program aspects needed to fully address needs, and assumption of risk inherent in program participation.

- Estimated direct cost of personnel for service delivery, project management, data reporting per year
    - At Scott & White Healthcare: $234,045
    - Subcontracts for services: $484,944
- Estimated indirect cost cost/year (off-campus rate = 19%): $117,559
- Incentive to Performing Provider: $15,275

Scott & White Memorial Hospital 137249208.2.1 (Project 2.9.1) Category 2 Milestones and Metrics			
137249208.2.1	**2.9.1**	**2.9.1.a – 2.9.1.e**	**Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized 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)**
Scott & White Memorial Hospital			**137249208**
Related Category 3 Outcome Measure (s):	**137249208.3.1 137249208.3.2**	**IT-2.11 IT-9.2**	**IT-2.11: Ambulatory Care Sensitive Conditional Admissions Rate IT-9.2: ED appropriate utilization**

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)
Milestone 1 [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. **Metric 1** [P-1.1]: Provide report identifying the following: • Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). • Gaps in services and service needs. • How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms,	**Milestone 3** [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. a. Workforce development plan for patient navigator recruitment, training and education	**Milestone 5** [P-5.]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care. Especially for disenfranchised or medically complex patients, navigation is about guiding people through and across the HC system, from provider to provider, ensuring they can get to and make multiple appointments, get prescriptions filled, access to community services for people with special needs (such as getting cancer patients access to support groups), etc. the patient navigator	**Milestone 7** [I-X]: Serve individuals in target population. **Metric 1** [I-X.1]: Number of individuals receiving at least one patient navigator service (e.g., chronic disease self-management class, needs assessment, referrals to primary care) **Baseline/Goal:** Baseline – 0 (no navigator services currently in place); Goal – 1,200 individuals receive navigation services in DY5. **Milestone 7 Estimated Incentive Payment**: **$485,539**

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 **Baseline/Goal:** Baseline - No formal document has been created or started; Goal - A single, concise, report that identifies the target population for the initial iteration of this program. **Data Source:** 1. Historical summary-level data from the Bell County Indigent Care Program, Scott & White Memorial Hospital, Cedar Crest Hospital & RTC, and Metroplex Health System on a) indigent care services and b) charity care program services, 2. Survey or interview reports from case managers at the same hospitals, personnel at one or more free clinic in the County, and the Bell County Indigent Care	**Baseline/Goal**: Baseline - No patient navigator program exists for indigent care or charity care program members; Goal - Have a minimum of 3FTE patient navigators hired, the first edition of navigation procedures distributed to all, and a schedule of at least 10 shared learning calls/in-person navigator meetings established for DY3. **Data Source:** Personnel training files, written program plans/ protocols. **Milestone 3 Estimated Incentive Payment: $340,729** **Milestone 4** [P-4]: Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources **Metric 1** [P-4.1]: Number of classes and/or initiations offered, or number or percent of patients enrolled in the program a. Numerator: Number of program members who attended at least one session of the Stanford	represents the liaison between primary, secondary, tertiary and quaternary health care. **Metric 1** [P-5.1]: Collect and report on all the types of patient navigator services provided. **Baseline/Goal:** Baseline - No patient navigation activities are occurring at baseline; Goal - Develop and use an implementation tracking system and to report out on *reach* of the program into the target population and on implementation fidelity. **Data Source:** Program implementation database **Milestone 5 Estimated Incentive Payment: $319,433** **Milestone 6** [I-X]: Serve individuals in target population. **Metric 1** [I-X.1]: Number of individuals receiving at least one patient navigator service (e.g., chronic disease self-management class, needs assessment, referrals to primary care)	

Program, and 3. In-person, telephone or survey reports from participants in Bell County Indigent Care program and/or charity care programs at one or more of the three hospitals involved in this program. **Milestone 1 Estimated Incentive Payment: $362,025** **Milestone 2** [P-X]: Establish mental health services in one free clinic in the County to serve patient navigation program members **<u>Metric 1</u>** [P-X.1]: Hire and orient at least .3FTE psychiatric nurse practitioner and .25 therapist (e.g., LCSW) to see patients at the chosen free clinic. **Baseline/Goal:** Baseline - No specialized mental health services are designated to serve patient navigation program members; Goal - Personnel to be hired and oriented to project protocols, including protocols for referrals to/from the patient navigation program. **Data Source:** Personnel training reports, project protocols	Chronic Disease Self-Management Program workshop b. Denominator: Number of program members with at least one chronic illness **Baseline/Goal**: Baseline - Chronic Disease Self-Management workshops are not currently offered at free clinics or to persons likely to enroll in the patient navigation program; Goal - Minimum of 3 workshops (capacity for a minimum of 60 persons) in 12 months for program members. **Data Source:** Program enrollment files, participation reports from Area Agency on Aging (subcontractor) **Milestone 4 Estimated Incentive Payment**: **$340,729**	**Baseline/Goal:** Baseline – 0 (no navigator services in place in DY2); Goal – 1,000 individuals receive navigation services in DY4. **Data Source:** Navigation program database **Milestone 6 Estimated Incentive Payment: $319,434**	

Milestone 2 Estimated Incentive Payment: $362,025			
Year 2 Milestone Bundle Amount: $724,050	**Year 3 Estimated Milestone Bundle Amount: $681,458**	**Year 4 Estimated Milestone Bundle Amount: $638,867**	**Year 5 Estimated Milestone Bundle Amount: $485,539**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,529,914			

Category 2 Project Narrative – Pass 2
Seton Highland Lakes Hospital – 094151004.2.1

Project Area, Option and Title: 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: the uninsured.
RHP Project Identification Number: 094151004.2.1

Performing Provider Name: Seton Highland Lakes Hospital
Performing Provider TPI #: 094151004

Project Summary:

- **Provider Description:** Seton Highland Lakes Hospital (SHL) is a 25-bed Critical Access Hospital, providing acute care services, emergency services and intensive care in a predominately rural area. It also operates several rural healthcare clinics that offer primary care services, as well as a home health agency. The hospital is located in the City of Burnet which has a population of approximately 6,000, and is located in Burnet County, with a population of approximately 43,000.
- **Intervention:** This project will implement a patient navigation system to connect indigent and uninsured patients with primary care or medical homes in order to reduce emergency department (ED) utilization and provide cost-effective, timely, and site-appropriate health care services. Patients will be routed to a medical home by care navigators responsible for managing long-term relationships with the patients to reduce the patient's need for advanced medical care, including the (ED).
- **Project Status:** This project is a new initiative and plans to navigate approximately 400 patients during the course of the waiver.
- **Project Need:** CN.1.4 - Limited access to primary health care for indigent and uninsured populations in Burnet County. There is insufficient access to primary care available in Burnet County to provide for the needs of the indigent and uninsured population.
- **Target Population:** The target population is estimated at 745 persons and includes the medically indigent patient population currently served by the Burent County Indigent Health Program, as well as other indigent and uninsured patients who are frequent visitors to SHL's ED.
- **Category 1 or 2 Expected Project Benefit for Patients:** Patient navigation presents a significant opportunity to manage healthcare conditions effectively and reduce the costs of preventable hospital admissions, readmissions and ED visits, save lives and keep families healthy through referrals to a primary care setting and empanelment to a medical home. Patients will also be offered the opportunity for preventive health care and disease self-management education. When appropriate, home health visits will be offered. The program will have the capacity to serve a minimum of 60 indigent and/or uninsured individuals in DY2, 130 in DY3, 250 in DY4 and 400 in DY5. Enrollments will increase by 120 in DY4 and by 150 in DY5; cumulative program enrollment will be 400. Please note that we expect a portion of program enrollees to leave the program and return in a subsequent year due to eligibility fluctuations; a re-enrollment will be counted

as a new enrollment. SHL anticipates this project will refer 125 DY4 enrollees to a primary care setting and be empanelled to a medical home and in DY5, refer 280 enrollees to a primary care setting and be empaneled to a medical home (Improvement Milestone I-6.1).

- **Category 3 Outcomes:** IT-2.11: Our goal is to reduce acute admissions in DYs 4-5 by a percentage to be determined in DY3. SHL expects to see improvement in ambulatory conditions of patients and a reduction in the number unnecessary hospitalization of the indigent and uninsured Burnet County patients enrolled in the program and seeking treatment at a SHL facility.

Project Description:

Patient Care Navigation

Provider, SHL, will develop a comprehensive, effective patient navigation services for indigent and uninsured patients from Burnet County, Texas. Patients will be routed to a medical home by care navigators responsible for managing long-term relationships with the patients to reduce the patient's need for advanced medical care, including the (ED).

A collaborative care team of Navigators, including Community or Home Health Workers, Licensed Nurses, and/or Case Managers will provide proactive care management, navigate patients to a medical home, perform home environment assessments, and provide medication management assistance. The care team will also provide education to enrolled patients regarding chronic conditions, disease prevention and medication management.

Below are the anticipated roles and responsibilities of the care team of navigators:

- Medical Director: Care oversight of the Nurse Practitioner and ultimate responsibility of the care of the patients enrolled in the program
- Nurse Practitioner: Care management of the most vulnerable enrollees in the care management program. Those patients requiring a higher level of care coordination and oversight, education and medication reconciliation.
- Coordinator of the Program: Coordinates all activities related to developing enrollment materials, managing enrollment into the care coordination program
- Director of Home Health and Clinics: Operations oversight of clinics, Home Health & Hospice and development of care coordination program
- Case Manager, RN: Case Manager RN to be the first point of contact for patients enrolled in the program who can proactively manage preventive and educational visits to enrollees and who can be the first point of contact when enrollees interact with the hospital for complex services.
- Visiting Nurses: Team of multiple nurse positions who combine to visit, evaluate, educate and coordinate across the continuum care of all enrollees on a regular basis.
- Social Worker: Team of two qualified social workers at SHL who coordinate care and assist with patient navigation through the care continuum.
- Pharmacist: Proactively evaluate patient medication lists and assist clinicians with appropriate delivery of medications

SHL is an integrated, multi-level healthcare provider which is part of a larger system, Seton Healthcare Family, with provides the region with a full range of adult and pediatric tertiary and trauma care. To facilitate and support the medical home model, SHL will leverage its existing network of nine multi-specialty clinics and its home health and hospice services. It will also develop a network of other healthcare providers and community partners to provide timely access to primary and specialty care and other support services. Care coordinators will work with all of these entities with a goal of providing care in the most appropriate setting.

All medical interactions with the enrollees will be managed through the SHL electronic medical record system. Seton has a separate cost center for all activities related to the care coordination program which allows for financial tracking of the resources and investments in the program. The program coordinator, in combination with data from the above sources will develop a monthly activity report which will be used in correlation meetings with other community providers and in quarterly meetings with Burnet County on program progress.

Goals and Relationship to Regional Goals

The goal of this project is to ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators will assist in connecting patients to primary care physicians and/or medical home sites. The target population is estimated at 745 based on the number of indigent or uninsured patients who sought care at SHL between September 2011-August, 2012. Of these, approximately 110 were part of the Burnet County Indigent Health Program. Of the total, 474 visited the ED sometime in the last year. One of the goals of this project is to reduce the number of ED visits per capita by this population each year over the life of the program.

Project Goals:

- The care provided by the care team in the home of the enrollees and the relationship they will share with will result in improved access to timely, appropriate and high quality care for the residents of the SHL community.
- Patients will be enrolled in a medical home program with dedicated home health clinicians including physicians and physician extenders and dedicated care coordinators responsible for managing long-term relationships with the patients and their families.
- The care team will provide patient education on appropriate disease and prescription self-management. This will include prevention and how to appropriately interact with the SHL system to ensure optimal results at the lowest costs.
- The entire system will be focused on minimizing the patient's need for advanced medical care and to manage their care to the most appropriate setting including reduction of the number of ED visits.

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs;

- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:
The following are major challenges related to implementation of the program:
- A major challenge of the program is the potential growth of the uninsured or underinsured in the SHL service area and the corresponding strain on implementation and long-term management of the health status of the population. SHL is building a scalable infrastructure complete with appropriate software, staffing and leadership oversight to absorb fluctuations in the size of the population.
- The program will ultimately rely on compliance by enrollees who have previously not been asked to be compliant with rules and protocols associated with a care management program. Our solution has been to bring skilled, culturally competent and personable healthcare providers to their homes to develop lasting relationships which we believe will ultimately result in improved coordination and care.
- The program depends largely on the IGT source (Burnet County) which is, in turn, depending on this program remaining financially feasible for them throughout the entire four years. We have developed a collaborative spirit between SHL and Burnet County to proactively address issues and barriers which may arise to impact the viability of the program.

5-Year Expected Outcome for Provider and Patients:
SHL expects to see improvement in ambulatory conditions of patients and a reduction in the number unnecessary hospitalization of the indigent and Burnet County patients enrolled in the program and seeking treatment at a SHL facility.

Starting Point/Baseline
This is a new delivery system initiative for RHP 8 and will begin with a gap analysis and program development. The baseline for enrollment begins at 0; with a goal of enrolling 60 indigent individuals into the program by the end of DY2.

Rationale
<u>Community Need Addressed:</u>
- Community Need Area: CN.1 - Limited access to primary care
- Specific Community Need: CN.1.4 - Limited access to primary health care for indigent and uninsured populations in Burnet County

Patient navigators help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Services provided to patients enrolled in this navigation program will include:
- Coordinating care among providers;

- Arranging financial support and assisting with paperwork;
- Arranging transportation and child care;
- Facilitating follow-up appointments; and
- Community outreach and building partnership with local agencies and groups.

Community health workers will have close ties to the local community and serve as important links between underserved communities and the healthcare system. They 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 and community;
- Knowledgeable about the environment and healthcare system; and
- Connected with critical decision makers inside the system.

SHL selected Process Milestone P-1: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. This milestone was selected because detailed needs assessment will serve as the basis for design of the program and related materials to best serve the needs of the enrolled patients. Gaps in current services and resources needed to fill those gaps will be a primary focus of the needs assessment.

Process Milestone P-3.1, to provide navigator services to targeted individuals was selected to begin in DY2 to serve the community need as soon as possible.

SHL selected Improvement Measure I-6, to increase the number of PCP referrals and medical empanelment in DYs 4 and 5 to ensure that the majority of enrollees' health care needs are managed in a cost-effective, timely and site appropriate manner.

<u>Core Project Components:</u>

a) *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* Low income patients using the ED for primary care services with social or economic barriers to accessing primary care will be offered navigation services. Patient Navigators will create social services notes in the electronic health record (EHR) 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. Further, Patient Navigators will undergo training in providing culturally competent care and receive education regarding disparities and social determinants of health, community outreach, and chronic disease management.

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 utilize bilingual Patient Navigators with a background in community health, social services, mental health, or public health, with experience providing direct care to disadvantaged populations.

c) *Connect patients to primary and preventive care.* The care team will be trained to assess enrollees and their environments and to provide education regarding disease self-management and prevention. Contact with enrollees will occur at three points: 1) when contacted by the patient using a centralized care coordination phone number; 2) through periodic home health visits; and 3) when enrollees enter the SHL network and referred to the program**,** with special attention paid to patients in SHL's ED.

d) *Increase access to care management and/or chronic care management, including education in chronic disease self-management.* At the initial assessment meeting with the patient and their family, which may occur in their home, patients will be educated on the benefits and inner-workings of the program and chronic disease self-management, if applicable. The patient and/or the family will be proactively contacted and visited by the care team to improve patient compliance in 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.* SHL will utilize an established an oversight board which consists of members of the community, the hospital system and Burnet County representatives to provide steering and oversight of the program. A portion of the oversight Board's agenda will be dedicated to continuous improvement efforts and leveraging existing and new partnerships to improve the program and the related health status of its enrollees. SHL will also conduct periodic internal coordination meetings between multiple areas of the health system and externally with other healthcare providers and non-healthcare partners in the community to identify best practices and implement or pilot new ideas.

<u>How the project represents a new initiative or significantly enhances an existing delivery system reform initiative</u>: Currently, a patient navigation program does not exist for these patients at SHL. SHL offers case management services, but this is typically only offered during an inpatient admission and requires a physician order.

This project complements, but does not duplicate other current initiatives funded by the U.S. Department of Health and Human Services, either directly or indirectly or through state initiatives. SHL participates in the Medicare and Medicaid Electronic Health Records Incentive Program for hospitals; extension of this program to SHL-affiliated physician offices and clinics is in development; participation in the EHR program is expected to support the care delivered under this project and coordination between providers. SHL's parent company, Seton Healthcare, is a participant in the Pioneer ACO, however, it is not expected to serve this project's target population. SHL also benefits indirectly from the participation of Ascension Health, Seton Healthcare Family's parent company, in CMS' Partnership for Patients.

Related Category 3 Outcome Measure(s)

- OD-2 Ambulatory Care Sensitive Conditions Admissions Rate

- IT-2.11 Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years.

SHL selected IT-2.11 to measure the effectiveness of the program at avoiding unnecessary or preventable admissions for the indigent and patients and families of Burnet County and the SHL service area. Many SHL community members struggle with access to care due to the many years of living in a rural environment. SHL invests significant resources reaching out to the members of the community through various outreach programs such as health fairs and the Kid's Care-a-van. Many still use the ED or are admitted for what would be considered an ambulatory sensitive admission or visit. This metric will demonstrate the program's effectiveness at improving access to care particularly for indigent and uninsured individuals.

Relationships to Other Projects:
Related Category 4, population-Improvement measures (based on hospital data) are:

- Domain 1 – Potentially Preventable Admissions
- Domain 2 – Potentially Preventable Readmissions
- Domain 4 - Patient-Centered Healthcare

Relationship to Other Performing Providers' Projects and Plans for Learning Collaborative:
There are three other patient navigation projects in RHP 8:

- Scott & White Memorial Hospital #137249208.2.1
- Scott & White Hospital – Llano #020840701.2.1
- Williamson County & Cities Health Department #126936702.2.1

In addition, there are a several projects which are associated with patient navigation. These include Bluebonnet Trials' Emergency Services Diversion project (#126844305.2.2), Scott & White Hospital – Llano's Sheriff Transport project (#020840701.2.2) and Williamson County & Cities Health Department's Paramedicine project (#126936702.1.2).

SHL will fully participate in RHP-wide learning collaboratives for projects that directly address patient navigation and chronic care management. Because of the wide scope of such services and the integration of care at all levels, plans to participate in learnings regarding care transitions, enhancement of interpretation services, culturally competent care, palliative care and telemedicine. Regular sharing between providers with similar projects and/or target populations to discuss challenges, ideas and solutions between providers is expected to lead to successful implementation and outcomes for the project throughout the demonstration period. The exchange of ideas between providers may be conducted in-person, by teleconference or electronically.

Project Valuation
Project valuation considered costs, cost avoidance, population impact, patient experience, the overall impact to the community, as well as the project's ability to transform the delivery of healthcare by providing the right care, at the right place, the right time, and in the most cost

efficient way for the patient and family unit. SHL is on pace to see more than 18,500 visits in its Emergency Department this year and 1,250+ admissions. SHL is anticipating this program will result in approximately 300 fewer visits per year including inpatient and outpatient resulting in an approximate cost avoidance of $700,000. Patient navigation presents a significant opportunity to manage healthcare conditions effectively and reduce the cost of preventable hospital admissions, readmissions and ED visits, save lives and keep families healthy.

Seton Highland Lakes Hospital 094151004.2.1 (Project 2.9.1 – Pass 2) Category 2 Milestones and Metrics				
094151004.2.1	**2.9.1**	**2.9.1.a – 2.9.1.e**	**Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized 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)**	
Seton Highland Lakes Hospital				**094151004**
Related Category 3 Outcome Measure (s):	**094151004.3.1**	**IT-2.11**	**IT-2.11: Ambulatory Care Sensitive Conditional Admissions Rate**	
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)**
Milestone 1 [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. **Metric 1** [P-1.1]: Provide report identifying the following: a. Targeted patient population characteristics b. Gaps in services and service needs. c. How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). d. Ideal number of patients targeted for enrollment in the patient navigation program e. Number of Patient Navigators	**Milestone 5** [X-1]: Provide navigation services to targeted patients. **Metric 1** [I-X.1]: Increase in the number of targeted patients enrolled in the Patient Navigation Program. **Baseline/Goal:** Baseline - At beginning of DY2, Patient Navigation Program did not exist; therefore baseline is 0. Enroll 70 patients in the navigation program in DY3. Goal – Cumulative program enrollment will be 130. **Data Source:** Enrollment records **Milestone 5 Estimated Incentive Payment: $540,540**		**Milestone 7** [I-X]: Provide navigation services to targeted patients. **Metric 1** [I-X.1]: Increase in the number of patients enrolled in the navigation program at SHL. **Baseline/Goal:** Baseline - At beginning of DY2, Patient Navigation Program did not exist; therefore baseline is 0. Goal – Enroll 120 patients in the navigation program in DY4 (Cumulative program enrollment will be 250). **Data Source:** Enrollment records **Milestone 7 Estimated Incentive Payment: $253,378**	**Milestone 11** [I-X]: Provide navigation services to targeted patients. **Metric 1** [I-X.1]: Increase in the number of patients enrolled in the navigation program at SHL. **Baseline/Goal:** Baseline - At beginning of DY2, Patient Navigation Program did not exist; therefore baseline is 0. Goal – Enroll 150 patients in the navigation program in DY5 (Cumulative program enrollment will be 400). **Data Source:** Enrollment records **Milestone 11 Estimated Incentive Payment: $256,756**

needed to be hired f. 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 **Baseline/Goal:** Produce a report covering all points above based on available data. **Data Source**: Program documentation; claims, publically available State and county data sources. **Milestone 1 Estimated Incentive Payment: $287,162** **Milestone 2** [P-8]: Participate in face-to-face learnings 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. Each participating provider should publicly comment on implementing these	**Milestone 6** [P-8]: Participate in face-to-face learnings 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. Each participating provider should publicly comment on implementing these improvements. **Metric 1** [P.8-1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Goal - Participate in face-to-face learning at least twice per year. **Data Source:** Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 6 Estimated Incentive Payment: $540,541**	**Milestone 8** [P-5]: Provide reports on the type of navigation services provided to patients using the ED as high users or for episodic care. The navigation program is accountable for making PCP or medical home appoints and ensuring continuity of care. **Metric 1** [P-5.1]: Collect and report on all the type of patient navigator services provided to ED patients. **Baseline/Goal:** Baseline – 0, ED Reports not collected in DY2 or DY3. Goal - Produce semi-annual reports of patient navigation services provided to ED patients. **Data Source:** Program Analytics **Milestone 8 Estimated Incentive Payment: $253,378** **Milestone 9** [P-8]: Participate in face-to-face learnings 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. Each participating	**Milestone 12** [P-8]: Participate in face-to-face learnings 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. Each participating provider should publicly comment on implementing these improvements. **Metric 1** [P.8-1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Participate in face-to-face learning at least twice per year. **Data Source:** Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 12 Estimated Incentive Payment: $256,757** **Milestone 13** [I-6.1]: Increase medical home empanelment of patients referred from navigator program.

improvements. **Metric 1** [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Participate in face-to-face learning at least twice per year. **Data Source**: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 2 Estimated Incentive Payment: $287,162** **Milestone 3** [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. **Metric 1** [P-2.1]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education		provider should publicly comment on implementing these improvements. **Metric 1** [P.8-1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Baseline/Goal:** Goal - Participate in face-to-face learning at least twice per year. **Data Source:** Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. **Milestone 9 Estimated Incentive Payment**: **$253,378** **Milestone 10** [I-6]: Increase medical home empanelment of patients referred from navigator program. **Metric 1** [I-6.1]: Increase the number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Baseline/Goal:** Baseline - At beginning of DY2, Patient Navigation Program did not exist; therefore baseline is 0. Goal – 60 of the DY4	**Metric 1** [I-6.1]: Increase the number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. **Baseline/Goal:** Baseline - At beginning of DY2, Patient Navigation Program did not exist; therefore baseline is 0. Goal – 112 of the DY5 enrollees seen in a primary setting will be empanelled to a medical home (Cumulative referrals – 172). **Data Source:** Enrollment and referral records. **Milestone 13 Estimated Incentive Payment: $256,757**

sessions for patient navigators. **Baseline/Goal:** Baseline - At beginning of DY2, Patient Navigators did not exist; therefore baseline is 0. Goal - Develop training program with procedures and continuing education plan. Train and deploy a team of 5 navigators. **Data Source:** Human Resources and Training Documentation. **Milestone 3 Estimated Incentive Payment: $287,162** **Milestone 4** [I-X]: Provide navigation services to targeted patients. **Metric 1** [I-X.1]: Increase in the number of targeted patients enrolled in the Patient Navigation Program. **Baseline/Goal:** Baseline - At beginning of DY2, Patient Navigation Program did not exist; therefore baseline is 0. Goal - Program enrollment total of 60 **Data Source:** Enrollment records		enrollees seen in a primary setting will be empanelled to a medical home (Cumulative referrals – 60). **Data Source:** Enrollment and referral records. **Milestone 10 Estimated Incentive Payment: $253,379**	

Milestone 4 Estimated Incentive Payment: $287,162			
Year 2 Milestone Bundle Amount: $1,148,648	**Year 3 Estimated Milestone Bundle Amount: $1,081,081**	**Year 4 Estimated Milestone Bundle Amount: $1,013,513**	**Year 5 Estimated Milestone Bundle Amount: $770,270**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $4,013,512			

Category 2 Project Narrative
Williamson County and Cities Health District – 126936702.2.1

Project Area, Option and Title: 2.9.1 Provide patient navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.
RHP Project Identification Number: 126936702.2.1

Performing Provider Name: Williamson County and Cities Health District
Performing Provider TPI #: 126936702

Project Summary:

- **Provider Description:** Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
- **Intervention:** This project will provide navigation services to persons with targeted chronic conditions or pregnancy that are at high risk of disconnect from institutionalized health care to prevent hospital admissions and readmissions.
- **Project Status:** This project is an expansion of an existing initiative and will add a total of 400 navigation services in addition to the current 200 by the end of DY5.
- **Project Need:** CN.3.4 Fragmented system in navigating access to appropriate level of care for uninsured Williamson County residents. According to the Texas Department of State Health Services *Potentially Preventable Hospitalizations Report,* 2005-2010, Williamson County residents had 7,713 potentially preventable hospitalizations for Congenital Heart Failure (CHF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and complications of diabetes for those 5 years. The current safety-net providers have waiting lists for new patients, making it difficult for chronically-ill patients to access primary care at the appropriate times for their conditions. The combined factors of difficult access to healthcare coupled with social factors continue to leave this population in need of navigation assistance to maneuver, learn and appropriately utilize services and manage their own health. According to the August 2012 WCCHD Epidemiology Program Report, in 2010, 22% of the Williamson County births were to mothers who accessed prenatal care after their first trimester of pregnancy.
- **Target Population:** The number of patients/clients the project will target is approximately 10,900 by DY5. The target population is patients that need assistance navigating the healthcare system to access appropriate level of care without utilizing the Emergency Department for services. Approximately 45% of patients are either Medicaid eligible, low income uninsured or indigent, so we expect they will benefit from about half of the proposed navigation services.
- **Category 1 or 2 Expected Project Benefit for Patients:** The project seeks to provide 10,400 individuals with navigation services in DY4 and 10,900 which is an increase of 500 in DY5 (see Improvement Milestone 1-6.4).
- **Category 3 Outcomes:** IT-6.1: Percent improvement over baseline of patient satisfaction scores: are getting timely care, appointments, and information. Approximately 1,040

individuals completing a patient satisfaction survey will report satisfaction in receiving time care, appointments and information which is an improvement rate of 10% from the 10,400 individuals provided with a patient navigation service in DY4 and 2,180 in DY5.

- **Collaboration** Texas A&M Health Science Center (TAMHSC) had a Pass 1 allocation it could not use, since TAMHSC did not have providers in RHP 8. TAMHSC allowed its allocation to be used by local health departments and local mental health authorities (public entities) which had much smaller provider allocations in Pass 1, so these entities could have more broad, transformative, regional projects. TAMHSC has not played a role in these projects, other than the role of anchor. There are no impermissible provider-related donations involved. This usage of the TAMHSC allocation ensured these providers, who could self-fund the required IGT, could participate in the waiver. This project addresses the key need of diverting individuals from the emergency department for preventive care services that can be obtained through a medical home. Navigating the healthcare system when individuals are uninsured, can be complex and leave the uninsured individual to a route for care where they know they'll be seen regardless. This practice increases unnecessary cost to hospitals but more importantly the ultimate result is the lack in continuity of care for the patient. Transforming this process will ensure individuals are connected to the appropriate level of medical care for preventive or acute instead of through the emergency department.

Project Description:

Navigation Program - ***The Williamson County and Cities Health District proposes to provide navigation services to persons with targeted chronic conditions or pregnancy that are at high risk of disconnect from institutionalized health care.***

The project would improve accessibility to health care services for Williamson County individuals who have a diagnosed chronic condition or pregnancy and who are at high risk of disconnect from institutionalized health care, to prevent hospital admissions and readmissions, while improving their experience of timely care. According to the Texas Department of State Health Services *Potentially Preventable Hospitalizations Report,* 2005-2010, Williamson County residents had 7,713 potentially preventable hospitalizations for Congenital Heart Failure (CHF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and complications of diabetes for those 5 years, with accompanying hospital charges of $179,728,355. The Community Health Profile of Williamson County Precincts (2011) http://www.wcchd.org/statistics and reports/) illustrates the social determinants of health of low income and lower educational status with higher incidence of chronic disease (diabetes example). The current safety-net providers have waiting lists for new patients, making it difficult for chronically-ill patients to access primary care at the appropriate times for their conditions. The combined factors of difficult access to healthcare coupled with social factors, continue to leave this population in need of navigation assistance to maneuver, learn and appropriately utilize services and manage their own health. According to the August 2012 WCCHD Epidemiology Program Report, in 2010, 22% of the Williamson County births were to mothers who accessed prenatal care after their first trimester of pregnancy.

The WCCHD Navigation Program proposes to optimize and individualize services of a collaborative team of community health workers, Program Navigators, Case Managers (Social Workers and Public Health Nurses) and other types of health care professionals to persons by:

- Hiring community health workers/promotoras within each of the 4 smaller sectors of the county. The team will cover all 4 Public Health Center sites in Georgetown, Round Rock, Cedar Park and Taylor. These Public Health Centers are geographically spread through the larger cities in the county and are central to each of the major rural areas.
- Cross-training with staff in other agencies with some similarity of functions, such as EMS personnel, to support consistency of core purpose and processes.
- Having Patient Navigators able to meet people in their own communities to build trust and find those in need of healthcare services before they present to an Emergency Department (ED) or for late prenatal care.
- Helping patients' access care by connecting them with enabling services, such as transportation.
- Using electronic tools such as Health Information Exchange (HIE) and Electronic Health Records (EHR) to support consistent communication about health needs and treatment for people with chronic diseases, pregnancy, and high-ED utilization.

Patients will be identified for navigation services proactively through intake calls received from the community (quite often from citizens with chronic health conditions seeking access to care), from daily hospital reports, HIE ICare reports, other agency and provider referrals, and ongoing personalized visits within communities by members of the team. Additionally, another project is focused on outreach and communication strategies that will supplement connection to those in need of patient navigation services, with an emphasis on reaching pregnant women.

Patients will, based on their condition or need, be able to participate in assessments to include health literacy, risk stratification, and health risk appraisals, while navigators work to ensure financial access to care, appointment with a Primary Care Provider (PCP)/ Obstetrician (OB), and enabling services in place, such as transportation. Patients may choose to also participate in case management and health education services within their home communities. These multi-agency/multi-community services will be offered in a culturally and linguistically appropriate manner.

Documentation of patient navigation will be initiated in the WCCHD CHASSIS electronic system. Tracking of encounters, services/service types, appointments with PCP/OB, dates of entry into prenatal care, completion of eligibility for healthcare funding programs will be monitored and tracked. A process for patient satisfaction measure tracking will be developed during DY2. Hospitalization and ED usage will be monitored through HIE reports to assist in compiling a complete picture of the needs and results from patient navigation services.

Goals and Relationship to Regional Goals:

The goal of this project is to use community health workers, case managers, social workers and registered nurses as patient navigators to provide enhanced care coordination, community outreach, social support, and culturally competent care to high-risk patients with COPD, CHF, hypertension and/or diabetes. Patient navigators will help and support these patients to

navigate through the continuum of health care services, and establish a medical home. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services, and are linked to chronic disease education and/or self-management tools.

Project Goals:

- Increase over baseline in patients with a PCP appointment to establish a medical home
- Increase in patient satisfaction with receiving timely care, appointments and information

This Project meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing the proportion of residents with a regular source of care;
- Increasing coordination of prevention and care for residents, including those with behavioral and mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:

Williamson County is among the ten fastest growing counties in the US, with 16.5% of the population uninsured (approximately 80,000 people). The challenge for this project in such a rapidly changing environment, is to target and reach populations and people in need in the most direct and streamlined fashion, in a culturally competent manner with understanding of each person's unique situation. Lack of public transportation has been consistently identified as a priority need in Williamson County, especially in the rural areas. WCCHD will continue to work with existing community transportation coalitions addressing this challenge.

5-Year Expected Outcome for Provider and Patients:

WCCHD expects to see reductions in inappropriate hospitalizations and ED use for patients with targeted chronic conditions, increase in patients accessing prenatal care in their first trimester of pregnancy and increased use of a medical home, while meeting the project goals above.

Starting Point/Baseline:

WCCHD has had a nurse and social worker case management programs for many years. These have been for a variety of patient populations and each program has answered to different goals and metrics of the funding source. Additionally, there has been a "Health Care Helpline" in place for many years, again, acting as an entry point into the health care system for people who are lost in navigating to meet their needs. There are currently four positions that have been "re-purposed" this Fall to begin a Patient Navigation system within WCCHD. This project will allow for substantial expansion of Patient Navigators into the communities, thereby increasing access for those most difficult to reach. Additionally, this program will allow for a community-wide system of care to develop with unified data, reporting and communications.

Mechanisms to gather more standardized data on which to build improvements and manage it electronically, is essential to moving away from the current fragmented system internally and externally.

Rationale:

Community Need Addressed**:**

- Community Need Area: CN.3 - Lack of coordinated care for those with multiple needs
- Specific Community Need: CN.3.4 - Fragmented system in navigating access to appropriate level of care for uninsured Williamson County residents
- Other Community Needs:
  - CN.1.6 – Limited access to primary care and preventive services
  - CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals diagnosed with chronic disease

This project option supports the integration of many of the initiatives of both WCCHD and the community at large. WCCHD was one of the first "integrated eligibility" sites in Texas in the 1980s, looking for ways to reduce redundancy in patient applications and verifications to receive funding for healthcare services. This quest for integration of processes to support vulnerable populations in accessing health care in the broadest sense is the catalyst for selecting this project option. As noted earlier, the vulnerable citizens with chronic conditions account for large, potentially preventable healthcare expenditures of $179,728,355 in a five-year period, and 22% of pregnant women do not access care in their first trimester. The common denominator for these vulnerable populations, and hence the selection of this project is the need for advocacy, information and connection for their situations in accessing care in a coordinated system. This project will allow us to focus on expanding internal capacity to serve patients with limited health literacy levels, as well as to tie those to other community services in a more seamless and effective system. Currently, clients continue to call the "Healthcare Helpline" for assistance in navigation, but the need has exceeded the capacity of this model. This project will allow for expansion of the comprehensive patient navigation services through the team model into the community. The project will:

- Help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system;
- Ensure that patients receive coordinated, timely, and site-appropriate health care services;
- Assist in connecting patients to primary care physicians and/or medical home sites;
- Coordinate with other RHP projects that focus on diversion of non-urgent patient care from the ED to site-appropriate locations;
- Assist in connecting patients to potential healthcare funding programs; and
- Assist nurse and social work case managers in connecting patients/families to appropriate health education and community resources.
- Through an Electronic Health Record, screening and eligibility tool and Healthcare Helpline, staff will monitor and track metrics, activities and patients assisted by this project.

While there is no one common definition of patient navigators, the WCCHD project will use a team-based model that includes nurses, social workers and community health workers/promotoras based in their respective communities.

While there is no set education required for a patient navigator to be successful, a successful navigator should be:

- Compassionate, sensitive, culturally attuned to the people and community being served and able to communicate effectively.
- Knowledgeable about the environment and healthcare system.
- Connected with critical decision makers inside the system.

Hiring practices will focus on these key interpersonal skills and abilities.

Project Components:

We propose to meet all of the required project components through the Patient Navigation program.

a. *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* The hospital partners will initially identify ED frequent users through daily reporting. Connection to navigators will be geographically-based, so that outreach into communities will be facilitated. Initial and ongoing training in cultural competency will be part of the work in DY2 and 3.
b. *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* Based on the Public Health Center model, many of the various professionals and staff will be deployed in navigation roles.
c. *Connect patients to primary and preventive care.* Connection to a medical home is imperative in this project, with follow-up to assess barriers and completion of transition to this medical home.
d. *Increase access to care management and/or chronic care management.* Patient Navigators will assist patients in connecting to these services that are offered through WCCHD and other providers in a comprehensive and coordinated manner.
e. *Conduct quality improvement for project using methods such as rapid cycle improvement.* Core WCCHD interdisciplinary teams will monitor and use Plan, Do, Study, Act (PDSA) cycle for rapid improvement throughout the patient navigation program. Several of these teams are currently in place and include epidemiology, case management, patient navigation, nursing, marketing and communications, community relations and research staff.

Continuous Quality Improvement: WCCHD 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 share information such as challenges, lessons learned and considerations for safety net populations.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project allows for a large enhancement of patient navigation into the community, using multiple venues and partners in a coordinated approach. As noted above, the "skeleton" of this project is in place; this project will allow for full transition from the "Health Care Helpline" concept to a fully-integrated patient navigation program serving patients in a coordinated, rather than episodic fashion.

WCCHD receives funding from the U.S. Department of Health and Human Services but will not use those funds for this project.

Related Category 3 Outcome Measures

- OD-6 Patient Satisfaction (Standalone Measure)
  - IT-6.1 Percent Improvement over baseline of patient satisfaction scores

Reasons/rationale for selecting the outcome measures:
We selected this measure as an outcome to reflect the patient-centered model of care we will be providing and the patient's perception of timeliness, appointments and information in meeting perceived needs. This increase in satisfaction should be reflective of continuously improving the Patient Navigation process and relationships to support patients more individually, effectively and efficiently. Ensuring linkage to a medical home by navigating the health care system will provide patients with opportunities to seek appropriate level of care, knowledge of chronic condition, and promotion through encounters with the medical provider.

Relationships to Other Projects:
All the proposed projects are oriented toward providing more coordinated care throughout Williamson County, to simplify healthcare system access for patients, to lower costs and to improve the quality of care at the place of service.

This project will coordinate with the following other WHHCD projects in Williamson County:

- Expanded Capacity to Access Care (#126936702.1.1)
- Implement project to enhance collection, interpretation, and/or use of REAL data (#126936702.1.3)
- Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for Non-emergent conditions (#126936702.1.2)
- Engage in population based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population (#126936702.2.2)

This project also coordinates with a project performed by St. David's Round Rock Medical Center will expand access to primary care (#020957901.1.1).

Relationship to Other Performing Providers; Projects and Plan for Learning Collaborative:
Scott & White Memorial Hospital (#137249208.2.1) and Scott & White Hospital – Llano (#020840701.2.1) have patient navigation projects.

The Williamson County Wellness Alliance (WWA) and the WilCo Integrated Care Collaborative are forums where we will be exchanging ideas, successes and needs as we move through this delivery system improvement. Both of these groups include other performing providers, as well as schools, businesses, consumers, agencies, government, etc., so that we will have a full-focus on progress in these areas.

Project Valuation:
The valuation of each WCCHD project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. WCCHD considers this project as high value because it will serve a significant number of residents in the community, where they "live, work, play and pray." Helping people navigate the healthcare system proactively will significantly decrease the overall cost of care by assisting in avoidance of ED visits for primary care services, teaching about and supporting healthier lifestyles and choices to help prevent or manage chronic illness, and by giving babies a "Healthy Start". Additionally, the project seeks to accomplish delivery system reform by understanding that the diversion of inappropriate non-emergent care services through the ED, to connection to appropriate level of care, would improve patient care and decrease the cost for preventable services currently performed in the ED and decrease preventable hospitalizations. The cost of this project for DYs 2-5 is estimated at $844,630 which is an added savings of over $4,000,000 when compared to the costs of ED visits.

Williamson County and Cities Health District 126936702.2.1 (Project 2.9.1) Category 2 Milestones and Metrics			
126936702.2.1	**2.9.1**	**2.9.1.a - 2.9.1.e**	**Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized 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)**
Williamson County and Cities Health District			**126936702**
Related Category 3 Outcome Measure(s):	**126936702.3.6**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**

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)
Milestone 1 [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. **Metric 1** [P-1.1]: A report identifying the following: • Patient characteristics • Services gaps • Triage and referral • Number of patients targeted for enrollment in the program • Number of Patient Navigators needed to be hired • Program location **Baseline/Goal**: To produce a comprehensive report detailing all	**Milestone 3**[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[23] 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 continuing education sessions for patient navigators. **Baseline/Goal**: To complete a hiring and training plan along with protocols and procedures for Patient Navigators.	**Milestone 4** [I-X]: Provide navigation services to patients. **Metric 1** [I-X.1]: Increase in the number of patients receiving navigation serves. **Baseline/Goal**: Baseline - Established in DY3 is anticipated to be 8,700; Goal - Provide navigation services to an additional 1,700 individuals in DY4. **Data Source:** Enrollment reports comparing DY3 and DY4 enrollment **Milestone 4 Estimated Incentive Payment: $202,319**	**Milestone 5** [I-X]: Provide navigation services to patients. **Metric 1** [I-X.1]: Increase in the number of patients receiving navigation serves. **Baseline/Goal**: Baseline established in DY3 is anticipated to be 8,700; Goal: Provide navigation services to an additional 2,200 individuals in DY5. **Data Source:** Enrollment reports comparing DY3 and DY4 enrollment **Milestone 5 Estimated Incentive Payment: $202,319**

23 Could be facility-oriented, illness/condition-oriented, and/or focused on patient populations who are at most risk of disconnected care (e.g., "Limited English Proficiency Patient Family Advocate" available here http://www.innovations.ahrq.gov/content.aspx?id=2726, urgent care, ED)

points above. **Data Source**: Community Health Profiles, Community Health Assessment, GIS Mapping of targeted population needs assessment **Milestone 1 Estimated Incentive Payment: $72,581** **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[22] 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 continuing education sessions for patient navigators. **Baseline/Goal**: To establish a hiring and training plan along with protocols and procedures for Patient Navigation Program.	**Data Source**: Hiring, education and training plans; Policies and Procedures **Milestone 3 Estimated Incentive $202,319**		

22 Could be facility-oriented, illness/condition-oriented, and/or focused on patient populations who are at most risk of disconnected care (e.g., "Limited English Proficiency Patient Family Advocate" available here http://www.innovations.ahrq.gov/content.aspx?id=2726, urgent care, ED)

Data Source: Human Resource Policies and Procedures **Milestone 2 Estimated Incentive Payment: $72,581**			
Year 2 Milestone Bundle Amount: $145,162	**Year 3 Estimated Milestone Bundle Amount: $202,319**	**Year 4 Estimated Milestone Bundle Amount: $202,319**	**Year 5 Estimated Milestone Bundle Amount: $202,319**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $752,119			

Category 2 Project Narrative – Pass 2
Williamson County and Cities Health District – 126936702.2.2

Project Area, Option and Title: 2.6.1 - Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population
Unique Project ID: 126936702.2.2

Performing Provider Name: Williamson County & Cities Health District
Performing Provider TPI: 126936702

Project Summary:

- **Provider Description:** Williamson County and Cities Health District (WCCHD) is the local public health department for Williamson County and is responsible for serving a 1,118 square mile area and a population of an estimated 442,782 (2011 Census data).
- **Intervention:** This project will use an interdisciplinary team to promote preventive health awareness by offering health education classes, eligibility assistance, case management and health literacy education in the community, specifically women of child bearing age, high incidence rate of frequent hospitalizations for chronic conditions and women entering prenatal care after the first trimester.
- **Project Status:** This is a new project.
- **Project Need:** CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals with diagnosed chronic disease. According to data obtained from the 2012 County Health Rankings and Roadmaps, 13% of Williamson County residents report being in poor health and the county does not meet the national benchmarks for: health screening; incidence of low birth weight; teen birth rate; incidence of adult obesity; low health literacy and access to healthy food options, which indicates that residents are in need of accessible health promotion options and connection to available resources. Currently, health educators offer evidence-based health education programs to the community at no cost; however, the scarcity of these programs, compounded by existing barriers, specifically lack of transportation and health literacy, greatly affects the number of residents that are able to take advantage of these programs.
- **Target Population:** The project seeks to increase the availability of access to health promotion programs and activities strategically located in identified areas with a high rate of incidence in chronic illness and/or women of child bearing age. According to the latest Behavioral Risk Factor Surveillance Survey (BRFSS) from 2007-2010, 117,725 of the total population of Williamson County reported being diagnosed with either heart disease, diabetes, obesity or asthma. That is 31.7% of the total population. And, according to the 2100 Census Data, there are 96,246 women of children bearing age in the county. Number of patients the project will serve is approximately 400 to 600. The target population is our patients that need access to health education programs in venues accessible to them, specifically those with limited or no transportation. Approximately 60% of our current patients are either indigent, Medicaid -eligible or low-income uninsured, so we expect they will benefit from more than half of the proposed project.

- **Category 1 or 2 Expected Project Benefit for Patients:** The target population is patients that need access to health education programs/activities in venues accessible to them, specifically those with limited or no transportation. Because there are no public transportation services in Williamson County, geographically placing these services in venues that are within walking distance and trained community health workers will augment the patient's knowledge related to their chronic illness or their pregnancy, thereby increasing the probability they will maintain their health through self-management and/or appropriate primary care. It is estimated that approximately 261 patients attended over 26 health promotion-related classes/programs which were hosted by WCCHD Health Educators at one of the four Public Health Center locations. By the end of DY4, the goal is to increase the number of targeted population reached by 20% or 42,000 through health promotion activities and/or awareness campaigns (social media included). In DY5, approximately 25% of targeted population reached or 54,000 through health promotion activities and/or awareness campaigns (social media included). The increase in classes/activities, awareness campaigns and strategically placing community health workers in areas with high incidence rate of chronic illness and/or women of child bearing age, will bring a robust awareness in healthy lifestyle thereby potentially reducing hospitalization costs related to services that could have been prevented.
- **Category 3 Outcomes:** IT-6.1: To improve patient satisfaction scores in receiving timely care, appointments, and information rate from 0% currently to 100% by DY5. The results gathered from the patient satisfaction surveys will impact the number of individuals' successfully accessing primary care appropriately. The scores will also drive the continuous quality improvement (CQI) process to ensure appropriate health related activities are suitable for the patients served and addressing the issues of receiving health care in a timely fashion. Having the patients complete the satisfaction survey will enable WCCHD to share results with other local providers to make certain appointment schedules meet the need for this population.
- **Collaboration:** There was not a TAMHSC allocation in Pass 2 and, therefore, was not used for a Pass 2 project.

The project would promote preventive health awareness in the community to identified targeted populations, specifically women of child bearing age and individuals diagnosed with a chronic illness. Plans include the development of a team consisting of community health workers, case managers, health educators, marketing staff and health care professionals. Utilizing this team is a fundamental approach to providing health education, health screening and outreach based on cultural background, English proficiency, and health literacy level of the individual or community. Marketing strategies, methods and interventions will be tailored to the specific needs of the targeted population within each community. In alignment with Wilco Wellness Alliance (WWA) community initiatives, WCCHD will develop health promotion activities through this interdisciplinary approach. WWA is a coalition built with representation of community business leaders, health care providers, school personnel and community based organizations.

The team will strategically position themselves in identified areas to promote, educate, empower and link targeted populations towards appropriate utilization and knowledge of their health care and medical homes, if applicable. WCCHD will utilize current methods of marketing

and promotion as well as education such as; social media (i.e. Facebook and You Tube) and texting. Without reinventing the system for social media campaigns, WCCHD will reference the Centers for Disease Control (CDC) and Prevention toolkit for connecting the community through social media. In addition to utilizing social media, the team will engage targeted populations through local venues where they live, work and pray. WCCHD understands these methods and others will need to be culturally competent, English Proficient and literacy level appropriate.

According to data obtained from the 2012 County Health Rankings and Roadmaps, 13% of Williamson County residents report being in poor health. The same report identified that there are an estimated 80,000 residents without health insurance coverage. This translates to approximately 17% of residents who do not have health insurance coverage.[1] This statistic, in addition to the fact that this county does not meet the national benchmarks for: health screening; incidence of low birth weight; teen birth rate; incidence of adult obesity; and access to healthy food options, indicates that Williamson County residents are in need of accessible health promotion options and connection to available resources. Currently, health educators throughout WCCHD offer evidence-based health education programs and self-management education to the community, at no cost to attendees. However, the scarcity of these programs, compounded by existing barriers, specifically lack of transportation and health literacy, greatly affects the number of residents that are able to take advantage of these programs.

WCCHD proposes to target zip codes in Williamson County with the poorest perinatal outcomes, low rates of entry to prenatal care within the first trimester, highest hospital utilization rate for targeted chronic conditions (Diabetes, Asthma, Hypertension and Obesity), and available resources. This data is currently available from the State, Community Health Profiles and County Rankings.

Goals and Relationship to Regional Goals:
The goal of this project is to use an interdisciplinary team to promote preventive health awareness in the community to identified targeted populations, specifically women of child bearing age and individuals diagnosed with a chronic illness. This is in alignment with regional goals of developing projects and interventions designed to reduce the need for inappropriate utilization of services.

<u>Project Goals:</u>

- Health promotion in targeted population of women of child bearing age;
- Health promotion in targeted population of individuals with chronic disease;
- Improved health literacy among targeted populations;
- Self-management education and information for individuals with chronic disease;
- 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 meets the following Regional Goals:

- Improving access to timely, high quality care for residents, including those with multiple needs;
- Increasing coordination of prevention and care for residents, including those with behavioral or mental health needs; and
- Reducing inappropriate utilization of services.

Challenges:
The challenge in working with a population who has limited understanding and knowledge base of their health with obstacles in transportation could have an effect in engaging targeted population. For this project to be effective, we must build rapport with the targeted populations. Training Community health workers in cultural competency, health literacy, and health education along with positioning them in identified areas within the county will help to establish rapport and encourage/support participation in programs.

5-Year Expected Outcome for Provider and Patients:
WCCHD expects to increase the number of health promotion programs accessible to clients, in the targeted populations—women of child bearing age and residents with chronic disease, eventually leading to a reduction in health disparities related to prenatal care and chronic disease. WCCHD proposes to expand programs each year to the broader community, taking into consideration the population that is currently served by this agency (the safety-net population who is uninsured and underinsured).

Starting Point/Baseline:
Currently, population-based campaigns or a program to promote healthy lifestyles using evidence-based methodologies through social media and the incorporation of Community Health Workers does not exist at this time. Therefore, the baseline for number of participants, as well as the number reached by these efforts, begins at 0 in DY2.

Rationale:
Community Need Addressed:

- Community Need Area: CN.1 – Limited Access to Primary Care
- Specific Community Need: CN.1.7 – Limited access to preventive interventions for women of child bearing age and individuals with diagnosed chronic disease

According to the Texas Department of State Health Services *Potentially Preventable Hospitalizations Report*, 2005-2010, Williamson County residents had 7,713 potentially preventable hospitalizations for Congenital Heart Failure (CHF), hypertension, Chronic Obstructive Pulmonary Disease (COPD) and complications of diabetes for those 5 years, with accompanying hospital charges of $179,728,355. The Community Health Profile of Williamson County Precincts (2011) (http://www.wcchd.org/statistics and reports/) illustrates the social determinants of health of low income and lower educational status with higher incidence of chronic disease (e.g.; diabetes). The current safety-net providers have waiting lists for new patients, making it difficult for chronically-ill patients to access primary care at the appropriate times for their conditions. The combined factors of difficult access to healthcare coupled with social factors, continue to leave this population in need of navigation assistance to maneuver,

learn, and appropriately utilize services and manage their own health. According to the August 2012 WCCHD Epidemiology Program Report, in 2010, 22% of the Williamson County births were to mothers who accessed prenatal care after their first trimester of pregnancy.

Vulnerable RHP 8 citizens with chronic conditions account for large, potentially preventable healthcare expenditures of $179,728,355 in a five-year period, and 22% of pregnant women do not access care in their first trimester. The common denominator for these vulnerable populations, and hence the selection of this project is the need for advocacy, information and connection for their situations in accessing care in a coordinated system. This project will allow us to focus on expanding internal capacity to serve patients with limited health literacy levels, as well as to direct these patients to other community services in a more seamless and effective system.

As the United States health care system strives to promote healthy lifestyles, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals. Community health workers can increase access to care and facilitate appropriate use of health promotion resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, and improve quality by contributing to patient-provider communication, continuity of care, and consumer protection. In addition, community health workers will incorporate case management services for high risk patients. According to the latest issue of *Guide to Community Preventive Services 2005,* case management is effective when delivered in conjunction with education and support interventions. Interventions combined with case management include self-management education, home visits, telephone call outreach, and client reminders Utilizing Community Health Workers to strengthen case management services will prove improvements within the targeted population. Several studies related to the utilization of community health workers reported significant improvements in participants' self-management behaviors, including appointment keeping and adherence to antihypertensive medications. Similar studies reported positive changes in healthcare utilization and in systems outcomes.[2] Reducing illness, disability, and premature death and improving the quality of life for people is a major public health objective found in Healthy People 2020.

One simple conclusion can be drawn and that is a project promoting healthy lifestyles and access to care is needed in Williamson County. It already has been proven to be effective when combining case management, community support, interventions and promotion.

<u>Continuous Quality Improvement</u>: WCCHD 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 share information such as challenges, lessons learned and considerations for safety net populations.

<u>How the project represents a new initiative or significantly enhances an existing delivery system reform initiative</u>: Currently, an initiative utilizing community health workers in the community does not exist for Williamson County. However, providing case management is a service offered but only to patients enrolled in the County Indigent Health Care Program. This initiative

is in alignment with the U.S. Department of Health and Human Services (DHHS) initiative on patients with multiple chronic conditions. Managing these clients in the community (such as with self-management educations and case management) can have a significant impact on their need for accessing the emergency departments (EDs) or hospitals. This project seeks to augment the work of the community health centers in providing coordinated care to clients and connect them to a medical home. Furthermore, by utilizing a multi-disciplinary team approach, client's medical, social, and diet needs will be addressed, in a culturally-competent manner. WCCHD does not receive funding from DHHS that will be used for this program.

Related Category 3 Outcome Measure(s):

- OD-6 Patient Satisfaction
  - IT-6.1 Percent improvement over baseline of patient satisfaction scores

Reasons/rationale for selecting the outcome measure:

This particular domain was chosen to help evaluate this project's interventions. We propose to address the community's limited access to preventive interventions. By measuring improvement of patient satisfaction scores, we will be able to determine effective intervention and a positive impact on the community. As we do not currently capture this data on our client survey, we will perform a gap analysis in DY2, so we can select a tool that will help us best capture all data in this domain. In DY3, we will be working to increase access to health promotion programs and activities, continuing to perform project planning activities, and establishing a baseline for patient satisfaction. Simultaneously, we will develop health promotion programs and increase access points to health promotion activities. Meeting the needs of the clients in the community will augment their knowledge related to their chronic disease or their pregnancy, increasing the chance that they will maintain their health through self-management and appropriate primary care. Furthermore, this particular domain is centered on patient satisfaction in getting timely care, appointments, and information. This project addresses three components of this domain, in the sense that they will get the education and screening that they need, increased and timely access to health promotion programs, and relevant information. By the end of DY4, our goal is to see a 10% increase over baseline, finally leading to a 20% increase in patient satisfaction over baseline by end of DY5.

Relationship to Other Projects:

This project is one in a system of DSRIP projects that will increase access to health care, improve quality of care, and improve health outcomes for rural populations including:

- 126936702.1.1 Expanded Capacity for Access to Care
- 126936702.1.2 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;
- 126936702.1.3 Implement project to enhance collection, interpretation, and/or use of REAL data; and
- 126936702.2.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

No other providers in RHP 8 are establishing this type of initiative, though several are working with chronic disease. This project is focused on increasing access to preventive interventions in Williamson County, ultimately reducing health disparities. We have collaborated with other performing providers in the RHP to include the continuum of care necessary for targeted population served. Through the St. David's Round Rock Medical Center project (#020957901.1.1), Williamson County residents under 200% FPL will be referred and connected to acute care type of services. In addition, we are working with Bluebonnet Trails Community Services – Emergency Services Diversion Project (#126844305.2.2) which will identify high utilizers of emergency services; provide early intervention or intensive wraparound services and supports for a targeted behavioral health population, including people with co-occurring disorders. By coordinating with these projects and providers, we can contain costs by avoiding the duplication of services, and provide meaningful delivery system reform to the underserved and low-income populations. Several learning collaboratives of professionals from the areas of primary care and mental health services exist in Williamson County. These active groups, who meet monthly, strive to provide continuous quality improvements, seek new ideas and solutions to improve patient outcomes, and share with others across the State of Texas and the nation. In addition, WCCHD will participate in RHP 8 learning collaboratives on at least a semi-annual basis.

Project Valuation:
The value cost of this project for DYs 2-5 is estimated at $1,342,175. Cost covers recruitment, hiring, and training staff; tools and equipment necessary for the implementation of the project; and promotional campaigns, material and literature. The valuation of this project takes into account the degree to which the project accomplishes the goals of the Waiver, community needs, the aggregate population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. WCCHD considers this project as high need because it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing health promotion services. Utilizing this team is a fundamental approach to providing health education, health screening and outreach based on cultural background, English proficiency, and health literacy level of the individual or community. Use of methodologies such as social media and text messaging will make the programs even more accessible to the increasingly tech-savvy population. Providing these types of health promotion services/programs, such as self-management programs, will serve to divert these types of needs from the urgent and emergent care facilities.

[1]County Health Rankings (2012) www.countyhealthrankings.org
[2]Addressing Chronic Disease Through Community Health Workers: A Policy and Systems-level Approach http://www.cdc.gov/dhdsp/docs/chw_brieft.pdf
[3] American Journal of Preventive Medicine – 2007 May;32(5): 435-47
www.ncbi.nlm.nih.gov/pubmed/17478270
Texas Department of State Health Services – Health Facts Profiles (2009)
http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles/
FY 2010 Texas Medicaid Managed Care STAR Quality of Care Report:
http://www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf
Community Health Profile of Williamson County Precincts (2011)
http://www.wcchd.org/statistics_and_reports/

Williamson County and Cities Health District 126936702.2.2 (Project 2.6.1 – Pass 2) Category 2 Milestones and Metrics				
126936702.2.2	2.6.1		Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population.	
Williamson County and Cities Health District				126936702
Related Category 3 Outcome Measure:	126936702.3.7	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
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)
Milestone 1 [P-1]: Conduct an assessment of health promotion programs that involve community health workers at local and regional level. **Metric 1** [P-1.1]: Document regional assessment **Baseline/Goal:** Produce a comprehensive report documenting assessment of findings **Data Source:** Site gap analysis, program documentation, assessment and summary of findings **Milestone 1 Estimated Incentive Payment: $155,830**	**Milestone 2** [P-X] (see Planning Protocol, page 7): Establish and complete a planning process for a health promotion program to provide support to patient populations who cannot participate in health promotion activities including program to train community health workers, develop procedures and establish education programs **Metric 1** [P-X.7]: Number of people hired and trained as Community Health Workers, number of procedures and number of education programs **Baseline/Goal**: Baseline – In DY1, Community Health Workers did not exist, so baseline is 0. Goal - Develop training program with procedures and education. Train and deploy a team of 10 health promotion staff comprising of: Community Health Workers, Social Workers, RNs, Information Specialist and Case Managers		**Milestone 4** [I-8]: Increase access to health promotion programs, awareness campaigns and activities using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to evidence-based health promotion programs but are not required. **Metric 1** [I-8.1]: Increase number of target population reached. **Baseline/Goal:** Baseline – Determined in DY3 and is expected to be 213,971; Goal – Increase number of targeted population reached through health promotion activities and awareness campaigns by 42,000 in DY4. **Data Source:** Documentation of target population reached through health promotion activities and awareness campaigns as designated in the project plan.	**Milestone 5** [I-8]: Increase access to health promotion programs, awareness campaigns and activities using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to evidence-based health promotion programs but are not required. **Metric 1** [I-8.1]: Increase number of target population reached. **Baseline/Goal:** Baseline – Determined in DY3 and is expected to be 213,971; Goal –Increase number of targeted population reached through health promotion activities and awareness campaigns to 54,000 in DY5. **Data Source:** Documentation of target population reached through health promotion activities and awareness campaigns as designated in the project plan. **Milestone 5 Estimated Incentive**

	Date Source: Training and procedures documentation **Milestone 2 Estimated incentive: $144,692** **Milestone 3** [P-2]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community **Metric 1** [P-2.1]: Document innovative strategy and plan **Baseline/Goal:** Baseline - Using data from the DY2 assessment of health promotion programs that involve community health workers at the local and regional level; Goal - Determine priority of interventions through findings **Data Source:** Evidence of innovational plan **Milestone 3 Estimated Incentive Payment: $144,691**	**Milestone 4 Estimated Incentive Payment: $296,883**	**Payment: $420,028**
Year 2 Milestone Bundle Amount: $155,830	**Year 3 Estimated Milestone Bundle Amount: $289,383**	**Year 4 Estimated Milestone Bundle Amount: $296,883**	**Year 5 Estimated Milestone Bundle Amount: $420,028**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,162,124			

Category 3 Quality Improvements - Narratives & Tables

- **Bell County Public Health District**
  - 088334001.3.1
  - 088334001.3.2
  - 088334001.3.3
  - 088334001.3.4 (Pass 2)

- **Bluebonnet Trails Community Services**
  - 126844305.3.1
  - 126844305.3.2
  - 126844305.3.3
  - 126844305.3.4
  - 126844305.3.5
  - 126844305.3.6 (Pass 2)
  - 126844305.3.7 (Pass 2)
  - 126844305.3.8 (Pass 2)
  - 126844305.3.9 (Pass 2)

- **Center for Life Resources**
  - 133339505.3.1

- **Central Counties Services**
  - 081771001.3.1
  - 081771001.3.2
  - 081771001.3.3
  - 081771001.3.4
  - 081771001.3.5
  - 081771001.3.6
  - 081771001.3.7 (Pass 2)
  - 081771001.3.8 (Pass 2)

- **Hill Country MHDD Centers**
  - 133340307.3.1
  - 133340307.3.2
  - 133340307.3.3
  - 133340307.3.4
  - 133340307.3.5
  - 133340307.3.6 (Pass 2)
  - 133340307.3.7 (Pass 2)

- **Little River Healthcare**
  - 183086102.3.1 (Pass 2)
  - 183086102.3.2 (Pass 2)
  - 183086102.3.3 (Pass 2)
  - 183086102.3.4 (Pass 2)

- **Scott & White Hospital – Llano**
  - 020840701.3.1
  - 020840701.3.2 (Pass 2)

- **Scott & White Memorial Hospital**
  - 137249208.3.1
  - 137249208.3.2

- **Seton Highland Lakes Hospital**
  - 094151004.3.1 (Pass 2)

- **St. David's Round Rock Medical Center**
  - 02095790.3.1

- **Williamson County and Cities Health District**
  - 126936702.3.1
  - 126936702.3.2
  - 126936702.3.3
  - 126936702.3.4
  - 126936702.3.5
  - 126936702.3.6
  - 126936702.3.7 (Pass 2)

Category 3 Project Narrative
Bell County Public Health District – 088334001.3.1

Outcome Domain: OD-9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.4 Other Evidence based outcome measure: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics.

Unique RHP Outcome Identification Number: 088334001.3.1

Title of Category 1 or 2 Project: 088334001.2.1 - 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)
Performing Provider Name: Bell County Public Health District
Performing Provider TPI #: 088334001

Outcome Measure Description:

- OD-9 Right Care, Right Setting
  - 088334001.3.1 - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics

<u>Associated Category 3 Measures:</u>

- OD-9 Right Care, Right Setting
  - 088334001.3.2 - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics
  - 088334001.3.3 IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics

Process Milestones:

- DY2:
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Baseline is percent of retests done on clients with positive Chlamydia.
- DY3:
  - P-3: Develop and test data systems

Outcome Improvement Targets for each Year:

- DY3:
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics; Goal is to retest 70% of positives clients.
- DY4:

- IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics; Goal is to retest 80% of positives clients.

- DY5:
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics; Goal is to retest 90% of positives clients.

Rationale:
In 2011 and similar to 2010, there were **254** patients who tested positive for Chlamydia in Health District clinics (Bell County Public Health District, 2012). A high prevalence of Chlamydia infection has been observed in women and men who were treated for Chlamydial infection during the preceding several months. Most post-treatment infections result from reinfection caused by failure of sex partners to receive treatment or the initiation of sexual activity with a new infected partner. Repeat infections confer an elevated risk for PID and other complications. Unlike the test-of-cure, which is not recommended, repeat *C. trachomatis* testing of recently infected women or men should be a priority for providers. Chlamydia-infected women and men should be retested approximately 3 months after treatment, regardless of whether they believe that their sex partners were treated (Fung M, Scott KC, Kent CK, et al. Chlamydial and gonococcal reinfection among men: a systematic review of data to evaluate the need for retesting. Sex Transm Infect 2007;83:304–9; Hosenfeld CB, Workowski KA, Berman S, et al. Repeat infection with Chlamydia and gonorrhea among females: a systematic review of the literature. Sex Transm Dis 2009;36:478–89). If retesting at 3 months is not possible, clinicians should retest whenever persons next present for medical care in the 12 months following initial treatment (CDC, 2012). If more clients, who had been treated for positive Chlamydia, would retest at 3 months, reinfections would be caught early and appropriate retreatment provided, thereby decreasing risk of transmission to others and/or hospitalization for serious sequelae (PID). In 2011, the Chlamydia cases / rate in Bell County were 3,933 cases, rate of 1,325.7 (compared to 2010 - 4,007 cases, rate of 1,375.2). The Chlamydia rates are the highest in the state in Bell County for 2010 & 2011 (Texas STD Surveillance Report, DSHS, 2010 & 2011). Unfortunately, it is often difficult to get positive clients to come back into the clinic for a retest. That is the reason why the outcome improvement targets are for 30% in DY3, 40% in DY4, and 50% in DY5, as opposed to a larger number.

Outcome Measure Valuation:
The cost of the project takes into consideration the salaries and fringe benefits of the nursing staff performing services, indirect costs of the administrative staff overseeing the project, and advertising costs to increase awareness of the project.

Bell County Public Health District Category 3 Project - 088334001.3.1 Related Category 2 Project - 088334001.2.1 (Project Area 2.7.1)			
088334001.3.1	IT-9.4	Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics	
Bell County Public Health District			088334001
Related Category 1 or 2 projects:	088334001.2.1		
Starting Point/Baseline:	Starting Point/Baseline: 586 clients tested for Gonorrhea in Bell County		
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:** Clinic schedule **Process Milestone 1 Estimated Incentive Payment: $1,051** **Process Milestone 2** [P-2]: Establish baseline rates **Data Source:** Clinic records **Process Milestone 2 Estimated Incentive Payment: $1,052**	**Process Milestone 3** [P-3]: Develop and test data systems **Data Source:** Clinic records **Process Milestone 3 Estimated Incentive Payment: $3,500** **Outcome Improvement Target 1** [IT-9.4]: Percent of Clients being retested at 3 months for Chlamydia in Health District clinics. **Improvement Target:** 30% improvement over baseline **Data Source:** Clinic records **Outcome Improvement Target 1 Estimated Incentive Payment: $3,500**	**Outcome Improvement Target 2** [IT-9.4]: Percent of Clients being retested at 3 months for Chlamydia in Health District clinics. **Improvement Target:** 40% improvement over baseline **Data Source:** Clinic records **Outcome Improvement Target 2 Estimated Incentive Payment: $9,809**	**Outcome Improvement Target 3** [IT-9.4]: Percent of Clients being retested at 3 months for Chlamydia in Health District clinics. **Improvement Target:** 50% improvement over baseline **Data Source:** Clinic records **Outcome Improvement Target 3 Estimated Incentive Payment: $19,000**
Year 2 Estimated Outcome Amount: $2,103	**Year 3 Estimated Outcome Amount: $7,000**	**Year 4 Estimated Outcome Amount: $9,809**	**Year 5 Estimated Outcome Amount: $19,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $37,912			

Category 3 Project Narrative
Bell County Public Health District – 088334001.3.2

Outcome Domain: OD-9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.4 Other Evidence based outcome measure: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics.

Unique RHP Outcome Identification Number: 088334001.3.2

Title of Category 1 or 2 Project: 088334001.2.1 - 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)
Performing Provider Name: Bell County Public Health District
Performing Provider TPI #: 088334001

Outcome Measure Description:

- OD-9 Right Care, Right Setting
  - 088334001.3.2 - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics

<u>Associated Category 3 Measures:</u>

- OD-9 Right Care, Right Setting
  - 088334001.3.1 - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics
  - 088334001.3.3 IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics

Process Milestones:

- DY2:
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Baseline is percent of retests done on clients with positive Gonorrhea.
- DY3:
  - P-3: Develop and test data systems

Outcome Improvement Targets for each Year:

- DY3:
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics; Goal is to retest 70% of positives clients.

- DY4:
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics; Goal is to retest 80% of positives clients.
- DY5:
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics; Goal is to retest 90% of positives clients.

Rationale:
In 2011 and similar to 2010, there were **107** patients who tested positive for Gonorrhea in Health District clinics (Bell County Public Health District, 2012). *N. gonorrhoeae* reinfection is prevalent among patients who have been diagnosed with and treated for Gonorrhea in the preceding several months (Peterman TA, Tian LH, Metcalf CA, et al. High incidence of new sexually transmitted infections in the year following a sexually transmitted infection: a case for rescreening. Ann Intern Med 2006;145:564–72; Fung M, Scott KC, Kent CK, et al. Gonorrheal and gonococcal reinfection among men: a systematic review of data to evaluate the need for retesting. Sex Transm Infect 2007;83:304–9; Hosenfeld CB, Workowski KA, Berman S, et al. Repeat infection with Gonorrhea and Gonorrhea among females: a systematic review of the literature. Sex Transm Dis 2009;36:478–89)). The majority of urethral infections caused by *N. gonorrhoeae* among men produce symptoms that cause them to seek curative treatment soon enough to prevent serious sequelae, but treatment might not be soon enough to prevent transmission to others. Among women, gonococcal infections might not produce recognizable symptoms until complications (e.g., PID) have occurred. PID can result in tubal scarring that can lead to infertility or ectopic pregnancy (CDC, 2012).

Most infections result from reinfection rather than treatment failure, indicating a need for improved patient education and referral of sex partners. Clinicians should advise patients with Gonorrhea to be retested 3 months after treatment. If patients do not seek medical care for retesting in 3 months, providers are encouraged to test these patients whenever they next seek medical care within the following 12 months, regardless of whether the patients believe that their sex partners were treated. Retesting is distinct from test-of-cure to detect therapeutic failure, which is not recommended (CDC, 2012).

If more clients, who had been treated for positive Gonorrhea, would retest at 3 months, reinfections would be caught early and appropriate retreatment provided, thereby decreasing risk of transmission to others and/or hospitalization for serious sequelae (PID). In 2011, the Gonorrhea cases / rate in Bell County were 1075 cases, rate of 362.4 (compared to 2010 - 1181 cases, rate of 405.3). The Gonorrhea rates are the among the highest in the state in Bell County for 2010 & 2011 (Texas STD Surveillance Report, DSHS, 2010 & 2011). Unfortunately, it is often difficult to get positive clients to come back into the clinic for a retest. That is the reason why the outcome improvement targets are for 30% in DY3, 40% in DY4, and 50% in DY5, as opposed to a larger number.

Outcome Measure Valuation:
The cost of the project takes into consideration the salaries and fringe benefits of the nursing staff performing services, indirect costs of the administrative staff overseeing the project, and advertising costs to increase awareness of the project.

Bell County Public Health District Category 3 Project - 088334001.3.2 Related Category 2 Project - 088334001.2.1 (Project Area 2.7.1)			
088334001.3.2	IT-9.4	Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics	
Bell County Public Health District			088334001
Related Category 1 or 2 projects:	088334001.2.1		
Starting Point/Baseline:	Starting Point/Baseline: 586 clients tested for Gonorrhea in Bell County		
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:** Clinic schedule **Process Milestone 1 Estimated Incentive Payment: $1,051** **Process Milestone 2** [P-2]: Establish baseline rates **Data Source:** Clinic records **Process Milestone 2 Estimated Incentive Payment: $1,052**	**Process Milestone 3** [P-3]: Develop and test data systems **Data Source:** Clinic records **Process Milestone 3 Estimated Incentive Payment: $3,500** **Outcome Improvement Target 1** [IT-9.4]: Percent of Clients being retested at 3 months for Gonorrhea in Health District clinics. **Improvement Target:** 30% improvement over baseline **Data Source:** Clinic records **Outcome Improvement Target 1 Estimated Incentive Payment: $3,500**	**Outcome Improvement Target 2** [IT-9.4]: Percent of Clients being retested at 3 months for Gonorrhea in Health District clinics. **Improvement Target:** 40% improvement over baseline **Data Source:** Clinic records **Outcome Improvement Target 2 Estimated Incentive Payment: $9,809**	**Outcome Improvement Target 3** [IT-9.4]: Percent of Clients being retested at 3 months for Gonorrhea in Health District clinics. **Improvement Target:** 50% improvement over baseline **Data Source:** Clinic records **Outcome Improvement Target 3 Estimated Incentive Payment: $19,000**
Year 2 Estimated Outcome Amount: $2,103	**Year 3 Estimated Outcome Amount: $7,000**	**Year 4 Estimated Outcome Amount: $9,809**	**Year 5 Estimated Outcome Amount: $19,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $37,912			

Category 3 Project Narrative
Bell County Public Health District – 088334001.3.3

Outcome Domain: OD-9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.4 Other Evidence based outcome measure: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics.

Unique RHP Outcome Identification Number: 088334001.3.3

Title of Category 1 or 2 Project: 088334001.2.1 - 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.)
Performing Provider Name: Bell County Public Health District
Performing Provider TPI #: 088334001

Outcome Measure Description:

- OD-9 Right Care, Right Setting
  - 088334001.3.3 - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics

<u>Associated Category 3 Measures:</u>

- OD-9 Right Care, Right Setting
  - 088334001.3.1 - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Chlamydia 3-months after treatment for positive Chlamydia in Bell County Public Health District clinics
  - 088334001.3.2 - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Gonorrhea 3-months after treatment for positive Gonorrhea in Bell County Public Health District clinics

Process Milestones:

- DY2:
  - P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Baseline is percent of retests done on clients with positive Syphilis.
- DY3:
  - P-3: Develop and test data systems

Outcome Improvement Targets for each Year:

- DY3:
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics; Goal is to retest 70% of positives clients.

- DY4:
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics; Goal is to retest 80% of positives clients.
- DY5:
  - IT-9.4: Other Evidence based Screening Outcome Measures: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics; Goal is to retest 90% of positives clients.

Rationale:
Syphilis, a genital ulcerative disease, causes significant complications if untreated and facilitates the transmission of HIV infection. Untreated early Syphilis in pregnant women results in perinatal death in up to 40% of cases and, if acquired during the 4 years before pregnancy, can lead to infection of the fetus in 80% of cases (Ingraham NR. The value of penicillin alone in the prevention and treatment of congenital Syphilis. Acta Derm Venereol. 1951:31 (Suppl 24):60-88.)

In 2011 and similar to 2010, there were **40** patients who tested positive for Syphilis in Health District clinics (Bell County Public Health District, 2012). Patients who test positive for Syphilis need regular follow up blood redraws to ensure treatment was successful or to detect reinfection. The recommended schedule for redraws is every 6 months for two years following treatment. Most infections result from reinfection rather than treatment failure, indicating a need for improved patient education and referral of sex partners. Clinicians should advise patients with Syphilis to be retested every six months after treatment. If patients do not seek medical care for retesting in 6 months, providers are encouraged to test these patients whenever they next seek medical care within the following 24 months, regardless of whether the patients believe that their sex partners were treated.

If more clients, who had been treated for positive Syphilis, would retest every 6 months, reinfections would be caught early and appropriate retreatment provided, thereby decreasing risk of transmission to others and/or hospitalization for serious sequelae. In 2011, the Syphilis cases / rate in Bell County were 5 cases, rate of 1.7 (compared to 2010 - 16 cases, rate of 5.5 (Texas STD Surveillance Report, DSHS, 2010 & 2011). Unfortunately, it is often difficult to get positive clients to come back into the clinic for a retest. That is the reason why the outcome improvement targets are for 30% in DY3, 40% in DY4, and 50% in DY5, as opposed to a larger number.

Outcome Measure Valuation:
The cost of the project takes into consideration the salaries and fringe benefits of the nursing staff performing services, indirect costs of the administrative staff overseeing the project, and advertising costs to increase awareness of the project.

Bell County Public Health District Category 3 Project - 088334001.3.3 Related Category 2 Project - 088334001.2.1 (Project Area 2.7.1)			
088334001.3.3	IT-9.4	Other Evidence based outcome measure: Increase the number of clients retested for Syphilis 6-months after treatment for positive Syphilis in Bell County Public Health District clinics.	
Bell County Public Health District			088334001
Related Category 1 or 2 projects:	088334001.2.1		
Starting Point/Baseline:	Starting Point/Baseline: 586 clients tested for Syphilis in Bell County		
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:** Clinic schedule **Process Milestone 1 Estimated Incentive Payment: $1,051** **Process Milestone 2** [P-2]: Establish baseline rates **Data Source:** Clinic records **Process Milestone 2 Estimated Incentive Payment: $1,052**	**Process Milestone 3** [P-3]: Develop and test data systems **Data Source:** Clinic records **Process Milestone 3 Estimated Incentive Payment: $3,500** **Outcome Improvement Target 1** [IT-9.4]: Percent of Clients being retested at 6 months for Syphilis in Health District clinics. **Improvement Target:** 30% improvement over baseline **Data Source:** Clinic records **Outcome Improvement Target 1 Estimated Incentive Payment: $3,500**	**Outcome Improvement Target 2** [IT-9.4]: Percent of Clients being retested at 6 months for Syphilis in Health District clinics. **Improvement Target:** 40% improvement over baseline **Data Source:** Clinic records **Outcome Improvement Target 2 Estimated Incentive Payment: $9,809**	**Outcome Improvement Target 3** [IT-9.4]: Percent of Clients being retested at 6 months for Syphilis in Health District clinics. **Improvement Target:** 50% improvement over baseline **Data Source:** Clinic records **Outcome Improvement Target 3 Estimated Incentive Payment: $19,000**
Year 2 Estimated Outcome Amount: $2,103	**Year 3 Estimated Outcome Amount: $7,000**	**Year 4 Estimated Outcome Amount: $9,809**	**Year 5 Estimated Outcome Amount: $19,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $37,912			

Category 3 DSRIP Project Narrative
Bell County Public Health District – 088334001.3.4 – Pass 2

Outcome Domain: OD-6 – Patient Satisfaction
Title of Outcome Measure (Improvement Target): IT-6.1 – Percent Improvement over baseline of patient satisfaction scores
Unique RHP Outcome Identification Number: 088334001.3.4

Title of Category 1 Project: 088334001.2.2 – 2.7.1 Implement Evidence-based Health Promotion & Disease Prevention Programs. Implement evidence-based strategies to increase screenings and referral for targeted populations.
Performing Provider TPI #: 088334001

Outcome Measure Description:

- OD-6 – Patient Satisfaction
  - IT-6.1: Percent Improvement over baseline of patient satisfaction scores

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-6.1]: Percent improvement over baseline of patient satisfaction scores; target 10% increase over baseline.
- **DY5:**
  - [IT-6.1]: Percent improvement over baseline of patient satisfaction scores; target 20% increase over baseline.

Rationale:
In Category 2, Bell County Public Health District's ("Health District") project goal is to increase the number of females screened for Sexually Transmitted Diseases (STD'S) in Health District clinics to reduce the sequelae associated with undiagnosed and untreated STD's. It is important to the Health District to inquire of clients accessing services as to the quality of services provided. The Health District will utilize CAHPS Clinician & Group Survey, Version 2.0, Adult, to establish that patients are receiving timely care, appointments, and information; how well their healthcare providers communicate; and that patients are involved in shared decision making in Health District clinics. The Health District will utilize this survey in DY2. In DY3, baseline scores for patient satisfaction will be established. In subsequent years, the Health District will strive to

improve over baseline on patient satisfaction scores, once baseline has been established. The Health District will utilize the information received from the surveys to improve the delivery of clinic services.

Outcome Measure Valuation:
The cost of the project takes into consideration the salaries and fringe benefits of the nursing staff performing services, indirect costs of the administrative staff overseeing the project, and costs associated with implementation and maintenance of the project. Not included in the cost but certainly part of the decision to propose this project, is the costs avoided to our community inappropriate medical facility use and the impact in human life.

Bell County Public Health District – 088334001.3.4 Related Category 2 Project – 088334001.2.2 (2.7.1)			
088334001.3.4	**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)***	
Bell County Public Health District			**088334001**
Related Category 1 or 2 projects:	**088334001.2.2**		
Starting Point/Baseline:	**Improve patient satisfaction above first surveyed results – Baseline TBD in DY3**		
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**: CAHPS Clinician & Group Survey, Version 2.0, Adult **Process Milestone 1 Estimated Incentive Payment: $5,000**	**Process Milestone 2** [P-2]: Establish baseline rates **Data Source:** CAHPS Clinician & Group Survey, Version 2.0, Adult **Process Milestone 2 Estimated Incentive Payment: $21,984**	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores **Improvement Target:** TBD improvement over baseline (TBD in DY3) of patient satisfaction scores for patients surveyed in BCPHD STD clinics **Data Source:** CAHPS Clinician & Group Survey, Version 2.0, Adult **Outcome Improvement Target 1 Estimated Incentive Payment: $26,381**	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores **Improvement Target:** TBD improvement over baseline (TBD in DY3) of patient satisfaction scores for patients surveyed in BCPHD STD clinics **Data Source:** CAHPS Clinician & Group Survey, Version 2.0, Adult **Outcome Improvement Target 2 Estimated Incentive Payment: $63,314**
Year 2 Estimated Outcome Amount: improvement target): $5,000	**Year 3 Estimated Outcome Amount: $21,984**	**Year 4 Estimated Outcome Amount: $26,381**	**Year 5 Estimated Outcome Amount: $63,314**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $116,679			

Bluebonnet Trails Community Services – 126844305.3.1

Outcome Domain: OD-6 Patient Satisfaction
Title of Outcome Measure (Improvement Target): IT-6.2 (Other) Percent improvement over baseline of patient satisfaction scores
Unique RHP Outcome Identification Number: 126844305.3.1

Title of Category 1 or 2 Project: 126844305.1.1 - 1.12.2 Expansion of Services to Chronically Mentally Ill Population to East Williamson County
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Performing Provider TPI #: 126844305

Outcome Measure Description:

- OD-6: Patient Satisfaction
  - IT-6.2: Percent improvement over baseline of patient satisfaction scores
    - Getting timely care, appointments, and information;
    - How well their doctors communicate; and
    - Patient's overall health status/functional status.

Process Milestones:

- DY2:
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems

Outcome Improvement Target for each Year:

- DY4:
  - IT-6.1: TBD Percent improvement over baseline of patient satisfaction scores
- DY5:
  - IT-6.1: TBD Percent improvement over baseline of patient satisfaction scores

Rationale:
Process Milestones – P-2 and P-3 were chosen because although the clinic will begin operating in DY2, there are no current services and therefore initial survey data regarding timeliness, communication and health status/functional status must be gathered. As we begin to provide and collect surveys, in DY2, we will then need to apply a Plan, Do, Study, Act (PDSA) cycle to assure that data systems are accurate, that we are collecting enough samples and for the patients as needed. This testing will proceed through DY3 in order to finalize baseline.

Although this measure is of satisfaction, it is specific within the ECHO^{tm} instrument to measurement of satisfaction related to timely care and appointments, adequacy of information provided at appointments, provider communication and self-assessment of the patient's overall health status and functional status. We feel that these are detailed, specific and therefore very strong improvement targets chosen to measure the important domains of timeliness, provider

communication and overall health status/functional status because these are three critical elements on the ECHO™ Survey and we feel they will be the best measure of overall success of the Clinic. A version of ECHO™ was adopted by NCQA for inclusion in HEDIS. It is also a registered CAHPS instrument that is specifically used with behavioral health interventions and therefore we feel it meets the Stand Alone requirements stated in this Measure. (ECHO™ Survey Homepage, http://www.hcp.med.harvard.edu/echo/.) These domains to be measured are related to the goals for this clinic, i.e., improving access to care, improving quality of care and improving overall health and functioning of the patients treated. These domains are also reflective of one of the triple aims, to improve the patient experience of health care.

Outcome Measure Valuation:
We expect to serve 1,500 adults and youth in DY4 and 2,000 new patients in DY5 and to do so in or closer to their home communities. 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).

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails Category 3 Project - 126844305.3.1 Related Category 1 Project - 126844305.1.1 (Project Area 1.12.2)			
126844305.3.1	**IT-6.2**	**Percent improvement over baseline of patient satisfaction scores**	
Bluebonnet Trails MHMR			**126844305**
Related Category 1 or 2 projects:	**126844305.1.1**		
Starting Point/Baseline:	**Baseline is 0 since no service now exists. Satisfaction Score baselines to be determined during DY2**		
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 rates. **Data Source:** ECHO™ Surveys **Process Milestone 1 Estimated Incentive Payment: $8,288**	**Process Milestone 2** [P-3]: Develop and test data systems **Data Source:** Program Records, surveys **Process Milestone 2 Estimated Incentive Payment: $57,567**	**Outcome Improvement Target 1** [IT-6.2]: Patients are getting timely care, appointments, and information. Percent improvement over baseline of patient satisfaction scores. **Improvement Target:** Percent TBD **Data Source:** ECHO™ Surveys and Reports **Outcome Improvement Target 1 Estimated Incentive Payment: $43,824**	**Outcome Improvement Target 2** [IT-6.2]: Percent improvement over baseline of patient satisfaction scores. **Improvement Target:** Percent TBD **Data Source:** ECHO™ Surveys and Reports **Outcome Improvement Target 2 Estimated Incentive Payment: $69,113**
Year 2 Estimated Outcome Amount: $8,288	**Year 3 Estimated Outcome Amount: $57,567**	**Year 4 Estimated Outcome Amount: $43,824**	**Year 5 Estimated Outcome Amount: $69,113**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $178,792			

Category 3 Project Narrative
Bluebonnet Trails Community Services – 126844305.3.2

Outcome Domain: OD-3 Potentially Preventable Re-Admissions - 30 day Readmission Rates
Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rates.
Unique RHP Outcome Identification Number: 126844305.3.2

Title of Category 1 or 2 Project: 126844305.1.2 - 1.13.1 Crisis Respite for Persons in Behavioral Health Crisis
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Performing Provider TPI #: 126844305

Outcome Measure Description:

- OD- 3 Potentially Preventable Re-Admissions- 30 day Readmission Rates
  - IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rates

Process Milestones:

- DY 2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2: Establish baseline rates
- DY 3:
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Target for each Year:

- DY 4
  - IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rates; Target TBD
- DY 5
  - IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rates; Target TBD

Rationale:
We selected project planning and stakeholder engagement as well as establishing baseline rates for the Process Milestones for DY2 because although we need to accomplish some very fundamental tasks with the community and with regard to better analysis of causes for readmissions, we also must begin providing this service. We will begin operations as soon as possible because of the need for crisis alternatives in the community. This will give us the opportunity to establish baseline and test it and the systems in DY3. We selected the Plan, Do Study, Act (PDSA) cycle in addition to developing and testing data systems for DY3 Process Milestone because we feel that rapid implementation will call for a rapid cycle analysis and improvements to those operations.

According to *Potentially Preventable Hospital Readmissions among Medicaid Recipients with Mental Health and/or Substance Abuse Health Conditions Compared with All Others: New York State, 2007*, a study published by the New York State Department of Health Division of Quality and Evaluation, "Medicaid recipients whose most significant primary health conditions in 2007 were both mental health and substance abuse conditions experienced potentially preventable hospital readmissions (PPR) over 3.5 times more frequently than recipients with neither of these health conditions. Recipients with a history of mental health and/or substance abuse conditions during 2007 were most commonly admitted to the hospital and subsequently readmitted for mental health and/or substance abuse, and HIV infections. Recipients with all other health conditions were most commonly initially admitted and subsequently readmitted for diseases and disorders of the circulatory, respiratory, or digestive systems" (http://www.health.ny.gov/health_care/managed_care/reports/statistics_data/3hospital_readmissions_mentahealth.pdf). We selected Improvement Target for DY4 and 5 is the stand-alone measure IT-3.8 Behavioral Health/ Substance Abuse 30 day readmission rates because of this well-known and researched connection between substance abuse/mental illnesses and hospital readmissions. **The goals of the project are to provide services to the target population of people who have been hospitalized or experienced a crisis event and/or have been in the Crisis Respite facility and to assist them to regain functioning and self-manage their wellness**. Improvement in functioning and self-management of symptoms and wellness are critical patient outcomes. When the goals are achieved then program participants should experience 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. We have not established the baseline and therefore we do not propose specific levels of reduction.

Outcome Measure Valuation:
We expect to serve 250 people in this community based crisis alternative in DY4 and 300 people in DY5. Our goal is to serve people in the community. This not only represents a substantial savings over using hospital and ED, but more importantly improves the lives of those who otherwise would have go to hospital out of County or spend wasted time in inappropriate ED settings. Currently hospital and EDs are the only options. 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/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7.

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails Category 3 Project - 126844305.3.2 Related Category 1 Project - 126844305.1.2 (Project Area 1.13.1)			
126844305.3.2	**IT-3.8**	**Behavioral Health/Substance Abuse 30 day readmission rate**	
Bluebonnet Trails MHMR			**126844305**
Related Category 1 or 2 projects:	**126844305.1.2**		
Starting Point/Baseline:	**Starting Point/Baseline is 0 for DY2**		
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:** Program Documents **Process Milestone 1 Estimated Incentive Payment: $37,500** **Process Milestone 2** [P-2]: Establish baseline rates. **Data Source:** EHR, local MH authority and state MH data system records. **Process Milestone 2 Estimated Incentive Payment: $37,500**	**Process Milestone 3** [P- 3]: Develop and test data systems **Data Source:** Business Intelligence reports. **Process Milestone 3 Estimated Incentive Payment: $87,500** **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. **Data Source:** QM data reports and Communication documents **Process Milestone 4 Estimated Incentive Payment: $87,500**	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rate **Improvement Target:** Baseline TBD in DY 3, Target TBD according to baseline **Data Source:** EHR, local MH authority and state MH data system records. **Outcome Improvement Target 1 Estimated Incentive Payment: $175,000**	**Outcome Improvement Target 2** [IT-3.8]: Behavioral Health/Substance Abuse 30 day readmission rate **Improvement Target:** Baseline TBD in DY 3, Target TBD according to baseline **Data Source:** EHR, local MH authority and state MH data system records. **Outcome Improvement Target 2 Estimated Incentive Payment: $320,000**
Year 2 Estimated Outcome Amount: $75,000	**Year 3 Estimated Outcome Amount: $175,000**	**Year 4 Estimated Outcome Amount: $175,000**	**Year 5 Estimated Outcome Amount: $320,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $745,000			

Category 3 Project Narrative
Bluebonnet Trails 126844305.3.3

Outcome Domain: OD-9 Right Care, Right Setting
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 Outcome Identification Number: 126844305.3.3

Title of Category 1 or 2 Project: 126844305.1.3 **-** 1.13.1 Child Crisis Respite through Therapeutic Foster Care
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails community Services
Performing Provider TPI #: 126844305

Outcome Measure Description:

- 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

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 Target for each Year:

- DY 4:
  - IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings; Target TBD
- DY 5:
  - IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings; Target TBD

Rationale:
We selected project planning and stakeholder engagement as the Process Milestones for DY2 because we need to accomplish these foundational tasks in order to establish Crisis Respite through Therapeutic Foster Care (TFC). Establishing this crisis stabilization alternative to referral to juvenile probation in order to secure an inpatient or secure residential setting will achieve the Outcome. We selected the DY3 Process Milestone because we need a year of operation to establish the number served and we need time to gather additional juvenile justice system data concerning the number referred for mental health services in order to measure our Improvement Target.

The Improvement Target for DY4 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. Unfortunately lack of behavioral health resources has led to the juvenile justice system and child protective system providing access to care. The Juvenile Probation Department is a major partner and therefore we feel that reducing the number of removals from home and community is one of the best measures of success. The project will also decrease the number of admissions and readmissions to the criminal justice system due to providing an alternative admission to a TFC.

The Outcome Measure is to provide the Right Care in The Right Setting and thereby decrease in mental health admissions and readmissions to criminal justice settings. It is not in the interest of youth, the community and families to incarcerate or remove youth who need behavioral health services. This project will divert youth so that they are not subject to incarceration and rather provided needed behavioral health services. Providing this local crisis alternative clearly provides a patient benefit by supporting access to needed treatment. The project proposed is to establish a crisis stabilization alternative that will allow for stabilization in the community and an environment that nurtures natural supports. Due to safety and security concerns, families and the community currently refer youth to juvenile justice even though the problem is a mental health problem because there is no other safe stabilization alternative. Providing such an alternative gives us the opportunity to achieve this Outcome while strengthening the resources available to youth and families in the community.

Outcome Measure Valuation:
The project seeks to provide 730 crisis respite bed days in DY4 serving 16 youth; and to provide 1,460 crisis respite bed days in DY5 serving 30 youth. These are very high intensity youth who otherwise would be removed from home and placed in a psychiatric hospital or residential treatment facility. Both of these options are expensive and separate the family from the treatment process and seriously reducing the chances for reunification with the family. Providing the Right Care in the Right Setting improves the lives of these youth and their families. 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/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7.

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails Category 3 Project - 126844305.3.3 Related Category 1 Project - 126844305.1.3 (Project Area 1.13.1)			
126844305.3.3	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons**	
Bluebonnet Trails MHMR			**126844305**
Related Category 1 or 2 projects:	**126844305.1.3**		
Starting Point/Baseline:	**Baseline is 0 TBD in DY3**		
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:** Program Documents **Process Milestone 1 Estimated Incentive Payment: $14,375**	**Process Milestone 2** [P- 2]: Establish baseline rates. **Data Source:** Juvenile justice system records, local MH authority and state MH data system records. **Process Milestone 2 Estimated Incentive Payment: $38,750**	**Outcome Improvement Target 1** [IT-9.1]: Decrease in mental health admissions and readmissions to juvenile justice settings. **Improvement Target:** Decrease in mental health admissions and readmissions to juvenile justice settings by TBD % of baseline from DY3. **Data Source:** Juvenile justice system records, local MH authority and state MH data system records **Outcome Improvement Target 1 Estimated Incentive Payment: $38,750**	**Outcome Improvement Target 2** [IT-9.1]: Decrease in mental health admissions and readmissions to juvenile justice settings. **Improvement Target:** Decrease in mental health admissions and readmissions to juvenile justice settings by TBD % of baseline from DY3. **Data Source:** Juvenile justice system records, local MH authority and state MH data system records **Outcome Improvement Target 2 Estimated Incentive Payment: $77,500**
Year 2 Estimated Outcome Amount: $14,375	**Year 3 Estimated Outcome Amount: $38,750**	**Year 4 Estimated Outcome Amount: $38,750**	**Year 5 Estimated Outcome Amount: $77,500**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $169,375			

Category 3 Project Narrative
Bluebonnet Trails 126844305.3.4

Outcome Domain: OD- 3 Potentially Preventable Re-Admissions- 30 day Readmission Rates
Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rates
Unique RHP Outcome Identification Number: 126844305.3.4

Title of Category 1 or 2 Project: 126844305.2.1 - 2.13.2 Transitional Housing Guided by Peer Support
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Performing Provider TPI #: 126844305

Outcome Measure Description:

- OD- 3 Potentially Preventable Re-Admissions - 30 day Readmission Rates
  - IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rates

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Target for each Year:

- DY4:
  - IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rates
- DY5:
  - IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rates

Rationale:
We selected project planning and stakeholder engagement for the Process Milestones for DY2 because we will be using Peer Support Specialists in an expanded and role and preparation for recruitment, research of models developing training materials will be critical for success. We also selected establishing baseline rates because Transitional Housing services are needed in the community as a resource for those coming from crises stabilization or an inpatient stay. We will provide the service while developing the Peer Supports more fully. We believe a baseline can be established during this initial period due to demand for the service. We expect to establish baseline and test it and the systems in DY3. We selected the Plan, Do, Study, Act (PDSA) cycle in addition to developing and testing data systems for DY3 Process Milestone

because we feel the research and development work needed to assure adherence to Recovery principles will demand constant review and adjustment at least through DY3.

Several states, among them New York, California and Minnesota have begun programs to provide housing as a way of reducing Potentially Preventable Readmissions, as documented in the article, *Residential therapy: Hospitals take on finding housing for homeless patients, hoping to reduce readmissions, lower costs*, in ModernHealthcare.com ; (http://www.modernhealthcare.com/article/20120922/MAGAZINE/309229988#). Some of the transitional and permanent housing programs are funded through CMS and some through health systems seeking to reduce readmissions. We selected the stand-alone measure IT-3.8 Behavioral Health/ Substance Abuse 30 day readmission rates for the Improvement Target for DY 4 and 5 because of the link between housing and readmissions. The goals of the project are to provide services to the target population of people who have been hospitalized or experienced a crisis event and/or have been in the Crisis Respite facility and to assist them to regain functioning and self-manage their wellness. When the goals are achieved then program participants should experience a reduction in symptoms and a reduction in crisis events. Along with those reductions in symptoms, stable housing will allow recovery to continue and wellness self-management to become incorporated into the lives of the consumers which is clearly a patient benefit for these individuals. The outcome of this is fewer readmissions to the hospital both for 30 days and in the long term.

Outcome Measure Valuation:
This project seeks to provide transitional housing services for 12 people in DY4 for 1080 bed days and 18 people in DY5 for 1620 bed days. Stable living gives provides an opportunity to improve life skills and functioning. This represents a substantial savings when compared to bed day costs for admissions and readmissions to substance abuse treatment facilities. It also represents substantial patient benefit in that it supports a healthy life in the community. 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/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7.

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails Category 3 Project - 126844305.3.4 Related Category 2 Project - 126844305.2.1 (Project Area 2.13.2)			
126844305.3.4	IT-3.8	Behavioral Health /Substance Abuse 30 day readmission rate	
Bluebonnet Trails MHMR			126844305
Related Category 1 or 2 projects:	126844305.2.1		
Starting Point/Baseline:	Baseline is 0 for DY2		
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:** Program Documents **Process Milestone 1 Estimated Incentive Payment: $12,187** **Process Milestone 2** [P- 2]: Establish baseline rates. **Data Source:** EHR, local MH authority and state MH data system records. **Process Milestone 2 Estimated Incentive Payment: $12,188**	**Process Milestone 3** [P- 3]: Develop and test data systems **Data Source:** Business Intelligence reports. **Process Milestone 3 Estimated Incentive Payment: $24,375** **Process Milestone 4** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. **Data Source:** QM data reports and Communication documents **Process Milestone 4 Estimated Incentive Payment: $24,375**	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rate **Improvement Target:** Baseline TBD in DY3, Target TBD according to baseline **Data Source:** EHR, local MH authority and state MH data system records. **Outcome Improvement Target 1 Estimated Incentive Payment: $53,625**	**Outcome Improvement Target 2** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rate **Improvement Target:** Baseline TBD in DY3, Target TBD according to baseline **Data Source:** EHR, local MH authority and state MH data system records. **Outcome Improvement Target 2 Estimated Incentive Payment: $117,975**
Year 2 Estimated Outcome Amount: $24,375	**Year 3 Estimated Outcome Amount: $48,750**	**Year 4 Estimated Outcome Amount: $53,625**	**Year 5 Estimated Outcome Amount: $117,975**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $244,725			

Category 3 Project Narrative
Bluebonnet Trails 126844305.3.5

Outcome Domain: OD- 9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization, reduce ED visits for high utilizers
Unique RHP Outcome Identification Number: 126844305.3.5

Title of Category 1 or 2 Project: 126844305.2.2 - 2.13.1 Emergency Services Diversion Project/ Community Health Initiative
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Performing Provider TPI #: 126844305

Outcome Measure Description:

- OD- 9 Right Care, Right Setting
  - IT-9.2: ED appropriate utilization

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Target for each Year:

- DY4:
  - IT-9.2: ED appropriate utilization, reduce ED visits for high utilizers; Target TBD
- DY5:
  - IT-9.2: ED appropriate utilization, reduce ED visits for high utilizers; Target TBD

Rationale:
We selected project planning and stakeholder engagement and establishing baselines as the Process Milestones for DY2 because we need to accomplish these foundational tasks in order to establish better define the characteristics and needs of the high utilizer population. We selected testing data systems and the Plan, Do, Study, Act, (PDSA) cycle for DY3 Process Milestone because we need a year of operation to establish the baseline and should confirm the data system support during DY3. We expect the QM department of BTCS to develop PDSA cycle projects to support baseline development and confirmation of the data system. We will disseminate this information through the Williamson County MH Task Force and the Professional Peer Review Committee described in the Category 2 Narrative.

The conclusion of the *Effectiveness of interventions targeting frequent users of emergency departments: a systematic review (*Ann Emerg Med. 2011 Jul;58(1):41-52.e42); is that, "Interventions targeting frequent users may reduce Emergency Department (ED) use. Case management, the most frequently described intervention, reduced ED costs and seemed to improve social and clinical outcomes. It appears to be beneficial to patients and justifiable for hospitals to implement case management for frequent users in the framework of a clear and consensual definition of frequent users and standardized outcome measures." We selected the Improvement Target IT-9.2 ED appropriate utilization, reduce ED visits for high utilizers for DY4 and 5 because we are implementing a team based system of case management for this group of patients and research indicates that the intervention is effective at achieving the outcome of reducing ED visits. This is a stand-alone measure. Clearly the Emergency Services Diversion project goals are directed at the target population of high utilizers and should achieve the outcome of reducing ED use.

Outcome Measure Valuation:
We expect to serve 45 patients in DY4 and 60 in DY5. As described above, this represents over 700 ED visits and millions of dollars in trips by EMS, ED cost and hospital cost. 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/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7.

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails Category 3 Project - 126844305.3.5 Related Category 2 Project - 126844305.2.2 (Project Area 2.13.1)			
126844305.3.5	IT-9.2	ED Appropriate Utilization	
Bluebonnet Trails MHMR			126844305
Related Category 1 or 2 projects:	126844305.2.2		
Starting Point/Baseline:	Baseline is 0; To Be Determined during DY2 and tested during DY3		
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:** Program records, agendas and minutes. **Process Milestone 1 Estimated Incentive Payment: $17,925** **Process Milestone 2** [P-2]: Establish baseline rate **Data Source:** EHR, EMS logs and Program records **Process Milestone 2 Estimated Incentive Payment: $17,925**	**Process Milestone 3** [P-3]: Develop and test data systems **Data Source**: EHR, EMS logs and BI **Process Milestone 3 Estimated Incentive Payment: $61,700** **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** QM data reports and Communication documents **Process Milestone 4 Estimated Incentive Payment: $61,700**	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization, reduce ED visits by high utilizers. **Improvement Target:** TBD depending on baseline established during DY2 and confirmed during DY3. **Data Source:** EHR, EMS logs **Outcome Improvement Target 1 Estimated Incentive Payment: $123,400**	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization, reduce ED visits by high utilizers. **Improvement Target:** TBD depending on baseline established during DY2 and confirmed during DY3. **Data Source:** EHR, EMS logs **Outcome Improvement Target 2 Estimated Incentive Payment: $246,800**
Year 2 Estimated Outcome Amount: $35,850	**Year 3 Estimated Outcome Amount: $123,400**	**Year 4 Estimated Outcome Amount: $123,400**	**Year 5 Estimated Outcome Amount: $246,800**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $529,450			

Category 3 Project Narrative - Pass 2
Bluebonnet Trails 126844305.3.6

Outcome Domain: OD- 3 Potentially Preventable Re-Admissions- 30 day Readmission Rates
Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rates.
Unique RHP Outcome Identification Number: 126844305.3.6

Title of Category 1 or 2 Project: 126844305.1.4 - 1.13.1 Crisis Respite for Persons in Behavioral Health Crisis
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails community Services
Performing Provider TPI #: 126844305

Outcome Measure Description:

- OD- 3 Potentially Preventable Re-Admissions- 30 day Readmission Rates
  - IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rates

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Target for each Year:

- DY4:
  - IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rates
- DY5:
  - IT-3.8: Behavioral Health /Substance Abuse 30 day readmission rates

Rationale:
We selected project planning and stakeholder engagement as well as establishing baseline rates for the Process Milestones for DY2 because although we need to accomplish some very fundamental tasks with the community and with regard to better analysis of causes for readmissions, we also must begin providing this service because of the number of screenings in the ED and because of the need to support mental health Deputies in Burnet County. We will begin operations as soon as possible because of the need for crisis alternatives in the community. This will give us the opportunity to establish baseline and test it and the systems in DY3. We selected the Plan, Do Study, Act (PDSA) cycle in addition to developing and testing data systems for DY3 Process Milestone because we feel that rapid implementation will call for a rapid cycle analysis and improvements to those operations.

According to *Potentially Preventable Hospital Readmissions among Medicaid Recipients with Mental Health and/or Substance Abuse Health Conditions Compared with All Others: New York State, 2007*, a study published by the New York State Department of Health Division of Quality and Evaluation, "Medicaid recipients whose most significant primary health conditions in 2007 were both mental health and substance abuse conditions experienced potentially preventable hospital readmissions (PPR) over 3.5 times more frequently than recipients with neither of these health conditions. Recipients with a history of mental health and/or substance abuse conditions during 2007 were most commonly admitted to the hospital and subsequently readmitted for mental health and/or substance abuse, and HIV infections. Recipients with all other health conditions were most commonly initially admitted and subsequently readmitted for diseases and disorders of the circulatory, respiratory, or digestive systems" (http://www.health.ny.gov/health_care/managed_care/reports/statistics_data/3hospital_readmissions_mentahealth.pdf). We expect to serve 200 people in this new community based crisis service in DY4 and 300 people in DY5. We selected Improvement Target for DYs 4 and 5 as IT-3.8 Behavioral Health/ Substance Abuse 30 day readmission rates because of this well-known and researched connection between substance abuse/mental illnesses and hospital readmissions. The goals of the project are to provide thorough crisis screening and assessment services to the target population of people who have been hospitalized or experienced a crisis event and have been screened in Burnet County. When local screenings and assessments are done and patients referred appropriately, it should result in quicker stabilization, reduction in symptoms and a reduction in crisis events. The outcome will be fewer readmissions to the hospital both for 30 days and in the long term. We have not established the baseline and therefore we do not propose specific levels of reduction.

Outcome Measure Valuation:
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/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7.

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails Category 3 Project 126844305.3.6 Related Category 1 Project - 126844305.1.4 (Project Area 1.13.1– Pass 2)			
126844305.3.6	IT-3.8	Behavioral Health/Substance Abuse 30 Day Readmission Rate	
Bluebonnet Trails MHMR			126844305
Related Category 1 or 2 projects:	126844305.1.4		
Starting Point/Baseline:	Baseline in DY 2 is 0. Baseline to be established in DY 2 and confirmed through testing data systems in DY 3.		
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**: Program Documents **Process Milestone 1 Estimated Incentive Payment: $26,969** **Process Milestone 2**[P-2]: Establish baseline rates. **Data Source**: EHR, local MH authority and state MH data system records. **Process Milestone 2 Estimated Incentive Payment: $26,969**	**Process Milestone 3** [P- 3]: Develop and test data systems **Data Source**: Business Intelligence reports. **Process Milestone 3 Estimated Incentive Payment: $55,000** **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. **Data Source**: QM data reports and Communication documents **Process Milestone 4 Estimated Incentive Payment: $55,000**	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rate **Improvement Target**: Baseline TBD in DY3, Target TBD according to baseline **Data Source**: EHR, local MH authority and state MH data system records. **Outcome Improvement Target 1 Estimated Incentive Payment: $121,000**	**Outcome Improvement Target 2** [IT-3.8]: Behavioral Health /Substance Abuse 30 day readmission rate **Improvement Target**: Baseline TBD in DY3, Target TBD according to baseline **Data Source**: EHR, local MH authority and state MH data system records. **Outcome Improvement Target 2 Estimated Incentive Payment: $250,000**
Year 2 Estimated Outcome Amount: $53,938	**Year 3 Estimated Outcome Amount: $110,000**	**Year 4 Estimated Outcome Amount: $121,000**	**Year 5 Estimated Outcome Amount: $250,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $534,938			

Category 3 Project Narrative - Pass 2
Bluebonnet Trails 126844305.3.7

Outcome Domain: OD-10 Quality Of Life/ Functional Status
Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life
Unique RHP Outcome Identification Number: 126844305.3.7

Title of Category 1 or 2 Project: 126844305.1.5 **-** 1.12.2 Outpatient Substance Addiction Services for Adult and Youth
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails Community Services
Performing Provider TPI #: 126844305

Outcome Measure Description:

- OD-10 Quality Of Life/ Functional Status
  - IT-10.1: Quality of Life (We expect to use the AQoL for adults and the PedsQL for children, but will determine that after further research. The measurement will be a percentage of those who report improvement in functioning on these scales.)

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
- DY3:
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Target for each Year:

- DY4:
  - IT-10.1: Quality of Life; 30% reporting improvement upon discharge from the program over baseline
- DY5:
  - IT-10.1: Quality of Life; 40% reporting improvement upon discharge from the program over baseline

Rationale:
Process Milestones – P-2 and P-3 were chosen because although the clinic will begin operating in DY2, there are no current services and therefore initial policies procedures and protocols need to be developed. Also we must complete these to obtain facility licensure. As we begin operations in DY2, we will then need to apply a Plan, Do, Study, Act (PDSA) cycle to assure that operations are correct and meeting the needs of the clients. Data systems to collect surveys and to summarize and report will be put in place in DY3. Another PDSA cycle will be used to

assure accuracy, sufficient sample size and reporting infrastructure that supports communication and utility.

Improvement Target was chosen because the goal of this project is to help people who have been in some inpatient or other detoxification program and those who self-refer 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 achieving a sustained self-report of quality of life improvement will increase the length of time in recovery and improve the chance for long term recovery. This 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. We plan to conduct a quality of life survey on admission and at set intervals. The length of time between intervals will be determined based on literature review concerning implementation of the selected survey. We expect a 30% reported improvement over baseline in Quality of Life for those surveyed in DY4 and 40% in DY5. Extended sobriety and productivity will improve their health outcomes, community life and Quality of Life. The patient experience of health is one of the triple aims and measured here through report of improvement in the quality of the patients' lives.

Outcome Measure Valuation:
The project seeks to provide services to 350 people in DY4 and 700 in DY5 in Williamson and Burnet Counties. Sobriety cannot be maintained without aftercare and this new intensive service provides that locally. 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/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7.

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Bluebonnet Trails Category 3 Project 126844305.3.7 Related Category 1 Project - 126844305.1.5 (Project Area 1.12.2 – Pass 2)			
126844305.3.7	IT-10.1	Quality of Life	
Bluebonnet Trails MHMR			126844305
Related Category 1 or 2 projects:	126844305.1.5		
Starting Point/Baseline:	Baseline for DY 2 is 0. We will survey beginning in DY 2 but establish baseline in DY 3.		
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**: Program documentation, agenda and minutes **Process Milestone 1 Estimated Incentive Payment: $13,759** **Process Milestone 2** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. **Data Source**: Program documentation, data reports and BI **Process Milestone 2 Estimated Incentive Payment: $13,759**	**Process Milestone 3** [P- 3]: Develop and test data systems. **Data Source**: Program documentation, return rate of surveys. **Process Milestone 3 Estimated Incentive Payment: $28,539** **Process Milestone 4** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. **Data Source**: Program documentation, data reports and BI **Process Milestone 4 Estimated Incentive Payment: $28,539**	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life **Improvement Target:** 30% of those surveyed report improvement over baseline **Data Source:** Quality of life surveys **Outcome Improvement Target 1 Estimated Incentive Payment: $57,450**	**Outcome Improvement Target 2** [IT-10.1]: Quality of Life **Improvement Target**: 40% of those surveyed report improvement over baseline **Data Source:** Quality of life surveys **Outcome Improvement Target 2 Estimated Incentive Payment: $116,516**
Year 2 Estimated Outcome Amount: $27,518	**Year 3 Estimated Outcome Amount: $57,078**	**Year 4 Estimated Outcome Amount: $57,450**	**Year 5 Estimated Outcome Amount: $116,516**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $258,562			

Category 3 Project Narrative - Pass 2
Bluebonnet Trails 126844305.3.8

Outcome Domain: OD- 9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization, reduce ED visits for high utilizers
Unique RHP Outcome Identification Number: 126844305.3.8

Title of Category 1 or 2 Project: 126844305.2.3 - 2.13.1 Assertive Community Treatment (ACT) Team Services for Persons with Intellectual and Developmental Disabilities (IDD)
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails community Services
Performing Provider TPI #: 126844305

Outcome Measure Description:

- OD- 9 Right Care, Right Setting
  - IT-9.2: ED appropriate utilization

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 Target for each Year:

- DY4:
  - IT-9.2: ED appropriate utilization; 33% reduced ED visits for high utilizers
- DY5:
  - IT-9.2: ED appropriate utilization, 40% reduced ED visits for high utilizers

Rationale:
DY2 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.

DY3 presents the opportunity to identify and refine data sources and establish the baseline for Emergency Department (ED) visits by those Individuals with Developmental Disabilities (IDD). As stated in the Narrative for Category 2 related project, #126844305.2.3, the detail related to IDD utilization of ED is not currently available through EHRs. It will be necessary to spend time with health systems to define the data and refine how to capture and report it.

The Improvement Target for DYs 4 and 5 is a stand-alone measure. We selected this measure because the goal of this project is to help persons with IDD to resolve behavioral crises and return to their long-term placements in the community.

The project will improve appropriate utilization of EDs by this targeted population. The goals stated for the related Category 2 Project are to establish an ACT Team that can respond and intervene to improve functioning during a crisis event. We expect the Team to specialize in the assessment and stabilization of persons with IDD in Williamson and Burnet Counties. We expect the Team to provide training to law enforcement, emergency room personnel, health care providers, psychiatric hospital providers, and community residential and non-residential providers regarding how to recognize behavioral issues in persons with IDD and how to access appropriate services. When the goals are achieved the participants and the community is informed and engaged, then these community-based interventions will help people to avoid unnecessary loss of community living arrangements and overuse of institutional care. When persons with IDD receive the proper care and interventions, then admissions to institutional care and multiple visits to EDs are avoided.

Outcome Measure Valuation:
We expect to serve 30 people in DY4 and 50 people in DY5. The behavior plan and team services will help individuals to improve regain their functioning level and return to community living. This reduces inappropriate use of inpatient hospital and is of substantial benefit to the patient who can remain in a community living setting. 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/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7.

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Bluebonnet Trails Category 3 Project - 126844305.3.8 Related Category 2 Project - 126844305.2.3 (Project Area 2.13.1 – Pass 2)			
126844305.3.8	**IT-9.2**	**ED Appropriate Utilization**	
Bluebonnet Trails MHMR			**126844305**
Related Category 1 or 2 projects:	**126844305.2.3**		
Starting Point/Baseline:	**Baseline for DY 2 is 0; enrollment and functional assessments in DY 3 will establish baseline.**		
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:** Program Documents **Process Milestone 1 Estimated Incentive Payment: $13,650**	**Process Milestone 2** [P- 2]: Establish baseline rates **Data Source**: Juvenile justice system records, local MH authority and state MH data system records **Process Milestone 2 Estimated Incentive Payment: $27,300**	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization, reduce ED visits by persons with target conditions; behavioral health/substance abuse. **Improvement Target:** The baseline for this service is 0 since no such emergency diversion for persons with IDD presenting in identified behavioral health crisis now exists. We expect to serve 30 individuals in DY4 and for the team to respond to 33% of those prior to a visit to the ED. This should be 10 diverted from contact with the ED. **Data Source:** EHR and program records **Outcome Improvement Target 1 Estimated Incentive Payment*:* $30,030**	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization, reduce ED visits by persons with target conditions; behavioral health/substance abuse. **Improvement Target:** The baseline for this service is 0 since no such emergency diversion for persons with IDD presenting in identified behavioral health crisis now exists. We expect to serve 50 individuals in DY5 and for the team to respond to 40% of those prior to a visit to the ED. This should be 20 diverted from contact with the ED. **Data Source:** EHR and program records **Outcome Improvement Target 2 Estimated Incentive Payment*:* $66,066**

Year 2 Estimated Outcome Amount: $13,650	**Year 3 Estimated Outcome Amount: $27,300**	**Year 4 Estimated Outcome Amount: $30,030**	**Year 5 Estimated Outcome Amount: $66,066**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $137,046			

Category 3 Project Narrative - Pass 2
Bluebonnet Trails 126844305.3.9

Outcome Domain: OD-9 Right Care, Right Setting
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 Outcome Identification Number: 126844305.3.9

Title of Category 1 or 2 Project: 126844305.2.4 - 2.13.1 Services to Justice-Involved Youth and Adults – Burnet and Williamson Counties
Performing Provider Name: Bluebonnet Trails Community Mental Health and Mental Retardation Center dba/ Bluebonnet Trails community Services
Performing Provider TPI #: 126844305

Outcome Measure Description:

- 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

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 Target for each Year:

- DY4:
  - IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings; 10% reduction for both adults and youth over baseline
- DY5:
  - IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings; 25% reduction for both adults and youth over baseline

Rationale:
We selected project planning and stakeholder engagement as the Process Milestones for DY2 because although we currently provide some services to justice-involved adults and youth, we are proposing to expand availability and role of clinical services and to expand eligible program participants. We need to carry out the processes to achieve community buy-in, utilization of the program and thorough review and assessment of interventions needed. We selected establishing baseline in DY3 because we do not have the rates of admission and readmission to adult and youth criminal justice settings for this expanded population and we need a year of operation to establish the number served. We will also need time to gather additional juvenile justice system data concerning the number referred for mental health services in order to measure our Improvement Target.

The Improvement Target for DYs 4 and 5 is a stand-alone measure. We selected this measure because the goal of this project is to help adults and youth successfully return to family and community. Unfortunately lack of behavioral health resources has led to the adult justice system and juvenile justice system providing care rather than providing that in the community. The justice system is complex, however and just the availability of care does not guarantee access and use. This program provides assessment, treatment planning and referral to the services as well as linkage between the justice system and the services. The project will also decrease the number of admissions and readmissions to the criminal justice system due to providing diversion and by providing community care to prevent recidivism.

The Outcome Measure is to provide the Right Care in the Right Setting and thereby decrease in mental health admissions and readmissions to criminal justice settings. It is our goal to implement this project and improve individual lives and the health and well-being of the communities we serve. Providing community care at the right time and in the right setting and thereby reducing inappropriate arrest and incarceration will lead to productive and contributing youth and adults. We believe that achieving the project goal and providing early intervention and treatment leads directly to the outcome of right care, right setting. We expect to serve an additional 50 people in DY4 and 75 in DY5. Clearly, this will provide a significant patient impact for these individuals, their families and communities. Allowing people to languish in jail due to mental illness or substance abuse is wrong and counterproductive for them and for our society. Providing this expanded alternative gives us the opportunity to achieve this Outcome while strengthening the resources available to adults, youth and families in the community.

Outcome Measure Valuation:
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/1098-3015/PIIS1098301510602161.pdf?mis=.pdf&refissn=1098-3015&refuid=S1098-3015%2811%2903563-7.

A description of the method used, titled *Valuing Transformation Projects*, has been posted on the performing provider website which will be linked to www.bbtrrails.org under the Medicaid 1115 Transformation Waiver tab. Complete write-up of the project will be available at performing provider site.

Bluebonnet Trails Category 3 Project 126844305.3.9 Related Category 2 Project - 126844305.2.4 (Project Area 2.13.1 – Pass 2)			
126844305.3.9	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons**	
Bluebonnet Trails MHMR			**126844305**
Related Category 1 or 2 projects:	**126844305.2.4**		
Starting Point/Baseline:	**Baseline for DY 2 is 0. Will begin enrollment in DY 2 to establish census baseline; establish admission and readmission baseline in DY 3.**		
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**: Project documentation, implementation action plans, agendas and minutes **Process Milestone 1 Estimated Incentive Payment: $10,263**	**Process Milestone 2** [P-2]: Establish baseline rates. **Data Source**: Program documentation, justice system documentation and EHR. **Process Milestone 2 Estimated Incentive Payment: $10,525** **Process Milestone 3** [P-3]: Develop and test data systems **Data Source:** Program documentation, justice system documentation and EHR. **Process Milestone 3 Estimated Incentive Payment: $10,525**	**Outcome Improvement Target 1** [IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons **Improvement Targe**t: 10% reduction for both adults and youth over baseline **Data Source**: Justice system assessments and records; EHR. **Outcome Improvement Target 1 Estimated Incentive Payment: $25,050**	**Outcome Improvement Target 2 [**IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons **Improvement Target:** 25% reduction for both adults and youth over baseline **Data Source**: Justice system assessments and records; EHR. **Outcome Improvement Target 2 Estimated Incentive Payment: $74,100**
Year 2 Estimated Outcome Amount: $10,263	**Year 3 Estimated Outcome Amount: $21,050**	**Year 4 Estimated Outcome Amount: $25,050**	**Year 5 Estimated Outcome Amount: $74,100**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $130,463			

Category 3 Project Narrative
Center for Life Resources – 133339505.3.1

Outcome Domain: OD-9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate Utilization (Standalone measure). Reduce Emergency Department visits for target conditions. Target conditions being Behavioral Health/Substance Abuse.
Unique RHP Outcome Identification Number: 133339505.3.1

Title of Category 1 or 2 Project: 133339505.1.1 - 1.11.1 Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services
Performing Provider Name: Center for Life Resources
Performing Provider TPI #: 133339505

Outcome Measure Description:

- OD-9 Right Care, Right Setting
  - IT-9.2: ED Appropriate Utilization: Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse.

Process Milestones:

- DY2:
  - P-1: Project planning -engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Target for each Year:

- DY4:
  - IT-9.2: ED appropriate utilization, Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse – Reduction to Baseline to be determined
- DY5:
  - IT-9.2: ED appropriate utilization, Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse Reduction to Baseline to be determined

Rationale:
We chose to use project planning and establishing baselines in DY2 in order to form a solid foundation to measure the change we hope to introduce. In DY3 we will test our conclusions from DY2 and make adjustments in order to better plan, do, study and act. In DYs 4 and DY5 we will implement what we have learned in the previous years. We expect to see the resultant information become useful for other rural/frontier areas facing similar issues.

Outcome Improvement Targets:
Our goal with the right care, right setting emphasis is to do just what is implied but also to reduce unnecessary emergency department (ED) visits. As our program begins to provide services to those who thought they would need to go to an ED for behavioral health/substance use treatment previously. Individuals will now have a choice to receive telemedicine services in their own community without having to drive to another county. This would both benefit the consumer as well as the emergency services of Mills and San Saba Counties that are already very stretched for resources.

Outcome Measure Valuation:
According to txpricepoint.org, the average cost accounted for just one possibly preventable condition such as psychosis at Brownwood Regional Medical Center (BRMC) located in Brown County is $6,030 a day with a median charge of $14,472. Further research shows the average cost to transport an individual to a local hospital by local Emergency Medical System (EMS) services is $655. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, were an officer is on hand, can range from 1 to 3 hours. A law enforcement deputy's average pay can range from $12.50 to $20+ per hour, so in an average situation this would be an additional $30-$45 cost. When multiplied by the average number of preventable situations per year, 24, the total costs for EMS transport and law enforcement time is around $16,620 per year. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services. The given $16,620 is solely an average and our best estimation based on prior experience. The Center for Life Resources (CFLR) currently provides behavioral health services for clients with Medicaid, Medicare, private insurance and both uninsured and underinsured clients. CFLR does not currently receive any U.S. Department of Health and Human Services for telemedicine services.

CFLR has met with and spoken to several judges, law enforcement officials and county commissioners and has determined that there is a significant need for telemedicine services in their respective counties as telemedicine will assist in lowering costs for their departments while expanding and enhancing behavioral health services in these counties. Additionally, it will allow for the right care to be provided at the right place and the right time.

Even though these financial costs are significant, the human cost which is much harder to measure can be even more significant. It is believed that early intervention in appropriate settings could reduce unnecessary utilization of community resources and emergency departments as well as improve individual care.
Similar to other projects in our region we looked at cost utility analysis and quality of adjusted life year (QALY) with respect to the varying level these were valued. Data provided by the Agency of Health Care Research and Quality (AHRQ) gave a range from $50,000 to $200,000 per (QALY) in the United States. Specifically stated,

"Finally, uncertainty about how to value health will surely change estimates of the magnitude and even sign of *NHB* calculations and all calculations that rely on them. Given this, the robustness of the results of analyses the setting (e.g., at least $50,000 to $200,000 per QALY in the United States)"
http://www.ahrq.gov/research/iomqrdrreport/futureqrdrapf1.html

Center for Life Resources Category 3 Project - 133339505.3.1 Related Category 1 Project - 133339505.1.1 (Project Area 1.11.1)			
133339505.3.1	**IT-9.2**	**IT-9.2 – ED Appropriate Utilization: Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse**	
Center for Life Resources			**133339505**
Related Category 1 or 2 projects:	**133339505.1.1**		
Starting Point/Baseline:	**Starting Point/Baseline is 0 for DY2; TBD**		
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:** Program records, agendas and minutes. **Process Milestone 1 Estimated Incentive Payment: $0** **Process Milestone 2** [P-2]: Establish baseline rate **Data Source:** Anasazi, program records, law enforcement, EMS **Process Milestone 2 Estimated Incentive Payment: $0**	**Process Milestone 3** [P-3]: Develop and test data systems **Data Source**: Anasazi, Program Records, Law Enforcement, EMS **Process Milestone 3 Estimated Incentive Payment: $6,739** **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** QM data reports and Communication documents **Process Milestone 3 Estimated Incentive Payment: $6,740**	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization, reduce ED visits for targeted conditions – behavioral health/substance abuse **Improvement Target:** TBD depending on baseline established during DY2 and confirmed during DY3. **Data Source:** Anasazi, Program Records, Law Enforcement, and EMS **Improvement Target 1 Estimated Incentive Payment: $13,813**	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization, reduce ED visits for targeted conditions – behavioral health/substance abuse **Improvement Target:** TBD depending on baseline established during DY2 and confirmed during DY3. **Data Source:** Anasazi, Program Records, Law Enforcement, and EMS **Improvement Target 2 Estimated Incentive Payment: $31,404**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $13,479**	**Year 4 Estimated Outcome Amount: $13,813**	**Year 5 Estimated Outcome Amount: $31,404**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $58,696			

Category 3 Project Narrative
Central Counties Services – 081771001.3.1

Outcome Domain: OD-10 – Quality of Life/Functional Status
Title of Outcome Measure (Improvement Target): IT-10.1 Improvement in quality of life

Unique RHP Outcome Identification Number: 081771001.3.1

Title of Category 1 Project: 081771001.1.1 - 1.1.1. School-based behavioral health services
Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Outcome Measure Description:
The quality of life functioning of the children enrolled in these services will serve as the basis for demonstrating the positive impact of this school-based behavioral health clinic. The children's quality of life functioning/level of adaptation to the scholastic environment will be measured through the use of an evidence-based evaluation tool when the children are first referred to the clinic (baseline score), and then again after 9, and 15 months participation in the clinic's services to demonstrate improvement in quality of life/level of adaptation to the scholastic environment. The percentage of quality of life functioning/adaptation to the scholastic environment improvement is expected to be 15%, and 25% at the respective reassessment intervals.

Our Center intends to establish a dedicated performance improvement team to collect, analyze and manage real-time data and to monitor the improvement trajectory and improvement activities associated with our 1115 Transformation Waiver projects. We are convinced that having a performance improvement team will increase our Center's organizational commitment to, and achievement of on-going performance improvement.

Process Milestones:
- DY2:
  - Not Applicable
- DY3:
  - Establish baseline rate - quality of life functioning of children referred to school-based behavioral health services throughout the year

Outcome Improvement Targets for each Year:
- DY4:
  - IT-10.1: Quality of life functioning scores of children enrolled in school-based behavioral health services for 9 months or more will improve by 15% over his/her baseline score.
- DY5:
  - IT-10.1: Quality of life functioning scores of children enrolled in school-based behavioral health services for 15 months or more will improve by 25% over his/her baseline score.

Rationale:
Children, who are experiencing behavioral health problems themselves or in their families, often have difficulty socially and functionally adjusting to the school environment. Their poor social skills and

behavior problems are often disruptive to the class learning environment, and impede their own learning. Their ability to focus their attention on the learning information/activity is often hampered by their behavioral health problems. Their attention span – time on task- for their personal learning task (reading, math skills, etc.) is often also limited by their behavioral health problems/symptoms. If a child is not adjusting well to his/her school/learning environment then that child's quality of life is also poor, in that the child's ability to achieve age-appropriate, academic and social milestones is compromised and will have long-term effects on the child's adjustment to adult life as well. This project and its outcomes view child scholastic adjustment (age-appropriate achievement) to equate with the child's quality of life. The outcome measure chosen for this project measures a child's quality of life/school adjustments at different points in time for the child, and will document each participating child's improvement in quality of life/school adjustments over time as a result of this project's impact on the child and his/her family.

The improvement target regarding the child's/families' satisfaction with services is an indicator of their level of engagement with the services and service provider. Their feedback on the satisfaction surveys will serve as the primary basis for this project's continuous quality improvement effort to achieve the best possible engagement with the best possible services. We also intend to regularly survey the TISD personnel and leadership regarding ways to continuously improve these services. The improvement target intervals were chosen to correspond with the improvement in the schools school adaptation evaluation needed to move from low adaptation to the school environment to a moderate adaptation to the school environment rating.

Showing improvement in the quality-of-life functioning of the children enrolled in these services will serve as the basis for demonstrating the positive impact of this school-based behavioral health clinic. For many of the children served in this project these improvement levels will make possible their passing from one grade to the next due to increased behavioral and social adaptation to the school group-learning environment. They will have learned how to adapt and thrive in the socio-learning environment so that they can successfully prepare for life as independent functioning adults. The long-term view of these children should show a lower than average school dropout rate, higher than average graduation rate and good educational/ vocational readiness for their next life stage as young adults. The impact of behavioral change for at least 210 children 5-9 years old that will make a quality of life, social and vocational difference in the 70 plus years for each child (14,700 person-years) that follow these effective interventions and skill development activities.

Outcome Measure Valuation:
The valuation of this Category 3 Outcome Improvement Measuring Process begins in DY3 and takes into account development/acquisition costs of selecting a Quality of Life/scholastic-adjustment evidence-based measurement tool that can be used with children ages 5-9. The valuation includes the testing materials necessary to periodically evaluate each participating child's level of quality of life/school adaption. The valuation of this project outcome monitoring includes the preparation of individual progress reports and collective impact reports regarding the overall collective progress of the children participating in the project. These progress analysis reports will also focus on the children who are not making the expected progress in improving his/her quality of life/school adjustment which will inform the "plan, do, study, act" improvement process so that the project's approach to the less-than-desired-improvement

child's situation can be more personally targeted and productive. The valuation of this project includes pulling together an annual report on how well this project is meeting its goals, how it is of value to the Temple Independent School District regarding reduced absences, fewer grade retentions, etc. and areas for potential improvement of the project's operations and effectiveness. The effectiveness of this school-based behavioral health clinic will have a profound effect on the children it serves. This positive effect will carry forward into the student's entire learning experience at TISD and other learning experiences beyond high school. Over the lifespan of this project more than 500 children with the poorest scholastic/learning environment adaptive skills will be helped to be successful in their school years and as productive adults contributing to society instead of being a drain on society.

Central Counties Services Category 3 Project – 081771001.3.1 Related Category 1 Project - 081771001.1.1 (Project Area 1.1.1)			
081771001.3.1	**IT-10.1**	**Quality of Life**	
Central Counties Services			**081771001**
Related Category 1 or 2 projects:	**081771001.1.1**		
Starting Point/Baseline:	**Currently there is no school-based behavioral health clinic in operation in the Temple Independent School District and no children's quality of life scores are known at this time**		
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] (see page 363 of the Planning Protocol): Establish baseline rate - quality of life functioning of children referred to school-based behavioral health services throughout the year. **Metric 1:** Choose the age-appropriate quality of life functioning survey instrument(s) to be used by the project, and receive training on how to properly administer and score them. **Data Source:** Provider may select a validated assessment tool for quality of life measurement. Some example include AQoL, ST-36, 20 or 12, Peds QL (p. 406 of the Regional Health care Partnership Planning Protocol). Metric 2: Administer the age-appropriate quality of life survey to each child enrolled in the school-based behavioral health program to	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life functioning scores of children enrolled in school-based behavioral health services for 9 months or more. **Improvement Target:** 50% of the children enrolled in school-based behavioral health services for 9 months or more will improve by 15% over baseline scores. **Data Source:** Re-test children's quality of life functioning after 9 months enrollment in school-based behavioral health services. **Outcome Improvement Target 1 Estimated Incentive Payment: $65,336**	**Outcome Improvement Target 2** [IT-10.1]: Quality of Life functioning scores of children enrolled in school-based behavioral health services for 15 months or more improve **Improvement Target:** 60% of the children enrolled in school-based behavioral health services for 15 months or more will improve by 25% over baseline scores. **Data Source:** Re-test children's quality of life functioning after 15 months enrollment in school-based behavioral health services. **Outcome Improvement Target 2 Estimated Incentive Payment: $147,900**

	establish each child's quality of life baseline measure. **Process Milestone 1 Estimated Incentive Payment: $66,986**		
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $66,986**	**Year 4 Estimated Outcome Amount: $65,336**	**Year 5 Estimated Outcome Amount: $147,900**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $280,222			

Central Counties Services – Project 081771001.3.2

Outcome Domain: OD-6 Patient Satisfaction
Title of Outcome Measure (Improvement Target): IT-6.2 Other Improvement Target: Improvement over patient baseline satisfaction scores with behavioral health services delivered via telemedicine technology
Unique RHP Outcome Identification Number: 081771001.3.2

Title of Category 1 Project: 081771001.1.2 - 1.11.2 Replacement/expansion of Center's telemedicine/telehealth system
Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Outcome Measure Description:

- OD-6 Patient Satisfaction
  - IT-6.2: Other Improvement Target: Improvement over patient baseline satisfaction scores with behavioral health services delivered via telemedicine technology –

The basis for demonstrating the positive impact of this telemedicine/telehealth system upgrade/expansion is through measuring the patient's satisfaction level regarding their receiving behavioral health services through this improved telemedicine/telehealth system. Patient satisfaction with services delivered through the telemedicine technology will be obtained through patient surveys which they will complete after every third appointment. The survey would have some open-ended questions on it which would encourage patients to identify what they like about telemedicine services and what they don't like about telemedicine services. Their comments, along with monitoring other satisfaction/ dissatisfaction indicators (no-show rates, anxious behavior prior to, or after a telemedicine session, etc.) will help Center staff to make improvements in how telemedicine services are scheduled, facilitated, followed-up on, etc. to increase our patient satisfaction with services provided via telemedicine technology to their highest potential satisfaction level.

Our Center intends to establish a dedicated performance improvement team to collect, analyze and manage real-time data and to monitor the improvement trajectory and improvement activities associated with our 1115 Transformation Waiver projects. We are convinced that having a performance improvement team will increase our Center's organizational commitment to, and achievement of on-going performance improvement.

Process Milestones:

- DY2:
  - Not Applicable
- DY3:
  - P-2: Establish a baseline rate

Outcome Improvement Targets for each Year:

- DY4:
  - IT-6.2: Other Improvement Target: Improvement over patient baseline satisfaction scores with behavioral health services delivered via telemedicine technology; TBD% improvement over patient satisfaction baseline scores.
- DY5:
  - IT-6.2: Other Improvement Target: Improvement over patient baseline satisfaction scores with behavioral health services delivered via telemedicine technology; TBD% improvement over patient satisfaction baseline scores.

Rationale:
Patient level of satisfaction with their services is a touchstone measure for the patient's confidence in the services they are receiving, and how willing they are to adhere to their service provider's directions regarding their medication, suggested behavior/lifestyle changes encouraged by their provider, and their attendance/participation at their assigned service appointments.

The therapeutic relationship between a behavioral health patient and his/her caregiver is an essential element for treatment improvement/success. This therapeutic relationship grows or improves over time as more and more contact occurs between the patient and the care-giving person. Our Center equates the level of patient satisfaction with Center services to the level of the patient's bonding in the therapeutic relationship with Center care-giving staff, and a reflection of the patients' prospect/belief for positive management/improvement of their behavioral health problems and its symptoms. Thus, we would also expect our patient's level of satisfaction/comfort level with services delivered via telemedicine to increase over time as the patient becomes more familiar with telemedicine service delivery dynamics and technology. Measuring patient satisfaction with our behavioral health services delivered through telemedicine technology will inform us if the use of such technology is a barrier to increased satisfaction/trust/confidence in our services, or if the use of such technology facilitates increased satisfaction/trust/confidence in our services by being perceived as less threatening than receiving services directly in a face-to-face manner. Our citizens are becoming more informed and comfortable with the use of technology in their everyday lives and hopefully will be very accepting of behavioral health services delivered via telemedicine technology.

The outcome measurement process for this project, whether paper-based or electronically based, will involve training appropriate staff on how to administer the survey instrument uniformly. It includes the design of an automated system to track the survey results on a patient-by-patient basis and at a patient group level. This includes the development of periodic reports that analyzes the satisfaction trends for individual patients and at the patient group level. These reports will inform the "plan, do, study, act" process for improving our Center's patient telemedicine experience. The outcome measurement of patient satisfaction with services delivered via the telemedicine technology will also include service delivery/receiving site analysis (lighting, background colors, extraneous noise levels, etc.) to seek and implement ways that service delivery via this technology can become more satisfactory from the patient's perspective.

Outcome Measure Valuation:
The valuation of this project's outcome measures includes the design of an automated system to track the survey results on a patient-by-patient basis and at a patient group level. This includes the development of periodic reports that analyzes the satisfaction trends for individual patients and at the patient group level, and facilitating a group change process which responds to the satisfaction survey feedback. These improvements in the telemedicine service delivery system will also be incorporated into the Center's telehealth/telemedicine training manual and clinical protocols. The Center's telemedicine improvement process may include consultation with TV production/technical staff, speech and presentation skill consultants, hearing-impairment and visual-impairment consultants, etc. to continuously improve the telepsychiatry delivery system and insure that the system accommodates individuals with sensory difficulties. The valuation process for this project includes the cost of training (including the opportunity costs from not being in service production) of professional staff that is recommended by this quality improvement process and the advice of consulting experts on telemedicine/video production quality improvement. The valuation for this improvement outcome also takes into account the no-show reduction savings from patients whose satisfaction with services delivered via telemedicine technology.

Central Counties Services Category 3 Project - 081771001.3.2 Related Category 1 Project – 081771001.1.2 (Project Area 1.11.2)			
081771001.3.2	IT-6.2	Other Outcome Improvement Target: Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure)	
Central Counties Services			081771001
Related Category 1 or 2 projects:	081771001.1.2		
Starting Point/Baseline:	No baseline measures regarding patient satisfaction with telemedicine services have been established at this time		
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] *(see page 363 of the Planning Protocol):* Establish baseline rate **Data Source:** CG-CAHPS, other recognized, validated surveys identified through internet searches. The outcome data from the completion of the selected satisfaction survey will be used as the baseline to measure improvement. **Process Milestone 1 Incentive Payment: $91,790**	**Outcome Improvement Target 1** [IT-6.2]: Percent improvement over baseline of patient satisfaction scores with services provided to them via the newly updated telemedicine/ telehealth technology among those patients who have received 9 or more services via the telemedicine/ telehealth technology. **Improvement Target:** Achieve 10% improvement over baseline, once the baseline is known (e.g. if the satisfaction survey is scored on a 100 point scale with the score of 1-35 = poorly satisfied; 36-70 = moderately satisfied; & 71-100 = highly satisfied, the Center would expect 60% of the patients [180]served per month to score in the moderate to high satisfaction range: satisfied = deriving positive value from the services.) **Data Source:** ECHO™ Surveys and	**Outcome Improvement Target 2** [IT-6.2]: Percent improvement over baseline of patient satisfaction scores with services provided to them via the newly updated telemedicine/ telehealth technology among those patients who have received 15 or more services via the telemedicine/telehealth technology. **Improvement Target:** Achieve 20% improvement over baseline, once the baseline is known (e.g. if the satisfaction survey is scored on a 100 point scale with the score of 1-35 = poorly satisfied; 36-70 = moderately satisfied; & 71-100 = highly satisfied, the Center would expect 70% of the patients [280]served per month to score in the moderate to high satisfaction range: satisfied = deriving positive value from the services.) **Data Source:** ECHO™ Surveys and Reports

		Reports **Outcome Improvement Target 1 Estimated Incentive Payment: $92,121**	**Outcome Improvement Target 2 Estimated Incentive Payment: $220,160**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $91,790**	**Year 4 Estimated Outcome Amount: $92,121**	**Year 5 Estimated Outcome Amount: $220,160**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $404,071			

Category 3 Project Narrative
Central Counties Services - 081771001.3.3

Outcome Domain: OD-10 Quality of Life/Functional Status
Title of Outcome **Measure (Improvement Target):** IT-10.1 Quality of Life
Unique RHP Outcome Identification Number: 081771001.3.3

Title of Category 1 or 2 Project: 081771001.1.3 - 1.12.2 "Coffeehouse" Model of Social Skills Training
Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Outcome Measure Description:

- OD – 10 Quality of Life/Functional Status
  - IT-10.1: Quality of Life

Process Measures:

- DY2:
  - Not Applicable
- DY3:
  - P-1: Project Planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establishing baseline rates applies to the use of the training curriculum in relation to the engagement of the program participants and the scoring of the AQoL assessment tool.

Outcome Improvement Targets for each Year:

- DY4:
  - IT-10.1: Quality of Life/Functional Status - Demonstrate improvement in quality of life scores as evidenced by 50% of the participants in the program six months or greater having increased scores on the Quality of Life satisfaction survey
- DY5:
  - IT-10.1: Quality of Life/Functional Status - Demonstrate improvement in quality of life scores as evidenced by 75% of the participants in the program one year or longer having increased scores on the Quality of Life satisfaction survey

The Process Milestone P-1 Project Planning that will occur in DY3 will focus on the development of the implementation plan and the engagement of the participants in the social skills training program. The goal in DY3 of serving 14 persons in the program and the needed resources to do this will be solidified. This includes the finalization of the training curriculum, and the use of the AQoL Satisfaction Survey. The project plan to delineate specific timelines will be developed and Gantt Charts will be used for project implementation tasks.

The P-2 Milestone of establishing baseline rates applies to the use of the training curriculum in relation to the engagement of the program participants. Too much training vs. too little

training will be assessed in this regard to achieve a balance of engagement. Baselines will also be established relative to the scoring of the satisfaction surveys and the benchmark method of carrying out the scoring.

Program files will be kept in the aggregate and for each of the participants. During regularly scheduled staff meetings, the assessment of the project's progress will be carried out.

The Quality Improvement Target 1 (IT-10.1) will be measured by the scores obtained on the evidenced-based AQoL Survey. The measure target goal in Year 4 is a 50% enhanced satisfaction for those participants who have participated in the program for six months or more while in Year 5 the goal is a 75% enhanced satisfaction for those persons in the program one year or more.

Our Center intends to establish a dedicated performance improvement team to collect, analyze and manage real-time data and to monitor the improvement trajectory and improvement activities associated with our 1115 Transformation Waiver projects. We are convinced that having a performance improvement team will increase our Center's organizational commitment to, and achievement of on-going performance improvement.

Rationale:
The process milestones chosen are an integral part of a formal project management method of implementing and monitoring a project. We have included the participative management components of engaging stakeholders on an ongoing basis and during the required Learning Collaboratives to be held two times per year. The need to develop baselines and to test the training curriculum and the Survey implementation and scoring system are also core elements of project management. Using Shewhart's Plan Do Check Act cycle will provide a self-assessment and self-correcting component to the project. Any revision to the project will be based on the Check component of the cycle. We also seek to continually engage all relevant stakeholders pertaining to the findings since this model of social skills training stands to transform the service delivery system for the target population.

The Outcome Improvement (IT-10.1) was chosen because it is an evidenced-based way to measure a person's increased Quality of Life Satisfaction. Baselines scores are obtained via the use of the tool chosen-the AQoL (see AQoL.com). The project provides an intervening independent variable in the life of the person with High functioning Autism or Asperger's disorder. The participation in a group social skills training program is the intervening independent variable. The participant then receives training and/or support as a result of this independent variable. The social skills training will be highly interactive within a framework of an informal learning environment. Specialized staff will facilitate group interaction using proven methods of training. Responses to the training will be documented for each person to reveal progress or lack of progress.

During strategic times of the program, the AQoL is administered and the scores obtained. The goal is to have increased satisfaction scores as evidenced by the satisfaction score, which then can be attributed by the training and support received. The fact that the AQoL was chosen is due to the rich history of the use of this satisfaction tool.

The goal in DY4 of 50% of the persons in the program longer than six months achieve an increase in satisfaction scores on the AQoL was chosen due to the expected depth and quality of the curriculum and the framework of the model itself. An engaging learning environment should enhance one's quality of life and the stretch goals of 50% in DY4 and 75% in DY5 are considered attainable.

Outcome Measure Valuation:
Enhanced quality of life for anyone is a desirable goal but as a goal for someone diagnosed with High functioning Autism or Asperger's Disorder, it becomes a predominant goal in their life. The person with Autism or Asperger's Disorder celebrates success in small increments. We feel that this project can enhance the person's ability to copy with the environment, especially as it relates to interpersonal relationships. Less inappropriate behavior, including aggression, can be imagined as this project is implemented. If the individual participant can feel better about himself, feel better about how he interacts with others, then the person can contribute more positively to the community.

The scope of this project will focus on the approximately 30-35 adult consumers currently being served by Central Counties Services, the designated Local Authority for the five-county catchment area. This project will only address consumers in the counties of Bell, Lampasas and Milam. These consumers have been diagnosed with Autism or Asperger's disorder by formal psychometric testing completed by a Certified DADS Associate Psychologist. We will also focus on the 50-60 persons receiving services from the Department of Assistive and Rehabilitative Services (DARS). Over DYs 3-5, from 14 to 52 consumers will be trained and/or supported via this model. The day will include several interactive and engaging sessions facilitated by the staff, using evidenced-based social skills training curricula. If the consumer stays the day, he/she is expected to participate in 5-6 hours of social skills training, a half-day would be 3-4 hours.

As mentioned in the Narrative for Category 1, program services to persons diagnosed with Autism or Asperger's is a high priority community need and is recognized as such by stakeholders such as the local school districts, the Autism support group in Belton, the Planning and Network Advisory Committee (PNAC) of Central Counties Services, the Central Texas Aging and Disability Resource Center (ADRC), Department of Assistive and Rehabilitative Services (DARS) and the Board of Trustees of Central Counties. The community need is also recognized by the 2010 State of Texas Study on the Costs and Benefits of Initiating a Pilot Project to Provide Services to adults with Autism Spectrum Disorders and Related Disabilities.

The approach for valuing the outcome measure takes into account the project scheduling, which is approximately 240 days per year, five-days per week. A full day will be about 6 hours, which allows for transportation, to and from the training site. Several types of engagement activities will be carried out, based on evidenced-based social skills training curriculae. Each consumer will participate in a highly interactive group learning session while attending. The person diagnosed with high-functioning autism or Asperger's is expected to show improvement in social skills which leads to improved social and personal relationships, longer tenures in

employment, and less acting out or exhibition of inappropriate behaviors. Their quality of life will be enhanced through peer-support and reinforcement of social activities.

The benefit value to the community of this "coffeehouse" model of social skills training lies in the consumer's ability to cope with and function in a variety of community settings. The consumer should have an enhanced quality of life, feel more valued in inter-personal relations and is expected to interact positively in all phases of community life. There should be less crisis events, less hospitalizations, and less entanglement with law enforcement. Family members, friends, neighbors and the community-at-large should see a more positive stance from the individual participant in the group social skills training. Determining value also includes the costs of administering and scoring the Quality of Life satisfaction survey, the cost of project planning, and the cost to accurately and timely communicate the findings of the program's outcome measure to all relevant stakeholders. It also includes an expected cost avoidance of less hospital stays, less involvement with law enforcement, more stability with the Center's Person Directed Planning process, and greater ability to secure and maintain employment.

Central Counties Services Category 3 Project - 081771001.3.3 Related Category 1 Project - 081771001.1.3 (Project Area 1.12.2)			
081771001.3.3	**IT-10.1**	**Quality of Life**	
Central Counties Services			**081771001**
Related Category 1 or 2 projects:	**081771001.1.3**		
Starting Point/Baseline:	**Currently no persons are being served via this model; baseline will be 14 in DY 3, Baseline for Satisfaction Survey will be taken in DY 3.**		
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:** Project implementation plan, Monitoring of status and progress of training, documentation of participant records **Process Milestone 1 Estimated Incentive Payment: $36,786** **Process Milestone 2** [P-2]: Establish baseline rates to include curriculum finalization, method of teaching and scoring of survey. **Data Source:** Documented assessment of teaching curriculum;	**Outcome Improvement Target 1** [IT-10.1]: Demonstrate improvement in quality of life scores, as measured by evidence based and validated assessment tool, for the target population. **Improvement Target:** 50% of participants with six months or more in the program report increase in Quality of Life survey scores **Data Source**: AQoL Quality of Life survey, scoring sheets **Improvement Target 1 Estimated Incentive Payment: $75,446**	**Outcome Improvement Target 2** [IT-10.1]: Demonstrate improvement in quality of life scores, as measured by evidence based and validated assessment tool, for the target population. **Improvement Target**: 75% with one year or more in program report increase in Quality of Life scores. **Data Source**: AQoL Quality of Life survey, scoring sheets **Improvement Target 2 Estimated Incentive Payment: $186,335**

	what is going well and what needs to be changed and survey scores. **Process Milestone 2 Estimated Incentive Payment: $36,787**		
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $73,573**	**Year 4 Estimated Outcome Amount: $75,446**	**Year 5 Estimated Outcome Amount: $186,335**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $335,354			

Category 3 Project Narrative
Central Counties Services – 081771001.3.4

Outcome Domain: OD-11 Addressing Health Disparities in Minority Populations
Title of Outcome Measure: IT-11.1 Improvement in clinical indicator in an identified disparity group – e.g. Improvement in the chronic health conditions experienced by adult behavioral health patients who have taken psychotropic medications for prolonged periods of time
Unique RHP Outcome Identification Number: 081771001.3.4

Title of Category 1 or 2 Project: 081771001.2.1 - 2.2.2 Apply evidenced-based care management model to patients identified as having high-risk care needs
Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Outcome Measure Description:

- OD-11 Addressing Health Disparities in Minority Populations
  - IT-11.1: Improvement in clinical indicator in an identified disparity group – e.g. Improvement in the chronic health conditions experienced by adult behavioral health patients who have taken psychotropic medications for prolonged periods of time

The basis for demonstrating the positive impact of this project is the measurement of the severity of chronic health conditions (particularly diabetes, hypertension, and weight gain) which result from prolonged use of psychotropic medications. Central Counties Services (Center) would identify behavioral health patients who are on psychotropic medications and who have these chronic health conditions by searching the patient electronic health records in the Temple, TX and Killeen, TX clinics. Those patients identified with the worst chronic health conditions ratings would be the first patients referred for the services of this project. Patient symptom severity would be regularly measured by blood glucose levels, blood pressure readings, and weight measurement, and these measures would be recorded in the patient's electronic health record in a manner that these indicators would be electronically searchable and able to be electronically extracted for review and reporting purposes. Patients would be given copies of their condition measurement profiles so they could visually see how they are progressing/not progressing in their efforts to manage/reduce their chronic health conditions.

We know that the management and reduction of these chronic health conditions will involve a need for life-style choices/changes to be effective. We also know that developing life-style change plans and committing them to writing are indicators of probable success in making and sustaining the life-style changes needed to significantly reduce the severity of chronic health conditions. Measuring the number of patients who have embraced the life-style change process sufficiently to develop and agree to a written life-style change plan will be another indicator of the project's effectiveness in achieving chronic health condition self-management improvement outcomes. Therefore, regularly reporting on the number of patients with written life-style change goals will be another way to measure the positive impact of this project on the

lives of the behavioral health patients with such medication side-effects related health conditions. If such improvement in chronic health conditions could add 5-10 years to each patient's life span, that would result in a **net gain of 500 - 1,000 person years for each of the 3 full years of this project.**

Our Center intends to establish a dedicated performance improvement team to collect, analyze and manage real-time data and to monitor the improvement trajectory and improvement activities associated with our 1115 Transformation Waiver projects. We are convinced that having a performance improvement team will increase our Center's organizational commitment to, and achievement of on-going performance improvement.

Process Milestones:

- DY2:
  - Not Applicable
- DY3:
  - P-2: Establish a baseline rate

Outcome Improvement Targets:

- DY-4
  - IT-11.1: Improvement in clinical indicator in an identified disparity group – e.g. Improvement in the chronic health conditions experienced by adult behavioral health patients who have taken psychotropic medications for prolonged periods of time and enrolled in this project for 6 months; 35% improvement over baseline.
- DY-5
  - IT-11.1: Improvement in clinical indicator in an identified disparity group – e.g. Improvement in the chronic health conditions experienced by adult behavioral health patients who have taken psychotropic medications for prolonged periods of time and enrolled in this project for 9 months or more; 45% improvement over baseline.

Rationale:
We recognize that while the psychotropic medications we provide to improve their mental health symptoms can be very helpful to our patients experiencing an improved quality of life; these same medications can cause chronic medical conditions which then lowers the patient's quality of life. We therefore see that we have an ethical obligation to our patients to also help them with these potential chronic health side-effects. Medication side-effects are the most common reason given by patients for self-discontinuing their medications; therefore, assisting patients in the management/reduction of their medication-related side effects is one of the most effective strategies to help patients stay on the medication regimen that is most effective for the management/reduction of their behavioral health symptoms. We anticipate providing services to 100 patients in DY3, 150 patients in DY4 and 200 patients in DY5.

Outcome Measure Valuation:
The valuation of this Category 3 Outcome Improvement Measuring Process begins in DY3 and takes into account the costs of extracting focused patient information from our Center's

electronic health record system, analyzing that information and formulating recommendations regarding the project's effectiveness. This process would also involve the reporting of individual patient chronic health condition profiles to be used in assessing the project's effectiveness. The valuation of this project also takes into account the quality of life gains and medical cost savings achieved by successful chronic health condition management. If such improvement in chronic health conditions could add 5-10 years to each patient's life span, that would result in a **net gain of 500 - 1,000 person years for each of the 3 full years of this project.** The successful management of their chronic health conditions through these extra years of life would also reflect a significant health services cost savings by limiting or avoiding the more extreme health complications that come with the advance stages of these chronic health conditions.

Central Counties Services Category 3 Project - 081771001.3.4 Related Category 2 Project – 081771001.2.1 (Project Area 2.2.2)			
081771001.3.4	**IT-11.1**	**Improvement in Clinical Indicator in identified disparity group**	
Central Counties Services			**TPI# 081771001**
Related Category 1 or 2 projects:	**081771001.2.1**		
Starting Point/Baseline:	**This is a new service - individual baseline measures are established when patients are admitted to this service**		
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] (see page 363 in the Planning Protocol): Establish baseline ratings regarding the severity of the chronic health conditions noted in adult behavioral health patients resulting from prolonged use of psychotropic medications referred to this project in the Temple, TX and Killeen, TX clinics. **Data Source:** Patient electronic health records and personal interviews **Process Milestone 1 Estimated Incentive Payment: $6,755**	**Outcome Improvement Target 1** [IT-11.1]: Improvement in the chronic health conditions among adult behavioral health patients who have taken psychotropic medications **Improvement Target**: 35% of those patients participating in this program (expected to be 150 patients in DY4) will show some level of functional improvement over their baseline assessment after participating in this service for 6 months or more. a. Numerator: Persons participating in this service who show either stabilization or improvement of their chronic health issue resulting from their prolonged use of psychotropic medicine. b. Denominator: Total number of behavioral health patients participating in this self-care management program **Data Source:** Patient electronic	**Outcome Improvement Target 2** [IT-11.1]: Improvement in the chronic health conditions among adult behavioral health patients who have taken psychotropic medications **Improvement Target**: 45% of those patients participating in this program (expected to be 200 patients in DY5) will show some level of functional improvement over their baseline assessment after participating in this service for 9 months or more. a. Numerator: Persons participating in this service who show either stabilization or improvement of their chronic health issue resulting from their prolonged use of psychotropic medicine. b. Denominator: Total number of behavioral health patients participating in this self-care management program

		health records **Outcome Improvement Target 1 Estimated Incentive Payment: $7,548**	**Data Source:** Patient electronic health records **Outcome Improvement Target 2 Estimated Incentive Payment: $16,872**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $6,755**	**Year 4 Estimated Outcome Amount: $7,548**	**Year 5 Estimated Outcome Amount: $16,872**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $31,175			

Category 3 Project Narrative
Central Counties Services - 081771001.3.5

Outcome Domain: OD-11 Addressing Health Disparities in Minority Populations
Title of Outcome Measure: IT-11.1 Improvement in clinical indicator in an identified disparity group – e.g. increased number of behavioral health patients availing themselves of STD testing/education opportunities, STD confirmations, and STD treatments
Unique RHP Outcome Identification Number: 081771001.3.5

Title of Category 1 or 2 Project: 081771001.2.2 - 2.7.1 Implement innovative, evidence-based strategies to increase appropriate use of technology and testing for targeted populations
Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Outcome Measure Description:

- OD-11 Addressing Health Disparities in Minority Populations
  - IT-11.1: Improvement in clinical indicator in an identified disparity group – e.g. increased number of behavioral health patients availing themselves of STD testing/education opportunities, STD confirmations, and STD treatments

Persons with severe and persistent mental illness most often do not have a medical home, and consequently obtain most of their physical health services from local hospital emergency medicine departments. When receiving medical care in the hospital emergency department attention is usually given only to the patient's presenting health crisis, and not to the patient's general health status. This project intends to bring the STD testing and treatment to the behavioral health patients when they are in the Central Counties Services' clinics for their mental health visit. The project outcome measure then will focus on the number of behavioral health patients at our Center's Temple, TX and Killeen, TX clinics who avail themselves of the opportunity to receive STD education and testing services. We will also measure how many of the patients who test positive for an STD follow through with getting proper treatment for the particular disease they have contracted. Our outcome measure goal is to increase the number of behavioral health patients in each clinic who avail themselves of these STD education/testing opportunities at our behavioral health clinic sites over the course of this project.

Our Center intends to establish a dedicated performance improvement team to collect, analyze and manage real-time data and to monitor the improvement trajectory and improvement activities associated with our 1115 Transformation Waiver projects. We are convinced that having a performance improvement team will increase our Center's organizational commitment to, and achievement of on-going performance improvement.

Process Milestones:

- DY2:
  - Not Applicable
- DY3:

- P-2: Establish baseline rate

Outcome Improvement Targets for each Year:

- DY4:
  - IT-11.1: Improvement in (STD) education, assessment and treatment among people with SPMI who visit the Center clinics 30% increase over baseline
- DY5:
  - IT-11.1**:** Improvement in (*STD*) education, assessment and treatment among people with SPMI who visit Center clinics 40% increase over baseline

Rationale:
Our Center realizes that there is some stigma attached to pursuing STD education and testing services, similar to the stigma attached to seeking behavioral health services. By offering STD education/testing services within our clinics we are both seeking to diminish the stigma attached to seeking these services and to increase access to these services by a medically underserved and disparate population. We therefore chose to measure/monitor the number of such sessions held within the two days per week that they are offered. We have every expectation that through the ease of access to these services, general education among our behavioral health patients about sexually transmitted diseases, informal support for these services among the patient group by patients who have had positive results from treatments for sexually transmitted diseases, and the supportive encouragement of our behavioral health staff, that the number of behavioral health patients seeking these services will increase over time.

Our Center recognizes the co-relationship of good physical health and good mental health and how the two relate to each other. This project is ultimately focused on reducing the number of behavioral health patients being seen in our clinics whose health circumstance is compromised by having an STD. The more disease-free our behavioral health patients are, the more personal energy they will have available for them to work on the management and recovery from their behavioral health problems. We expect there will be 240 encounters in DY3, 288 in DY4 and 360 in DY5.

Outcome Measure Valuation:
The valuation of this Category 3 Outcome Improvement Measuring Process begins in DY3 and takes into account the costs of extracting focused patient information from our Center's electronic health record system, analyzing that information and formulating recommendations regarding the project's current and future effectiveness. The valuation of this outcome improvement measuring process includes the saved monetary and health costs of detecting and treating STDs at their earliest possible time, thus minimizing the potential long-term effects of untreated STD's on the patient's health status/quality of life.

The valuation of this project also takes into account the quality of life gains and medical cost savings achieved by successful early treatment of sexually transmitted diseases and the prevention/education services which assist the patients in avoiding future sexually transmitted diseases. Early detection and treatment avoids the personal health risks and costs of treating these same diseases at their advanced stages. If such improvement in patient health conditions

could add 5-10 years to each patient's life span, that would result in a **net gain of 500 - 1,000 person years for each of the 3 full years of this project.** The successful management of their chronic health conditions through these extra years of life would also reflect a significant health services cost savings by limiting or avoiding the more extreme health complications that come with the advance stages of these chronic health conditions.

Central Counties Services Category 3 Project - 081771001.3.5 Related Category 2 Project – 081771001.2.2 (Project Area 2.7.1)			
081771001.3.5	**IT-11.1**	**Improvement in Clinical Indicator in identified disparity group**	
Central Counties Services			**081771001**
Related Category 1 or 2 projects:	**081771001.2.2**		
Starting Point/Baseline:	**This is a new project; Baseline will be established in DY 3**		
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] (See page 363 of the Planning Protocol): Establish baseline rate during the month of October 2013 regarding the number of behavioral health patients who are treated for STD(s) and have a positive outcome from that treatment. **Data Source:** Patient electronic health records **Process Milestone 1 Estimated Incentive Payment: $6,755**	**Outcome Improvement Target 1** [IT-11.1]: Improvement in STD education, assessment, and treatment among people with SPMI who visit CCS clinics (Standalone measure) **Improvement Target**: 30% more patients show STD resolution than the baseline set in DY3 **Outcome Improvement Target 1 Estimated Incentive Payment: $7,548**	**Outcome Improvement Target 2** [IT-11.1]**:** Improvement in STD education, assessment, and treatment among people with SPMI who visit Center clinics (Standalone measure) **Improvement Target**: 40% more patients show STD resolution than the baseline set in DY3 **Outcome Improvement Target 2 Estimated Incentive Payment: $16,872**
Year 2 Estimated Outcome Amount: $ 0	**Year 3 Estimated Outcome Amount: $6,755**	**Year 4 Estimated Outcome Amount: $7,548**	**Year 5 Estimated Outcome Amount: $16,872**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $31,175			

Category 3 Project Narrative
Central Counties Services – 081771001.3.6

Outcome Domain: OD-9 Right Care, Right Setting
Title of Outcome Measure: IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings or psychiatric hospitalization
Unique RHP Outcome Identification Number: 081771001.3.6

Title of Category 1 or 2 Project: 081771001.2.3 - 2.13.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population
Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Outcome Measure Description:

- OD-9 Right Care, Right Setting
  - IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings or psychiatric hospitalization

The goal of this project is to reduce the amount of days people with severe and persistent mental illness spend in state psychiatric hospital services, or incarcerated in local jails due to minor crimes committed in the midst of a mental health crisis. The outcome we will be measuring is the number of days a person with severe and persistent mental illness is able to be in the community rather in one of these more restrictive and costly institutional settings. We will use the number of days each person was able to stay in the community between their last two admissions, or mental health crisis episodes in which they were at risk of institutionalization as the baseline measure. We will then periodically measure how many days a patient has been able to stay out of an institutional setting with the support of the services offered in this project, and compare that number of days with their established baseline. We expect that the longer a patient actively participates in these supportive day services, the more likely that the length of time between institutional episodes will likewise increase significantly. Information in each patient's electronic health record and the day services attendance roster will be the sources of data used to measure the service outcomes.

Our Center intends to establish a dedicated performance improvement team to collect, analyze and manage real-time data and to monitor the improvement trajectory and improvement activities associated with our 1115 Transformation Waiver projects. We are convinced that having a performance improvement team will increase our Center's organizational commitment to, and achievement of on-going performance improvement.

Process Milestones:

- DY2:
  - Not Applicable
- DY3:

- P-2: Establish individual baseline
- DY4:
  - P-4: Conduct plan, do, study, act cycles to improve data collection and intervention activities.

- DY5:
  - P-4: Conduct plan, do, study, act cycles to improve data collection and intervention activities.

Outcome Improvement Milestones for each Year:

- DY4:
  - IT-9.1: Decrease in mental health admissions and readmissions to psychiatric hospitals or criminal justice settings such as jails or prisons (standalone measure) by 30% over baseline for those patients who have participated in this service for 6 months or more.
- DY5:
  - IT-9.1: Decrease in mental health admissions and readmissions to psychiatric hospitals or criminal justice settings such as jails or prisons (standalone measure) by 40% over baseline for those patients who have participated in this service for 6 months or more.

Rationale:

This service has a goal to increase the support services available to persons with severe and persistent mental illness and introduce the patients to the recovery model of increasing the patient's personal strengths to manage their life and their illness in an improved manner that supports successful community living. This model promotes the patient acknowledging his/her mental illness and their need for medication to control its symptoms. We expect have an average census of 20 participants in DY4 and 25 in DY5. During this stable time, it is the service goal to enroll each patient in whatever benefit programs he/she might be eligible for, to include Section-8 housing, Medicaid, Social Security Disability, etc. Accessing these support services will assist the patient in re-structuring their community living supports and add to the options for the patient to use to effectively avoid hospitalization or incarceration. The simplest measure of improvement for the severely and persistently mentally ill person is an increase in the length of time they can sustain themselves in the community without re-entry into a psychiatric hospital or incarceration. The Center believes that clients that are enrolled in the program for at least 6 months will be able to see substantial reductions in admissions and readmissions.

Outcome Measure Valuation:

The valuation of this Category 3 Outcome Improvement Measuring Process begins in DY3 and takes into account the costs of extracting focused patient information from our Center's electronic health record system, analyzing that information and formulating recommendations regarding the project's effectiveness. This process would also provide information for our continuous improvement (plan-do-study-act,) processes used by the project staff and clinical

supervisory staff to continually improve the types and coordination of services offered to our patients. This process would also catalog the community resources that get identified to help our patients so that the project would have more and more complete catalog of these resources, how to access them, costs involved, etc. The patient participants in this service will also be periodically surveyed to obtain information about what aspects of the services are considered high value, and which aspects are considered low value. This process would also solicit suggestions for new service components that could enrich the effectiveness of this project by adding to the factors which encourage community-based living/coping instead of institutional dependency.

Central Counties Services Category 3 Project - 081771001.3.6 Related Category 2 Project - 081771001.2.3 (Project Area 2.13.1)			
081771001.3.6	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice setting such as jails or prisons.**	
Central Counties Services			**081771001**
Related Category 1 or 2 projects:	**081771001.2.3**		
Starting Point/Baseline:	**0, Baseline will be established in DY3**		
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 baseline measures of how many days elapsed between their last hospitalization/ incarceration and their most recent mental health crisis. **Data Source**: Patient self-disclosed information, significant others information, and incarceration/ hospitalization records for each individual **Process Milestone 1 Estimated Incentive Payment: $37,880**	**Process Milestone 2** [P-4]: Conduct plan, do, study, act cycles to improve data collection and intervention activities. **Data Source**: Patient electronic health records, interviews with patients and significant others, analysis of the number of session no-shows, service drop-outs, early returns to psychiatric hospital/criminal justice facility, etc. **Process Milestone 2 Estimated Incentive Payment: $30,741** **Outcome Improvement Target 1** [IT-9.1]: Decrease in mental health admissions and readmissions to psychiatric hospitals or criminal	**Process Milestone 3** [P-4]: Conduct plan, do, study, act cycles to improve data collection and intervention activities. **Data Source**: Patient electronic health records, interviews with patients and significant others, analysis of the number of session no-shows, service drop-outs, early returns to psychiatric hospital/criminal justice facility, etc. **Process Milestone 3 Estimated Incentive Payment: $77,620** **Outcome Improvement Target 2** [IT-9.1]: Decrease in mental health admissions and readmissions to psychiatric hospitals or criminal justice settings such as jails or prisons

		justice settings such as jails or prisons a. Numerator: The number of days since last psychiatric hospitalization or incarceration due to being in a mental health crisis. b. Denominator: The number of days that elapsed between the patient's last two psychiatric hospitalizations or incarceration episodes. **Outcome Improvement Target 1**: Improve baseline by 30% for those patients who have participated in this service for 6 months or more. **Data Source**: Patient electronic health record. **Outcome Improvement Target 1 Estimated Incentive Payment: $30,741**	a. Numerator: The number of days since last psychiatric hospitalization or incarceration due to being in a mental health crisis. b. Denominator: The number of days that elapsed between the patient's last two psychiatric hospitalizations or incarceration episodes. **Outcome Improvement Target 2**: Improve baseline by 40% for those patients who have participated in this service for 6 months or more. **Data Source**: Patient electronic health record. **Outcome Improvement Target 2 Estimated Incentive Payment: $77,619**
Year 2 Estimated Outcome Amount: $ 0	**Year 3 Estimated Outcome Amount: $37,880**	**Year 4 Estimated Outcome Amount: $61,482**	**Year 5 Estimated Outcome Amount: $155,239**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $254,601			

Category 3 Project Narrative – Pass 2
Central Counties Services – 081771001.3.7

Outcome Domain: OD-9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings
Unique RHP Outcome Identification Number: 081771001.3.7

Title of Category 1 Project: 081771001.1.4 – 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
Performing Provider Name: Central Counties Services
Performing Provider TPI #: 081771001

Outcome Measure Description:
Central Counties Services (Center) proposes establish a crisis respite/residential services program in our service region. The express purpose of having these services locally is to have such services be available as an alternative to psychiatric hospitalization or incarceration of persons who are experiencing a mental health crisis. When a person is experiencing a mental health crisis their symptoms are often extreme and interfere with the patient's ability to think in an orderly manner, distinguish between their thoughts and information processed from their surroundings, problem-solve, or take constructive action to reduce or overcome their mental health crisis. When a person is experiencing a mental health crisis, their ability to modulate their emotions and keep them organized to fit their circumstance is often also impaired. In this mental/emotional crisis state patients often have difficulty in exercising good judgment regarding their behavior and its consequences for others around them. Under this circumstance, persons in mental health crisis often commit minor crimes like trespassing, refusing to leave a business/property, engage in petty theft, act in a threatening manner towards others, etc. Persons experiencing a mental health crisis are often arrested and jailed. The project's proposed crisis respite services are designed as a potential alternative for law enforcement officers who respond to a person in this kind of situation that would offer treatment for the person in crisis, rather than incarceration. Measuring how many mental health crises can be managed by referral to the crisis respite services instead of incarceration is a direct indicator that these services are performing in the manner that they are intended.

Process Milestones:
- DY2:
  - Not Applicable
- DY3:
  - P-2: Establish a baseline

Outcome Improvement Targets for each Year:
- DY4:

- IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (Standalone measure); target 20% decrease over DY3 baseline

- DY5:
  - IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (Standalone measure); target 30% decrease over DY3 baseline

Rationale:
This outcome measure was chosen for this project because it very directly targets the purpose of this project, namely to offer less restrictive/less costly, more appropriate ways to assist a person who is experiencing a mental health crisis to address the resolution of the person's mental health crisis rather than incarcerating the person, which does nothing to address the dynamics of the person's mental health crisis other than to confine him/her in a jail cell. The diversion of persons who commit a minor crime while experiencing a mental health crisis from incarceration to crisis respite services instead will demonstrate that the purpose of implementing these services is being fulfilled. Documenting these diversions will also document the financial and personal benefit of these services by serving the person in the right place with the right care. The costs saved from diverting a person from a lengthy stay in the ED and the costs saved from diverting an incarceration (30+ days) are quite different, so it is hard to know how many people we will divert from each setting until we are actually operational. That said, we estimate admitting 640 in DY4 and 800 in DY5.

Outcome Measure Valuation:
The valuation of these service outcome evaluation activities is based on the staff time and use of data systems to carry out the complex data tracking needed to accomplish these evaluation processes and the compilation of subsequent data and narrative reports. The valuation also takes into account the funds saved by the state psychiatric hospital system, local law enforcement agencies, local EDs, and local jails. The valuation of this project outcome evaluation also takes into account the immense personal welfare and financial costs spared to persons who would have been incarcerated for 30-60 days for committing minor crimes while experiencing a mental health crisis. The valuation of evaluating these outcome measures also takes into account the Center's indirect programs costs, administrative overhead costs associated with this evaluation process and inflation of costs over the three year period (DYs 3-5).

Central Counties Services Category 3 Project – 081771001.3.7 Related Category 1 Project – 081771001.1.4 (Project Area 1.13.1– Pass 2)			
081771001.3.7	**IT-9.1**	**Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons**	
Central Counties Services			**081771001**
Related Category 1 or 2 projects:	**081771001.1.4**		
Starting Point/Baseline:	**TBD in DY3**		
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] (see page 363 of the Planning Protocol): Establish the baseline rates of those persons served by crisis respite services that would have been admitted or readmitted to jail or a psychiatric hospital **Data Source:** Claims/encounters and clinical record data, hospital records, criminal justice system records, local MH authority and state MH data system records. **Process Milestone 1 Estimated Incentive Payment: $358,982**	**Outcome Improvement Target 1** [IT-9.1]: Decrease in mental health admissions/readmissions to criminal justice settings **Improvement Target**: The improvement target is 20% of the baseline established in DY3 **Data Source:** Claims/encounters and clinical record data, hospital records, criminal justice system records, local MH authority and state MH data system records. **Outcome Improvement Target 1 Estimated Incentive Payment: $179,165**	**Outcome Improvement Target 2** [IT-9.1]: Decrease in mental health admissions/readmissions to criminal justice settings **Improvement Target**: The improvement target is 30% of the baseline established in DY3 **Data Source:** Claims/encounters and clinical record data, hospital records, criminal justice system records, local MH authority and state MH data system records. **Outcome Improvement Target 2 Estimated Incentive Payment: $452,262**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $358,982**	**Year 4 Estimated Outcome Amount: $179,165**	**Year 5 Estimated Outcome Amount: $452,262**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $990,409			

Category 3 Project Narrative – Pass 2
Central Counties Services – 081771001.3.8

Outcome Domain: OD-1 Primary Care and Chronic Disease Management
Title of Outcome Measure (Improvement Target): IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576
Unique RHP Outcome Identification Number: 081771001.3.8

Title of Category 1 Project: 081771001.1.5 – 1.10.2 Enhance improvement capacity through technology
Performing Provider TPI #: 081771001

Outcome Measure Description:

- OD-1 Primary Care and Chronic Disease Management
  - IT-1.18: Follow-Up After Hospitalization for Mental Illness- NQF 057

This outcome measure tracks what percentage of persons discharged from a psychiatric hospital receive an outpatient follow-up session within 30 days from being discharged. This outcome measure also tracks what percentage of persons discharged from a psychiatric hospital receive an outpatient follow-up session within 7 days from being discharged. This outcome measure strives to reach 100% but cannot do so because of lack of compliance with aftercare appointments by persons with severe and persistent mental illness.

Process Milestones:

- DY2:
  - Not Applicable
- DY3:
  - P-3: Develop and test data systems
  - P-2: Establish baseline rates for IT-1.18 - # of 7-day and 30-day hospital discharge follow-ups.

Outcome Improvement Targets for each Year:

- DY4:
  - IT-1.18: Follow-up after hospitalization for mental illness – NQF 0567
- DY5:
  - IT-1.18: Follow-up after hospitalization for mental illness – NQF 0567

Rationale:
The Central Counties Services (Center) is convinced that through the use of organizational system improvement projects and having improved data support that it can increase its service (Milestones 8 and 10: 2,000 more behavioral health service encounters than in DY4 than DY3 and 4,000 more in DY5 over DY3) capacity and its ability to better track persons being

discharged from psychiatric hospitals in a timely manner to insure their introduction/re-introduction to supportive outpatient services and access to their needed medication support. This Outcome Measure was chosen because of its importance as a patient decision point to pursue continuing service support or totally disengaging themselves from the behavioral health service system. For those patients who were suicidal at the time of being hospitalized, they are at higher than average risk of suicide within 30 days of their hospital discharge. When discharged from the hospital their medications have brought more control over their disorganized thinking patterns and they are more able to formulate suicide plans and have the mental organization to carry them out. Thus, it is imperative to get them re-involved with the local behavioral health treatment system so that their suicidal risk can be assessed, their treatment/medications continued in order to consolidate and build on the symptom management gains from their hospitalization. The patients also benefit from feeling supported as they work to re-establish their living arrangements and support system engagement in their home community.

"Nationally, only 42% of initial appointments following psychiatric hospitalization are kept. Missed appointments increase the likelihood of re-hospitalization and increase costs of outpatient care. Among several recent studies that have examined the phenomenon of lack of outpatient follow-up after hospital discharge, rates of failure to attend a first outpatient appointment have ranged from 18 to 67%, with a median rate of 58%. Over time periods ranging from one to nine years approximately 30% of patients disengage from mental health treatment services. Taken together, research suggests that a significant proportion of individuals with serious mental illness are not engage in mental health treatment as a result of dropping out of some form of care" (p.3 National Quality Forum publication #0576 – www.qualityforum.org/WorkArea/linkit.aspx?Linkidentifier=id&ItemID=70617).

The target improvement percentages will be set based on the baseline established in DY3. This outcome measure strives to reach 100% of the discharges (estimated to be 1,200+ during DY3 through DY5) receiving a prompt post-discharge appointment, but cannot do so because of lack of compliance with aftercare appointments by persons with severe and persistent mental illness.

Outcome Measure Valuation:
The valuation for implementing this post-psychiatric hospital discharge follow-up outcome measure includes staff costs for discharge planning and scheduling of follow-up, post-discharge outpatient appointments while the patients are still hospitalized in the state psychiatric hospital system. It also includes the staff service costs for providing the first post-discharge clinical service appointment. (Our Center had 496 state psychiatric hospital admissions in FY2011. Of the 496 admissions, 12 were children under 18 years of age. 20 of these admissions were forensic admissions to restore competency to stand trial, and were discharged back to the refer-ring County jail. 203 (41%) of these admissions were readmissions of people who had been previously hospitalized, while 293 (59%) were first admissions to the state psychiatric hospital sys-tem. Between 9 and 10 patients are hospitalized and discharge per week in FY2011.) The valuation takes into account the volume of discharged psychiatric hospital

patients who have to be closely tracked each week to insure their attendance at their first post-discharge behavioral health session. The valuation of this outcome measure also takes into account the personal and system cost avoidance that can be achieved when the number of readmissions and incarcerations is reduced. It further takes into account the financial and personal cost avoidance of suicide attempts and completions being reduced by a timely follow-up behavioral health session. The valuation of this outcome includes a portion of the Center's indirect program sup-port, administrative overhead and inflation costs.

This valuation reflects 79.5% of the total valuation (Region 8 contains 79.5% of our service region's population) while 20.5% of this project's valuation will be reflected in our project submitted to Region 16 (08177101.1.2).

Central Counties Services Category 3 Project – 081771001.3.8 Related Category 1 Project – 081771001.1.5 (Project Area 1.10.2 - Pass 2)			
081771001.3.8	**IT-1.18**	**Follow-up after hospitalization for mental illness**	
Central Counties Services			**081771001**
Related Category 1 or 2 projects:	**081771001.1.5**		
Starting Point/Baseline:	Established in DY3		
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-3] (See Planning Protocol, p. 363): Develop and test data systems. **Data Source**: Written test outcome/ certification that system is functioning within design specifications **Process Milestone 1 Estimated Incentive Payment: $26,769** **Process Milestone 2** [P-2] (See Planning Protocol, p. 363): Establish baseline rates for outpatient follow-up within 7 days and within 30 days after hospitalization for mental illness over the previous 6 month period. **Data Source:** The Center's electronic health record system,	**Outcome Improvement Target 1** [IT-1.18]: Follow-up after hospitalization for mental illness – estimated to be 400+ patients per year – NQF 0576 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.	**Outcome Improvement Target 2** [IT-1.18]: Follow-up after hospitalization for mental illness – estimated to be 400+ patients per year – NQF 0576 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.

	state and local psychiatric hospital data systems. **Process Milestone 2 Estimated Incentive Payment: $26,769**	b. Denominator: Persons 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 September 1 and August 31 of the measurement year. The denominator for this measure is based on discharges, not persons. Include all discharges for persons who have more than one discharge on or between September 1 and August 31 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 person was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition. **Improvement Target:** Rate 1. TBD% improvement in DY3	b. Denominator: Persons 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 September 1 and August 31 of the measurement year. The denominator for this measure is based on discharges, not persons. Include all discharges for persons who have more than one discharge on or between September 1 and August 31 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 person was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition. **Improvement Target:** Rate 1. TBD% improvement over DY3 baseline in follow-up within 30 days Rate 2. TBD% improvement over DY3 baseline in follow-up within 7 days

		baseline in follow-up within 30 days Rate 2. TBD% improvement in DY3 baseline in follow-up within 7 days **Data Source:** Center electronic health record system and the data systems of psychiatric hospitals. **Outcome Improvement Target 1 Estimated Incentive Payment: $41,985**	**Data Source:** Center electronic health record system and the data systems of psychiatric hospitals. **Outcome Improvement Target 2 Estimated Incentive Payment: $112,245**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $53,538**	**Year 4 Estimated Outcome Amount: $41,985**	**Year 5 Estimated Outcome Amount: $112,245**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $207,768			

Category 3 Project Narrative
Hill Country MHDD - 133340307.3.1

Outcome Domain: OD-10 Quality of Life/Functional Status
Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living
Unique RHP Outcome Identification Number: 133340307.3.1

Title of Category 1 or 2 Project: 133340307.2.1 **-** 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
Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Outcome Measure Description:

- OD-10 Quality of Life/Functional Status
  - 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 or Daily Living Activities (DLA-20) Youth Mental Health (Ages 6-18).

Process Milestones:
Not applicable

Outcome Improvement Targets for each Year:

- DY2
  - Not Applicable
- DY3
  - IT-10.2: Activities of Daily Living: TBD % of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY4
  - IT-10.2: Activities of Daily Living: TBD % of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY5
  - IT-10.2: Activities of Daily Living: TBD % of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Rationale:
Co-occurring Psychiatric and Substance Use Disorder impacts an individual's mental health and 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 used to provide an overview of functional status, determine activity limitations, establish a baseline for treatment, provide a guide for intervention planning, evaluate interventions, monitor progress, and 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 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.

No baseline is set as the measure is associated with the number of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services who show improvement on the DLA-20 compared to the total number receiving Co-occurring Psychiatric and Substance Use Disorder services in the program. Baseline will be determined in DY3.

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 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. The valuation on this project is based on 20 consumers over the life of the project.

Hill Country MHDD Category 3 Project - 133340307.3.1 Related Category 2 Project - 133340307.2.1 (Project Area 2.13.1)				
133340307.3.1	**IT-10.2**	**Activities of Daily Living**		
Hill Country MHDD				**133340307**
Related Category 1 or 2 projects:	**133340307.2.1**			
Starting Point/Baseline:	TBD in DY3			
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)**	
	Outcome Improvement Target 1 [IT-10.2]: Activities of Daily Living **Improvement Target:** TBD % of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 1 Estimated Incentive Payment*:* $6,142**	**Outcome Improvement Target 2** [IT-10.2]: Activities of Daily Living **Improvement Target:** TBD % of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 2 Estimated Incentive Payment*:* $9,854**	**Outcome Improvement Target 3** [IT-10.2]: Activities of Daily Living **Improvement Target:** TBD % of individuals receiving Co-occurring Psychiatric and Substance Use Disorder services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 3 Estimated Incentive Payment*:* $14,282**	
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $6,142**	**Year 4 Estimated Outcome Amount: $9,854**	**Year 5 Estimated Outcome Amount: $14,282**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $30,278				

Category 3 Project Narrative
Hill Country MHDD - 133340307.3.2

Outcome Domain: OD-10 Quality of Life/Functional Status
Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living/Trauma Informed Care
Unique RHP Outcome Identification Number: 133340307.3.2

Title of Category 1 or 2 Project: 133340307.2.2 **-** 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
Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Outcome Measure Description:

- OD-10 Quality of Life/Functional Status
  - 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 or Daily Living Activities (DLA-20) Youth Mental Health (Ages 6-18).

Process Milestones:
Not applicable

Outcome Improvement Targets for each Year:

- DY2:
  - Not Applicable
- DY3:
  - IT-10.2: Activities of Daily Living: TBD % of individuals receiving Trauma Informed Care services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY4:
  - IT-10.2: Activities of Daily Living: TBD % of individuals receiving Trauma Informed Care services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY5:
  - IT-10.2: Activities of Daily Living: TBD % of individuals receiving Trauma Informed Care services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)

Rationale:
Trauma impacts an individual's mental health and 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, evaluate interventions, monitor progress, and plan for the 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.

No baseline is set as the measure is associated with the number of individuals receiving Trauma Informed Care who show improvement on the DLA-20. This will be determined in DY3.

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 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. The valuation on this project is based on 25 consumers over the life of the project.

Hill Country MHDD Category 3 - 133340307.3.2 Related Category 2 Project 133340307.2.2 (Project Area 2.13.1)			
133340307.3.2	**IT-10.2**	**Activities of Daily Living**	
Hill Country MHDD			**133340307**
Related Category 1 or 2 projects:	**133340307.2.2**		
Starting Point/Baseline:	**TBD in DY3**		
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)**
	Outcome Improvement Target 1 [IT-10.2]: Activities of Daily Living **Improvement Target:** TBD % of individuals receiving Trauma Informed Care services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 1 Estimated Incentive Payment*:* $10,181**	**Outcome Improvement Target 2** [IT-10.2]: Activities of Daily Living **Improvement Target:** TBD % of individuals receiving Trauma Informed Care services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 2 Estimated Incentive Payment*:* $16,176**	**Outcome Improvement Target 3** [IT-10.2]: Activities of Daily Living **Improvement Target:** TBD % of individuals receiving Trauma Informed Care services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 3 Estimated Incentive Payment*:* $23,443**
Year 2 Estimated Outcome Amount: $ 0	**Year 3 Estimated Outcome Amount: $10,181**	**Year 4 Estimated Outcome Amount: $16,176**	**Year 5 Estimated Outcome Amount: $23,443**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $49,800			

Category 3 Project Narrative
Hill Country MHDD 133340307.3.3

Outcome Domain: OD-12 Primary Care & Primary Prevention
Title of Outcome Measure (Improvement Target): IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)
Unique RHP Outcome Identification Number: 133340307.3.3

Title of Category 1 or 2 Project: 133340307.2.3 - 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
Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Outcome Measure Description:

- OD-12 Primary Care & Primary Prevention
  - 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 Blanco and Llano counties as determined by Texas Department of State Health Services population estimates.

<u>Associated Category 3 Measures:</u>

- OD-12 Primary Care & Primary Prevention
  - 133340307.3.4 - IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9)
  - 133340307.3.5 - IT-12.5: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)

Process Milestones:
Not applicable

Outcome Improvement Targets for each Year:

- DY2:
  - Not Applicable
- DY3:
  - IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC): 2% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment
- DY4:

- IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC): 3% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment

- DY5:
  - IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC): 5% of population 12 to 18 years old have received PHQ-A/BDI-PC 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. Target percentages were chosen based on a report by the University of Arkansas Medical Sciences Partners in Behavioral Health Sciences that 5% of adolescents age 9 to 17 have major depressive disorder in any given six month span.

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 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. The valuation on this project is based on 400 consumers over the life of the project.

Hill Country MHDD Category 3 Project - 133340307.3.3 Related Category 2 Project 133340307.2.3 (Project Area 2.16.1)			
133340307.3.3	**IT-12.5**	**Other USPSTF endorsed screening (PHQ-A and BDI-PC)**	
Hill Country MHDD			**133340307**
Related Category 1 or 2 projects:	**133340307.2.3**		
Starting Point/Baseline:	**Service not currently offered**		
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)**
	Outcome Improvement Target 1 [IT-12.5]: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC) **Improvement Target:** 2% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment **Data Source:** Hill Country MHDD records/EHR/Primary Physician Reports **Outcome Improvement Target 1 Estimated Incentive Payment*:* $5,000**	**Outcome Improvement Target 2** [IT-12.5]: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC) **Improvement Target:** 3% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment **Data Source:** Hill Country MHDD records/EHR/Primary Physician Reports **Outcome Improvement Target 2 Estimated Incentive Payment*:* $7,500**	**Outcome Improvement Target 3** [IT-12.5]: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC) **Improvement Target:** 5% of population 12 to 18 years old have received PHQ-A/BDI-PC assessment **Data Source:** Hill Country MHDD records/EHR/Primary Physician Reports **Outcome Improvement Target 3 Estimated Incentive Payment*:* $10,000**
Year 2 Estimated Outcome Amount: $ 0	**Year 3 Estimated Outcome Amount: $5,000**	**Year 4 Estimated Outcome Amount: $7,500**	**Year 5 Estimated Outcome Amount: $10,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $22,500			

Category 3 Project Narrative
Hill Country MHDD 133340307.3.4

Outcome Domain: OD-12 Primary Care & Primary Prevention
Title of Outcome Measure (Improvement Target): IT-12.5 Other USPSTF-endorsed screening outcome measures (PHQ-9)
Unique RHP Outcome Identification Number: 133340307.3.4

Title of Category 1 or 2 Project: 133340307.2.3 - 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
Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Outcome Measure Description:

- OD-12 Primary Care & Primary Prevention
  - 133340307.3.4 - 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 Blanco and Llano counties as determined by Texas Department of State Health Services population estimates.

<u>Associated Category 3 Measures:</u>

- OD-12 Primary Care & Primary Prevention
  - 133340307.3.3 - IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)
  - 133340307.3.5 - IT-12.5: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)

Process Milestones:
Not applicable

Outcome Improvement Targets for each Year:

- DY2:
  - Not Applicable
- DY3:
  - IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9): 2% of population over the age of 18 have received PHQ-9 assessment
- DY4:

- IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9): 3% of population over the age of 18 have received PHQ-9 assessment

- DY5:
  - IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9): 5% of population over the age 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. Target percentages were chosen based on a report by the National Institute of Mental Health showing a prevalence rate for Major Depressive Disorder of 6.7% for the U.S. adult population.

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 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. The valuation on this project is based on 400 consumers over the life of the project.

Hill Country MHDD Category 3 Project - 133340307.3.4 Related Category 2 Project - 133340307.2.3 (Project Area 2.16.1)			
133340307.3.4	**IT-12.5**	**Other USPSTF endorsed screening (PHQ-9))**	
Hill Country MHDD			**133340307**
Related Category 1 or 2 projects:	**133340307.2.3**		
Starting Point/Baseline:	**Service not currently offered**		
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)**
	Outcome Improvement Target 1 [IT-12.5]: Other USPSTF-endorsed screening outcome measures (PHQ-9) **Improvement Target:** 2% of population over the age of 18 have received PHQ-9 assessment **Data Source:** Hill Country MHDD records/EHR/Primary Physician Reports **Outcome Improvement Target 1 Estimated Incentive Payment*:* $7,387**	**Outcome Improvement Target 2** [IT-12.5]: Other USPSTF-endorsed screening outcome measures (PHQ-9) **Improvement Target:** 3% of population over the age of 18 have received PHQ-9 assessment **Data Source:** Hill Country MHDD records/EHR/Primary Physician Reports **Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,900**	**Outcome Improvement Target 3** [IT-12.5]: Other USPSTF-endorsed screening outcome measures (PHQ-9) **Improvement Target:** 5% of population over the age of 18 have received PHQ-9 assessment **Data Source:** Hill Country MHDD records/EHR/Primary Physician Reports **Outcome Improvement Target 3 Estimated Incentive Payment*:* $20,435**
Year 2 Estimated Outcome Amount: $ 0	**Year 3 Estimated Outcome Amount: $7,387**	**Year 4 Estimated Outcome Amount: $12,900**	**Year 5 Estimated Outcome Amount: $20,435**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $40,722			

Category 3 Project Narrative
Hill Country MHDD 133304307.3.5

Outcome Domain: OD-12 Primary Care & Primary Prevention
Title of Outcome Measure (Improvement Target): IT-12.5 Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT)
Unique RHP Outcome Identification Number: 133340307.3.5

Title of Category 1 or 2 Project: 133340307.2.3 - 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
Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Outcome Measure Description:

- OD-12 Primary Care & Primary Prevention
  - 133340307.3.5 - 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 Blanco and Llano counties as determined by Texas Department of State Health Services population estimates.

<u>Associated Category 3 Measures:</u>

- OD-12 Primary Care & Primary Prevention
  - 133340307.3.3 - IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-A/BDI-PC)
  - 133340307.3.4 - IT-12.5: Other USPSTF-endorsed screening outcome measures (PHQ-9)

Process Milestones:
Not applicable

Outcome Improvement Targets for each Year:

- DY2:
  - Not Applicable
- DY3:
  - IT-12.5: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT): 2% of population over the age of 18 years old have received CAGE/AUDIT assessment

- DY4:
  - IT-12.5: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT): 3% of population over the age of 18 years old have received CAGE/AUDIT assessment
- DY5:
  - IT-12.5: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT): 5% of population over the age of 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. Target percentages were chosen based on the 2010 National Household Survey on Drug Abuse which showed a 7% prevalence of dependence on alcohol or illicit drugs for individuals 26 years of age or older.

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 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. The valuation on this project is based on 400 consumers over the life of the project.

Hill Country MHDD Category 3 Project - 133340307.3.5 Related Category 2 Project - 133340307.2.3 (Project Area 2.16.1)			
133340307.3.5	**IT-12.5**	**Other USPSTF endorsed screening (CAGE and AUDIT)**	
Hill Country MHDD			**133340307**
Related Category 1 or 2 projects:	**133340307.2.3**		
Starting Point/Baseline:	**Service not currently offered**		
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)**
	Outcome Improvement Target 1 [IT-12.5]: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT) **Improvement Target:** 2% of population over the age of 18 have received CAGE/AUDIT assessment **Data Source:** Hill Country MHDD records/EHR/Primary Physician Reports **Outcome Improvement Target 1 Estimated Incentive Payment*:* $5,000**	**Outcome Improvement Target 2** [IT-12.5]: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT) **Improvement Target:** 3% of population over the age of 18 have received CAGE/AUDIT assessment **Data Source:** Hill Country MHDD records/EHR/Primary Physician Reports **Outcome Improvement Target 2 Estimated Incentive Payment*:* $7,500**	**Outcome Improvement Target 3** [IT-12.5]: Other USPSTF-endorsed screening outcome measures (CAGE and AUDIT) **Improvement Target:** 5% of population over the age of 18 have received CAGE/AUDIT assessment **Data Source:** Hill Country MHDD records/EHR/Primary Physician Reports **Outcome Improvement Target 3 Estimated Incentive Payment*:* $10,000**
Year 2 Estimated Outcome Amount: $ 0	**Year 3 Estimated Outcome Amount: $5,000**	**Year 4 Estimated Outcome Amount: $7,500**	**Year 5 Estimated Outcome Amount: $10,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $22,500			

Category 3 Project Narrative – Pass 2
Hill Country MHDD 133340307.3.6

Outcome Domain: OD-10 Quality of Life/Functional Status
Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living
Unique RHP Outcome Identification Number: 133340307.3.6

Title of Category 1 or 2 Project: 133340307.2.4 - 2.18.1 Recruit, train and support consumers of mental health services to provide peer support services
Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Outcome Measure Description:

- OD-10 Quality of Life/Functional Status
  - 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:

- DY2 and DY3:
  - Not applicable

Outcome Improvement Targets for each Year:

- DY2:
  - Not Applicable
- DY3:
  - IT-10.2: TBD % of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY4:
  - IT-10.2: TBD % of individuals receiving Whole Health Peer Support services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY5:
  - IT-10.2: TBD % 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, 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. This will be determined in DY3.

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 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.

Hill Country MHDD Category 3 Project - 133340307.3.6 Related Category 2 Project - 133340307.2.4 (Project Area 2.18.1 – Pass 2)			
133340307.3.6	**IT-10.2**	**Activities of Daily Living**	
Hill Country MHDD			**133340307**
Related Category 1 or 2 projects:	**133340307.2.4**		
Starting Point/Baseline:	**TBD in DY3**		
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)**
	Outcome Improvement Target 1 [IT-10.2]: Activities of Daily Living **Improvement Target:** TBD % of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 1 Estimated Incentive Payment*:* $22,536**	**Outcome Improvement Target 2** [IT-10.2]: Activities of Daily Living **Improvement Target:** TBD % of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 2 Estimated Incentive Payment*:* $36,928**	**Outcome Improvement Target 3** [IT-10.2]: Activities of Daily Living **Improvement Target:** TBD % of individuals receiving Whole Health Peer Support services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 3 Estimated Incentive Payment*:* $54,810**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $22,536**	**Year 4 Estimated Outcome Amount: $36,928**	**Year 5 Estimated Outcome Amount: $54,810**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $114,274			

Category 3 Project Narrative – Pass 2
Hill Country MHDD 133340307.3.7

Outcome Domain: OD-10 Quality of Life/Functional Status
Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living
Unique RHP Outcome Identification Number: 133340307.3.7

Title of Category 1 or 2 Project: 133340307.2.5 - 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: Veteran Mental Health Services
Performing Provider Name: Hill Country Community MHMR Center (dba Hill Country MHDD Centers)
Performing Provider TPI #: 133340307

Outcome Measure Description:

- OD-10 Quality of Life/Functional Status
  - 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:

- DY2 and DY3:
  - Not Applicable

Outcome Improvement Targets for each Year:

- DY2:
  - Not Applicable
- DY3:
  - IT-10.2: 10% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY4:
  - IT-10.2: 20% of individuals receiving Veteran Mental Health services through the project show improvement on subsequent Activities of Daily Living scale (DLA-20)
- DY5:
  - IT-10.2: 30% 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, 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 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. Baseline will be determined in DY3.

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 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. The valuation on this project is based on 60 consumers over the life of the project.

Hill Country MHDD Category 3 Project 133340307.3.7 Related Category 2 Project - 133340307.2.5 (Project Area 2.13.1 – Pass 2)			
133340307.3.7	**IT-10.2**	**Activities of Daily Living**	
Hill Country MHDD			**133340307**
Related Category 1 or 2 projects:	**133340307.2.5**		
Starting Point/Baseline:	**TBD in DY3**		
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)**
	Outcome Improvement Target 1 [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 **Outcome Improvement Target 1 Estimated Incentive Payment*:* $16,968**	**Outcome Improvement Target 2** [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 **Outcome Improvement Target 2 Estimated Incentive Payment*:* $27,803**	**Outcome Improvement Target 3** [IT-10.2]: Activities of Daily Living **Improvement Target:** 30% of individuals receiving Veteran Mental Health services have improvement on subsequent Activities of Daily Living (DLA-20) **Data Source:** Hill Country MHDD records/EHR **Outcome Improvement Target 3 Estimated Incentive Payment: $41,266**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $16,968**	**Year 4 Estimated Outcome Amount: $27,803**	**Year 5 Estimated Outcome Amount: $41,266**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $86,037			

Category 3 Project Narrative - Pass 2
Little River Healthcare - 183086102.3.1

Outcome Domain: OD-9 Right Care Right Setting
Title of Outcome Measure (Improvement Target): 183086102.1.1 - IT-9.2 ED Appropriate Utilization; Reduce Emergency Department Visits for Targeted Conditions
Unique RHP Outcome Identification Number: 183086102.3.1

Title of Category 1 or 2 Project: 183086102.1.1 - 1.1.2 Expand Existing Primary Care Capacity
Performing Provider Name: Little River Healthcare
Performing Provider TPI #: 183086102

Outcome Measure Description:

- OD-9 Right Care Right Setting
  - IT-9.2: ED Appropriate Utilization

Process Milestones

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline rates

- DY3:
  - P-5: Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each Year:

- DY4:
  - IT-9.2: Reduce all ED visits (including ACSC)[24]; Target -TBD during project planning in DY2.
- DY5:
  - IT-9.2: Reduce all ED visits (including ACSC)[25]; Reduce ED utilization compared to baseline; % reduction TBD during DY2 planning process.

Rationale:
Improper use of hospital emergency departments (EDs) is a leading cause for continually rising national health care costs. Reducing total ED visits could save substantial dollars for both State and Federal Payers. Patients are using the ED for primary care needs on a regular basis; reasoning for this is lack of clinic availability and rising cost of healthcare. The overall goal of Little River Healthcare (LRH) is to shift patients utilizing of the ED for primary care services to a

[24] http://archive.ahrq.gov/data/safetynet/billappb.htm
[25] http://archive.ahrq.gov/data/safetynet/billappb.htm

primary care setting as detailed in our Expansion of Primary Care Category 1 (#183086102.1.1) project. Unfortunately, the transition of current unnecessary ED volume into our primary care clinics would further limit primary care access and reduce availability of primary care. The expansion of primary care, as detailed in our Category 1 Project, leads to expanded access and availability of primary care appointments. Thus our Category 1 project, expanding primary care availability, led us to choose ED appropriate utilization and its associated outcome, the improvement target of reducing ED utilization, as a reasonable metric to determining project success. While the specific percent reduction in ED utilization will not be determined until completion of our DY2 project plan, we believe the correlation of unnecessary ED utilization and limited access to primary care is substantial.

Outcome Measure Valuation:
During the calendar year 2011, LRH treated over 1,500 visits in the ED which were non-emergent, of which 23% were Medicaid claims, 24% were Medicare Claims, and 24% were services for the uninsured and indigent. Each visit has an associated charge of $1,750. Redirecting those patients would provide a cost savings of over $2,625,000 in the ED. Considering that Medicare and Medicaid comprise 71% of total ED utilization at LRH, this program could result in reductions of nearly $1,800,000 to State and Federal payers. In addition to the 1,500 non-emergency individuals in 2011 that would have access to expanded primary care, the 17,000 individuals who visited LRH clinics in 2012 would also benefit from access to primary care physicians and the improved convenience and shorter waiting times.

The associated cost for completing this project include the personnel and external entities we will utilize to establish a project plan, the personnel that will need to be hired to effect the implementation of our plan and the on-going cost of personnel and technology to monitor and effect reduced ED utilization. Such ongoing costs include but are not limited to training material, training personnel, training time, implementation material, implementation personnel, technology utilized to monitor outcomes as well as personnel used to monitor outcomes.

Little River Healthcare Category 3 Project - 183086102.3.1 Related Category 1 Project - 183086102.1.1 (Project Area 1.1.2 – Pass 2)			
183086102.3.1	**IT-9.2**	**ED Appropriate Utilization**	
Little River Healthcare			**183086102**
Related Category 1 or 2 projects:	**183086102.1.1**		
Starting Point/Baseline:	**TBD in DY2**		
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] (See Planning Protocol, page 363): Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source**: Registry, EHR, claims or other Performing Provider scheduling scores **Process Milestone 1 Estimated Incentive Payment: $55,687** **Process Milestone 2** [P-2] (See Planning Protocol, page 363): Establish baseline rates **Data Source**: Registry, EHR, claims or other Performing Provider	**Process Milestone 3** [P-5] (See Planning Protocol, page 363): Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source**: Registry, EHR, claims or other Performing Provider scheduling scores **Process Milestone 3 Estimated Incentive Payment: $138,207**	**Outcome Improvement Target 1** [IT-9.2]: Reduce all ED visits (including ACSC)[26] **Improvement Target:** Reduce ED utilization TBD% compared to baseline, which is determined in DY 2 **Data Source**: Registry, EHR, claims or other Performing Provider scheduling scores **Outcome Improvement Target 1 Estimated Incentive Payment: $251,165**	**Outcome Improvement Target 2** [IT-9.2]: Reduce all ED visits (including ACSC)[27] **Improvement Target:** Reduce ED utilization TBD % compared to baseline, which is determined during DY2 planning process. **Data Source**: Registry, EHR, claims or other Performing Provider scheduling scores **Outcome Improvement Target 2 Estimated Incentive Payment: $618,867**

[26] http://archive.ahrq.gov/data/safetynet/billappb.htm
[27] http://archive.ahrq.gov/data/safetynet/billappb.htm

scheduling scores **Process Milestone 2 Estimated Incentive Payment: $55,688**			
Year 2 Estimated Outcome Amount: $111,375	**Year 3 Estimated Outcome Amount: $138,207**	**Year 4 Estimated Outcome Amount: $251,165**	**Year 5 Estimated Outcome Amount: $618,867**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $1,119,614			

Category 3 Project Narrative – Pass 2
Little River Healthcare 183086102.3.2

Outcome Domain: OD-12 Primary Care and Primary Prevention
Title of Outcome Measure: IT-12.1 Breast Cancer Screening
Unique RHP Outcome Identification Number: 183086102.3.2

Title of Category 1 Project: 183086102.1.2 - 1.9.2 Improve access to specialty care
Performing Provider Name: Little River Healthcare
Performing Provider TPI: 183086102

Outcome Measure Description:

- OD-12 Primary Care and Primary Prevention
  - IT-12.1: Breast Cancer Screening

<u>Associated Category 3 Measures:</u>

- OD-12 Primary Care and Primary Prevention
  - 183086102.3.3 – IT-12.2: Cervical Cancer Screening
  - 183086102.3.4 – IT-12.3: Colorectal Cancer Screening

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-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Improvement Targets:

- DY4:
  - IT-12.1: Breast Cancer Screening; % TBD over baseline
- DY5:
  - IT-12.1: Breast Cancer Screening; % TBD over baseline

Rationale

As of the 2010 Census, there were 24,757 people living in Milam County, of which 50.6% were female. Of this population 49.2% were between the ages of 18 – 64 and 17.4% were 65 years of age or older. According to medical research findings, breast cancer is more likely to occur the older that people become. The U.S. Preventive Services Task Force, as of 2009, recommends that women between the ages of 50-74 be screened every two years for breast cancer. 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 the 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. It is important to evaluate the efficiency 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. Therefore, project planning and determination of target groups for screening and timelines will be established in DY2. Baselines will be established in DY3 with the improvement targets for DY4 and DY5 established in DY3 also. That said, we anticipate 100 new referrals (for all services) will be made in DY4 and 120 in DY5.

Outcome Measure Valuation

Little River Healthcare (LRH) will engage its physicians and staff to determine the appropriate target population within the existing patient base as well as patients from outside Milam County that desire access to Specialty Care. Based on the size of Milam County, expected growth, physician shortage designation and high number of emergency department (ED) visits, we anticipate savings of at least $1.5 million within the ED itself if patients are able to access specialty care and receive treatment in order to avoid costly ED visits and extended inpatient care. At this time, local funding does not exist for the expansion of specialty care and specialty care diagnostic treatment, screening and prevention services/testing. The funding that is received will be split equally between the three (3) proposed Category 3 projects.

The associated cost for completing this project include the personnel and external entities we will utilize to establish a project plan and baseline, the personnel that will need to be hired to effect the implementation of our plan and the on-going cost of personnel and technology to monitor and effect improved medical screening. Such ongoing costs include but are not limited to training material, training personnel, training time, implementation material, implementation personnel, technology utilized to monitor outcomes as well as personnel used to monitor outcomes.

Little River Healthcare Category 3 Project - 183086102.3.2 Related Category 1 Project – 183086102.1.2 (Project Area 1.9.2 – Pass 2)			
183086102.3.2	**IT-12.1**	**Breast Cancer Screening (HEDIS 2012)**	
Little River Healthcare			**183086102**
Related Category 1 or 2 projects:	**183086102.1.2**		
Starting Point/Baseline:	**TBD in DY3**		
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:** EMR **Process Milestone 1 Estimated Incentive Payment: $6,187** **Process Milestone 2** [P-3]: Develop and test data systems: **Data Source:** Information Technology System **Process Milestone 2 Estimated Incentive Payment: $6,188**	**Process Milestone 3** [P-2]: Establish baseline rates **Data Source:** EMR, Information Technology System **Process Milestone 3 Estimated Incentive Payment: $7,678** **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Meeting Notes and Reports from Information Technology System **Process Milestone 4 Estimated Incentive Payment: $7,679**	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening **Improvement Target:** % TBD over baseline **Data Source:** EMR, Information Technology System **Outcome Improvement Target 1 Estimated Incentive Payment: $27,907**	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening **Improvement Target**: % TBD over baseline **Data Source:** EMR, Information Technology System **Outcome Improvement Target 2 Estimated Incentive Payment: $68,763**
Year 2 Estimated Outcome Amount: $12,375	**Year 3 Estimated Outcome Amount: $15,357**	**Year 4 Estimated Outcome Amount: $27,907**	**Year 5 Estimated Outcome Amount: $68,763**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $124,402			

Category 3 Project Narrative – Pass 2
Little River Healthcare – 183086102.3.3

Outcome Domain: OD-12 Primary Care and Primary Prevention
Title of Outcome Measure (Improvement Target): IT-12.2 Cervical Cancer Screening
Unique RHP Outcome Identification Number: 183086102.3.3

Title of Category 1 or 2 Project: 088334001.2.1 - 1.9.2 Improve access to specialty care
Performing Provider Name: Little River Healthcare
Performing Provider TPI #: 183086102

Outcome Measure Description:

- OD-12 Primary Care and Primary Prevention
  - IT-12.2: Cervical Cancer Screening

<u>Associated Category 3 Measures:</u>

- OD-12 Primary Care and Primary Prevention
  - 183086102.3.2 - IT-12.1: Breast Cancer Screening
  - 183086102.3.4 - IT-12.3: Colorectal Cancer Screening

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-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Improvement Targets:

- DY4:
  - IT-12.2: Cervical Cancer Screening; % TBD over baseline
- DY5:
  - IT-12.2: Cervical Cancer Screening; % TBD over baseline

Rationale:
As of the 2010 Census, there were 24,757 people living in Milam County, of which 50.6% were female. Of this population 49.2% were between the ages of 18 – 64, and screening for cervical cancer is recommended every 3-5 years beginning at the age of 21. 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. It is important to evaluate the efficiency 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. Therefore, project planning and determination of target groups for screening and timelines will be in DY2. Baselines will be established in DY3 with the improvement targets for DY4 and DY5 established in DY3 also. That said, we anticipate 100 new referrals (for all services) will be made in DY4 and 120 in DY5.

Outcome Measure Valuation

Little River Healthcare (LRH) will engage its physicians and staff to determine the appropriate target population within the existing patient base as well as patients from outside Milam County that desire access to Specialty Care. Based on the size of Milam County, expected growth, physician shortage designation and high number of emergency department (ED) visits, we anticipate savings of at least $1.5 million within the ED itself if patients are able to access specialty care and receive treatment in order to avoid costly ED visits and extended inpatient care. At this time, local funding does not exist for the expansion of specialty care and specialty care diagnostic treatment, screening and prevention services/testing. The funding that is received will be split equally between the three (3) proposed Category 3 projects.

The associated cost for completing this project include the personnel and external entities we will utilize to establish a project plan and baseline, the personnel that will need to be hired to effect the implementation of our plan and the on-going cost of personnel and technology to monitor and effect improved medical screening. Such ongoing costs include but are not limited to training material, training personnel, training time, implementation material, implementation personnel, technology utilized to monitor outcomes as well as personnel used to monitor outcomes.

Little River Healthcare Category 3 Project - 183086102.3.3 Related Category 1 Project – 183086102.1.2 (Project Area 1.9.2 – Pass 2)			
183086102.3.3	**IT-12.2**	**Cervical Cancer Screening (HEDIS 2012)**	
Little River Healthcare			**183086102**
Related Category 1 or 2 projects:	**183086102.1.2**		
Starting Point/Baseline:	**TBD in DY3**		
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:** EMR **Process Milestone 1 Estimated Incentive Payment: $6,187** **Process Milestone 2** [P-3]: Develop and test data systems **Data Source:** Information Technology System **Process Milestone 2 Estimated Incentive Payment: $6,188**	**Process Milestone 3** [P-2]: Establish baseline rates **Data Source:** EMR, Information Technology System **Process Milestone 3 Estimated Incentive Payment: $7,678** **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Meeting Notes and Reports from Information Technology System **Process Milestone 4 Estimated Incentive Payment: $7,679**	**Outcome Improvement Target 1** [IT-12.2]: Cervical Cancer Screening **Improvement Target:** % TBD over baseline **Data Source:** EMR, Information Technology System **Outcome Improvement Target 1 Estimated Incentive Payment: $27,907**	**Outcome Improvement Target 2** [IT-12.2]: Cervical Cancer Screening **Improvement Target:** % TBD over baseline **Data Source:** EMR, Information Technology System **Outcome Improvement Target 2 Estimated Incentive Payment: $68,763**
Year 2 Estimated Outcome Amount: $12,375	**Year 3 Estimated Outcome Amount: $15,357**	**Year 4 Estimated Outcome Amount: $27,907**	**Year 5 Estimated Outcome Amount: $68,763**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $124,402			

Category 3 Project Narrative – Pass 2
Little River Healthcare – 183086102.3.4

Outcome Domain: OD-12 Primary Care and Primary Prevention
Title of Outcome Measure (Improvement Target): IT-12.3 Colorectal Cancer Screening
Unique RHP Outcome Identification Number: 183086102.3.4

Title of Category 1 or 2 Project: 088334001.2.1 - 1.9.2 Improve access to specialty care
Performing Provider Name: Little River Healthcare
Performing Provider TPI #: 183086102

Outcome Measure Description:

- OD-12 Primary Care and Primary Prevention
  - IT-12.3: Colorectal Cancer Screening

Associated Category 3 Measures:

- OD-12 Primary Care and Primary Prevention
  - 183086102.3.2 - IT-12.1: Breast Cancer Screening
  - 183086102.3.3 - IT-12.2: Cervical Cancer Screening

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-4: Conduct Plan Do Study (PDSA) cycles to improve data collection and intervention activities

Improvement Targets for each Year:

- DY4:
  - IT-12.3: Colorectal Cancer Screening; % TBD over baseline
- DY5:
  - IT-12.3: Colorectal Cancer Screening; % TBD over baseline

Rationale:
As of the 2010 Census, there were 24,757 people living in Milam County. Of this population 49.2% were between the ages of 18 – 64 and 17.4% were 65 years of age or older. According to current medical reports Individuals over the age of 50 should be screened for Colorectal Cancer, with follow up screening determined by the Specialty Care Physician. 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. It is important to evaluate the efficiency 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. Project planning and determination of target groups for screening and timelines will be performed in DY2. Baselines will be established in DY3 with the improvement targets for DY4 and DY5 established in DY3 also. That said, we anticipate 100 new referrals (for all services) will be made in DY4 and 120 in DY5.

Outcome Measure Valuation

Little River Healthcare (LRH) will engage its physicians and staff to determine the appropriate target population within the existing patient base as well as patients from outside Milam County that desire access to Specialty Care. Based on the size of Milam County, expected growth, physician shortage designation and high number of emergency department (ED) visits, we anticipate savings of at least $1.5 million within the ED itself if patients are able to access specialty care and receive timely treatment and avoid costly ED visits and extended inpatient care. At this time, local funding does not exist for the expansion of specialty care and specialty care diagnostic treatment, screening and prevention services/testing. The funding that is received will be split equally between the three (3) proposed Category 3 projects.

The associated cost for completing this project include the personnel and external entities we will utilize to establish a project plan and baseline, the personnel that will need to be hired to effect the implementation of our plan and the on-going cost of personnel and technology to monitor and effect improved medical screening. Such ongoing costs include but are not limited to training material, training personnel, training time, implementation material, implementation personnel, technology utilized to monitor outcomes as well as personnel used to monitor outcomes.

Little River Healthcare Category 3 Project - 183086102.3.4 Related Category 1 Project – 183086102.1.2 (Project Area 1.9.2 – Pass 2)			
183086102.3.4	**IT-12.3**	**Colorectal Cancer Screening (HEDIS 2012)**	
Little River Healthcare			**183086102**
Related Category 1 or 2 projects:	**183086102.1.2**		
Starting Point/Baseline:	**TBD in DY3**		
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:** EMR **Process Milestone 1 Estimated Incentive Payment: $6,187** **Process Milestone 2** [P-3]: Develop and test data systems: **Data Source:** Information Technology System **Process Milestone 2 Estimated Incentive Payment: $6,188**	**Process Milestone 3** [P-2]: Establish baseline rates **Data Source:** EMR, IT **Process Milestone 3 Estimated Incentive Payment: $7,678** **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Meeting Notes and Reports from Information Technology System **Process Milestone 4 Estimated Incentive Payment: $7,679**	**Outcome Improvement Target 1** [IT-12.3]: Colorectal Cancer Screening **Improvement Target: %** TBD over baseline **Data Source:** EMR, and Information Technology System **Outcome Improvement Target 1 Estimated Incentive Payment: $27,907**	**Outcome Improvement Target 2** [IT-12.3]: Colorectal Cancer Screening **Improvement Target: %** TBD over baseline **Data Source:** EMR and Information Technology System **Outcome Improvement Target 2 Estimated Incentive Payment: $68,763**
Year 2 Estimated Outcome Amount: $12,375	**Year 3 Estimated Outcome Amount: $15,357**	**Year 4 Estimated Outcome Amount: $27,907**	**Year 5 Estimated Outcome Amount: $68,763**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $124,402			

Category 3 Project Narrative
Scott & White Hospital – Llano – 020840701.3.1

Outcome Domain: OD-9 Right Care, Right Setting
Outcome Measure: IT-9.2 ED Appropriate Utilization
Unique RHP Outcome Identification Number: 020840701.3.1

Project Area, Option and Title: 020840701.2.1 - 2.8.1 Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency
Performing Provider Name: Scott & White Hospital—Llano
Performing Provider TPI #: 020840701 (New TPI: 220798701)

Outcome Measure Description:

- OD-9 Right Care, Right Setting
  - IT-9.2 ED Appropriate Utilization

Process Milestones:

- DY2:
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems

Outcome Improvement Targets for each Year:

- DY4:
  - IT-9.2 ED Appropriate Utilization Rate reduced by 6% over baseline
- DY5:
  - IT-9.2 ED Appropriate Utilization Rate reduced by 10% over baseline

Rationale:
We selected Emergency Department (ED) utilization as a metric because it is closely-tied to the locally-identified need for additional EMS services in Llano County. By changing processes in the County to better meet the needs of persons utilizing EMS services for non-urgent or non-emergent concerns will both reduce demand for EMS services and reduce avoidable ED utilization. Appropriate ED utilization is a measure of health needs being met at appropriate levels of care. Some ED visits are necessary. Others occur because of lack of convenient access to other levels of care or exacerbation of illnesses thought to be manageable through high quality ambulatory care. Our improvement target is reduction of all ED visits because that overall reduction should capture reductions in inappropriate visits and capture reductions due to reduction in unnecessary EMS service utilization. Process improvement work will be directed toward reducing inappropriate EMS utilization as one means to reduce inappropriate ED utilization.

Our goal is to reduce ED utilization by the selected target group by 10% by the end of DY5; reduction by at least 6% in DY4 will represent noticeable progress toward that goal. We selected 10% reduction because that degree of reduction is expected to have a noticeable impact on EMS service capacity without reducing access to needed services. The quality improvement team will select its target group for the project with this goal in mind. That will require identification of existing problems with an impact on utilization that is high enough to allow at least a 10% reduction in potentially preventable ED utilization. The team's selection of changes to test must be scaled to the scope of this target. That is, the team must choose a) a target group with noticeable potential for reduction in unnecessary ED utilization, and b) process changes that represent true departures from current practice in order to obtain these meaningful reductions in ED utilization.

Process measures were chosen for DYs 2 and 3 to mark progress in the team's employment of the Model for Improvement. In DY2, we will select our target population and establish baseline ED utilization rates for that population. Target populations much be selected by the team, considering both sources of EMS calls and sources of ED utilization that are potentially avoidable. For example, the team may choose to focus on residents in long-term care settings, residents of certain geographic areas in the County, or individuals utilizing services for particular reasons deemed potentially avoidable. In DY3, we will establish data systems for ongoing monitoring of the impact of specific process changes (both positive and negative) and impact of the program overall on ED utilization for the targeted group. The baseline rates of implementation and implementation impact for tests of changes will be established during the planning phase of each PDSA cycle. A project manager will be responsible for collating data from the system(s) and reporting to the group for use in decision-making.

Baseline:
Baseline rates of ED utilization will be established in DY2 (Milestone P-2) for the target population chosen by the quality improvement team in the same year.

Outcome Measure Valuation:
The costs of all measures and reporting was included in the value calculation for the overall project because data collection and reporting is integrally related to successful process improvement. The required percent allocation of total project value was then applied for each year—10% in DY2, 10% in DY3, 15% in DY4, and 33% in DY5.

Scott & White Hospital - Llano Category 3 Project - 020840701.3.1 Related Category 2 Project - 020840701.2.1 (Project Area 2.8.1)			
020840701.3.1	**IT-9.2**	**ED Appropriate Utilization**	
Scott & White Llano Memorial Hospital			**020840701**
Related Category 1 or 2 projects:	**020840701.2.1**		
Starting Point/Baseline:	**Baseline will be established in DY2**		
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] (see page 363 of planning protocol): Establish baseline rates **Data Source:** Administrative billing data, EMS data **Process Milestone 1 Estimated Incentive Payment: $19,885**	**Process Milestone 2** [P- 3] (see page 363 of planning protocol): Develop and test data systems **Data Source:** Program files, new data base iterations **Process Milestone 2 Estimated Incentive Payment: $27,000**	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization (Standalone measure) **Improvement Target:** Reduce all ED visits (including ACSC) for adults by 6% over baseline established for the target population (in DY2 milestone) **Data Source:** Administrative billing data, program records **Outcome Improvement Target 1 Estimated Incentive Payment: $40,500**	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization (Standalone measure) **Improvement Target:** Reduce all ED visits (including ACSC) for adults by 10% over baseline established for the target population (in DY2 milestone) **Data Source:** Administrative billing data, program records **Outcome Improvement Target 2 Estimated Incentive Payment: $89,100**
Year 2 Estimated Outcome Amount: $19,885	**Year 3 Estimated Outcome Amount: $27,000**	**Year 4 Estimated Outcome Amount: $40,500**	**Year 5 Estimated Outcome Amount: $89,100**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $176,485			

Category 3 Project Narrative – Pass 2
Scott & White Hospital – Llano – 020840701.3.2

Outcome Domain: OD-9 Right Care, Right Setting
Outcome Measure Description: IT-9.2 ED appropriate utilization (Standalone measure)
Unique Project Identifier: 020840701.3.2

Project Area, Option and Title: 020840701.2.2 - 2.8.1 Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
Performing Provider Name: Scott & White Hospital--Llano
Performing Provider TPI #: 020840701

Outcome Measure Description:

- OD-9 Right Care, Right Setting
  - IT-9.2 ED Appropriate Utilization

Process Milestones:

- DY2:
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems

Outcome Improvement Targets for each Year:

- DY4:
  - IT-9.2: ED Appropriate Utilization Rate reduced by 3% over baseline
- DY5:
  - IT-9.2: ED Appropriate Utilization Rate reduced by 5% over baseline

Rationale:
Appropriate Emergency Department (ED) utilization is a measure of health needs being met at appropriate levels of care. Some ED visits are necessary. Others occur because of lack of convenient access to other levels of care or exacerbation of illnesses thought to be manageable through high quality ambulatory care. Process improvement work will be directed toward reducing exacerbations of behavioral health illnesses leading to forced transfer of individuals to care sites. The current processes require transfers to include ED visits for medical clearance before transfer to out-of-County sites of care. Changing processes to reduce the need for transfers or reduce the need for ED-based medical clearance has the potential to reduce avoidable ED visits.

Our goal is to reduce all-cause ED utilization by 5% by the end of DY5; reduction by at least 3% in DY4 will represent noticeable progress toward that goal. These goals were selected as initial targets based on perceptions of what would be noticeable indication of real process change that may justify to stakeholders the continuation of project activities.

Outcome Measure Valuation:
The costs of all measures and reporting was included in the value calculation for the overall project because data collection and reporting is integrally related to successful process improvement. The required percent allocation of total project value was then applied for each year—10% in DY2, 10% in DY3, 15% in DY4, and 33% in DY5.

Scott & White Hospital - Llano Category 3 Project 020840701.3.2 Related Category 2 Project - 020840701.2.2 (Project Area 2.8.1 – Pass 2)			
020840701.3.2	**IT-9.2**	**ED Appropriate Utilization**	
Scott & White Llano Memorial Hospital			**020840701**
Related Category 1 or 2 projects:	**020840701.2.2**		
Starting Point/Baseline:	**No baseline has been established, TBD in DY2**		
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 rates of appropriate ED Utilization at Participating Provider ED **Data Source:** Administrative billing data, EMS data **Process Milestone 1 Estimated Incentive Payment: $1,375**	**Process Milestone 2** [P- 3]: Develop and test data systems **Data Source:** Program files, new data base iterations **Process Milestone 2 Estimated Incentive Payment: $15,219**	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization •Reduce all ED visits (including ACSC) **Outcome Improvement Target 1**: Reduce all-cause adult ED visits by 3% over baseline **Data Source**: Administrative billing data, program records **Outcome Improvement Target 1 Estimated Incentive Payment: $22,482**	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization •Reduce all ED visits (including ACSC) **Outcome Improvement Target 2**: Reduce all-cause adult ED visits by 5% over baseline **Data Source**: Administrative billing data, program records **Outcome Improvement Target 2 Estimated Incentive Payment: $49,461**
Year 2 Estimated Outcome Amount: $1,375	**Year 3 Estimated Outcome Amount: $15,219**	**Year 4 Estimated Outcome Amount: $22,482**	**Year 5 Estimated Outcome Amount: $49,461**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $88,537			

Category 3 Project Narrative
Scott & White Memorial Hospital 137249208.3.1

Outcome Domain: OD-2 Potentially Preventable Admissions
Outcome Measure Description: IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate (Standalone measure)
Unique RHP Outcome Identification Number: 137249208.3.1

Project Area, Option and Title: 137249208.2.1 - 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized 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)
Performing Provider Name: Scott & White Memorial Hospital
Performing Provider TPI #: 137249208

Outcome Measure Description:

- OD-2 Potentially Preventable Admissions
  - IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate

Process Milestones:

- DY2:
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems

Outcome Improvement Targets for each Year:

- DY4:
  - IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate reduced by 5% over baseline.
- DY5:
  - IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate reduced by 15% over baseline.

Rationale:
We selected Ambulatory Care Sensitive Conditions Admissions because these admissions are 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. Patient navigation services should connect patients to the appropriate care and community-based services to meet their needs before their conditions worsen to a degree requiring inpatient treatment.

In DY2, we will establish baseline rates of Ambulatory Care Sensitive Condition Admissions (P-2) for our target population at Scott & White Memorial Hospital (performing provider), Cedar Crest Hospital and Metroplex Hospital (the three hospital partners). Baseline rates will be established using administrative billing data from the three hospitals.

In DY3, we will develop and test data systems for tracking hospital admissions, ED visits, interactions with patients across navigator settings, and aspects of protocol implementation (e.g., number and types of contacts). Data outputs will be formatted in ways that can be readily used by program teams to monitor progress and plan improvements.

In DYs 4 and 5, we aim to decrease the rate of ambulatory care sensitive conditions among program participants (specs described in milestones table). Reductions will be at least 5% over baseline by the end of DY4 and 15% over baseline by the end of DY5. We chose 5% in DY4 because it would represent a noticeable impact suggesting that the navigator program had begun to impact health and healthcare access behaviors of program members. By DY5, we expect at least a 15% reduction in hospitalizations for ambulatory care sensitive hospitalizations. We expect this level of reduction to show convincing evidence of cost savings to the hospital partners and County to allow a serious discussion about continuing to fund the program moving forward. This expectation is based extrapolations for the Indigent Care Program's hospital payment experience from 05/31/2011 through 06/01/2012:

- 301 bills submitted for hospitalization
- Average amount paid per bill = $5,672
- Assuming 33% were potentially avoidable, 100 hospitalizations may have been avoidable
- If 15% of avoidable admissions were prevented, the County would experience a savings of more than $87,000
- Assuming each hospital has populations of at least the same size in their charity care programs on average, we can extrapolate that the County plus three partner hospitals could save $348,000 on costs directly incurred for patient care (in charity care programs and County-paid claims).

This rough estimate does not consider the additional savings to the Medicaid program and does not consider savings for avoided ED visits. Revenue loss from reduced utilization is not considered because much care for Medicaid beneficiaries and Indigent Care program members is delivered by the hospitals at cost that is equal to or higher than available reimbursement. The combined financial savings plus demonstrated improvement in individuals' health may be sufficient at a 15% reduction to consider sustaining the program.

<u>Baseline:</u>
Baseline rates for ambulatory care sensitive condition hospitalizations in the program's target group will be established in DY2 after the team chooses its target population based on data on utilization and experience with the needs of Medicaid beneficiaries, Indigent Care Program members, and local hospital charity care programs. Baseline rates will be established using administrative billing data from Scott & White Memorial Hospital, Cedar Crest Hospital & RTC, and Metroplex hospital for DY1 (October 1, 2011 through September 30, 2012).

Outcome Measure Valuation:
The valuation of all Category 3 process and improvement metrics was built into the value of the overall DSRIP project, as measuring and meeting metrics must be part of usual program activities if the program is successful. We designated the following required value percentages to Category 3 in each year—10% in DY2, 10% in DY3, 15% in DY4, and 33% in DY5. In DYs 2 and 3, no value is assigned to the planning activities for IT-2.11 because the value will be place entirely on similar activities required for IT-9.2, a related improvement target. Similarly, relatively more of the 15% DSRIP project value in DY3 is placed on IT-9.2 because we believe the project will show impact on ED utilization before it shows improvement on hospitalization. In DY4, the majority of the Category 3 value is shifted to IT-2.11 to encourage the team to focus on both ED visits (9.2) and ambulatory care sensitive hospitalizations (2.11).

Scott & White Memorial Hospital Category 3 Project - 137249208.3.1 Related Category 2 Project - 137249208.2.1 (Project Area 2.9.1)			
137249208.3.1	**IT-2.11**	**Ambulatory Care Sensitive Conditions Admissions Rate**	
Scott & White Memorial Hospital			**137249208**
Related Category 1 or 2 projects:	**137249208.2.1**		
Starting Point/Baseline:	**Baseline will be established in DY2**		
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 rates **Data Source:** Historical payment and enrollment records for Bell County Indigent Care Program, historical billing and administrative records for participating hospitals **Process Milestone 1 Estimated Incentive Payment: $0**	**Process Milestone 2** [P- 3]: Develop and test data systems **Data Source:** Program files/protocols **Process Milestone 2 Estimated Incentive Payment: $0**	**Outcome Improvement Target 1** [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 among program participants (see the related "Numerator Inclusions/Exclusions") • Inclusions - Total number of acute care hospitalizations for ambulatory care sensitive conditions* under age 75 *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	**Outcome Improvement Target 2** [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 among program participants (see the related "Numerator Inclusions/Exclusions") • Inclusions - Total number of acute care hospitalizations for ambulatory care sensitive conditions* under age 75 *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

		Conditions (ASCS) document listed in the "Companion Documents" field for codes used. Exclusions • Program enrollees 75 years of age and older • Death before discharge b. Denominator: Total mid-year population under age 75 enrolled in patient navigator program **Improvement Target:** Reduce ambulatory care sensitive hospital admissions for program participants by 5% from baseline rates established in DY2 planning **Data Source:** Program enrollment files, hospital administrative billing data **Outcome Improvement Target 1 Estimated Incentive Payment: $37,773**	codes used. Exclusions • Program enrollees 75 years of age and older • Death before discharge b. Denominator: Total mid-year population under age 75 enrolled in patient navigator program **Improvement Target:** Reduce ambulatory care sensitive hospital admissions for program participants by 15% from baseline rates established in DY2 planning **Data Source:** Program enrollment files, hospital administrative billing data **Outcome Improvement Target 2 Estimated Incentive Payment: $141,102**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $0**	**Year 4 Estimated Outcome Amount: $37,773**	**Year 5 Estimated Outcome Amount: $141,102**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $178,875			

Category 3 Project Narrative
Scott & White Memorial Hospital 137249208.3.2

Outcome Domain: OD-9 Right Care, Right Setting
Outcome Measure Description: IT-9.2 ED Appropriate Utilization
Unique RHP Outcome Identification Number: 137249208.3.2

Project Area, Option and Title: 137249208.2.1- 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized 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)
Performing Provider Name: Scott & White Memorial Hospital
Performing Provider TPI #: 137249208

Outcome Measure Description:

- OD-9 Right Care, Right Setting
  - IT-9.2: ED Appropriate Utilization

Process Milestones:

- DY2:
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems

Outcome Improvement Targets for each Year:

- DY4:
  - IT-9.2: ED Appropriate Utilization Rate reduced by 5% over baseline
- DY5:
  - IT-9.2: ED Appropriate Utilization Rate reduced by 15% over baseline

Rationale:
We chose reduction of Emergency Department (ED) visits as one of our two Category 3 metrics because the emergency department is usually the entry point for Ambulatory Care Sensitive Conditions and other potentially preventable utilization of high-cost, high-intensity services. Reduction of ED visits for all conditions should capture both ED visits for exacerbation of ambulatory-care sensitive conditions and visits for non-urgent and non-emergent concerns that may be better addressed in other settings like primary care. That is, we expect reduction of inappropriate ED utilization to be particularly sensitive to patient navigator services because part of the reductions may be due to patients making different choices about where to get convenient care.

In DY2, we will establish baseline rates of all types of ED utilization (P-2) for our target population at Scott & White Memorial Hospital and Metroplex Hospital (Cedar Crest Hospital

does not have an ED). Baseline rates will be established using administrative billing data for the chosen target population.

In DY3, we will develop and test data systems for tracking ED admissions (in addition to hospitalizations and protocol implementation as described in the Category 3 narrative for IT-2.11). Data outputs will be formatted in ways that can be readily used by program teams to monitor progress and plan improvements.

In DY 3 and 4, we aim to decrease the rate of all caused ED visits among program participants (specs described in milestones table). Reductions will be at least 5% over baseline by the end of DY4 and 15% over baseline by the end of DY5. These reductions are consistent with our anticipated reductions in ambulatory care sensitive condition hospitalizations for the same program. At the time of this submission, we do not have data on the unique costs of ED utilization or the percent of ED visits that result in admissions in the population of interest. Those data will be carefully examined by the team as they select the program's target population and for the purpose of planning appropriate interventions.

Baseline:
Baseline rates for all cause ED visits in the program's target group will be established in DY2 after the team chooses its target population based on data on utilization and experience with the needs of Medicaid beneficiaries, Indigent Care Program members, and local hospital charity care programs. Baseline rates will be established using administrative billing data from Scott & White Memorial Hospital and Metroplex hospital for DY1 (October 1, 2011 through September 30, 2012).

Outcome Measure Valuation:
The valuation of all Category 3 process and improvement metrics was built into the value of the overall DSRIP project, as measuring and meeting metrics must be part of usual program activities if the program is successful. We designated the following required value percentages to Category 3 in each year—10% DY2, 10% DY3, 15% DY4, and 33% DY5. In DYs 2 and 3, no value is assigned to the planning activities for IT-2.11 because the value will be place entirely on similar activities required for IT-9.2, a related improvement target. Similarly, relatively more of the 15% DSRIP project value in Year 3 is placed on IT-9.2 because we believe the project will show impact on ED utilization before it shows improvement on hospitalization. In DY4, the majority of the Category 3 value is shifted to IT-2.11 to encourage the team to focus on both ED visits (9.2) and ambulatory care sensitive hospitalizations (2.11).

Scott & White Memorial Hospital Category 3 Project - 137249208.3.2 Related Category 3 Project - 137249208.2.1 (Project Area 2.9.1)			
137249208.3.2	IT-9.2	ED Appropriate Utilization	
Scott & White Memorial Hospital			137249208
Related Category 1 or 2 projects:	137249208.2.1		
Starting Point/Baseline:	Baseline will be established in DY2		
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 rates **Data Source:** Historical payment and enrollment records for Bell County Indigent Care Program, historical billing and administrative records for participating hospitals **Process Milestone 1 Estimated Incentive Payment: $85,182**	**Process Milestone 2** [P- 3]: Develop and test data systems **Data Source:** Program files/protocols **Process Milestone 2 Estimated Incentive Payment: $85,182**	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization Reduce all ED visits (including ACSC)[28] **Improvement Target:** Reduce adult (18 and older) ED visits (all causes) for patient navigator program participants by 5% from baseline established in DY2 **Data Source:** Billing data from participating hospitals, claims data from indigent care program administrative files **Outcome Improvement Target 1 Estimated Incentive Payment: $90,000**	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization Reduce all ED visits (including ACSC)[29] **Improvement Target:** Reduce adult (18 and older) ED visits (all causes) for patient navigator program participants by 15% from baseline established in DY2 **Data Source:** Billing data from participating hospitals, claims data from indigent care program administrative files **Outcome Improvement Target 2 Estimated Incentive Payment: $140,000**
Year 2 Estimated Outcome Amount: $85,182	**Year 3 Estimated Outcome Amount: $85,182**	**Year 4 Estimated Outcome Amount: $90,000**	**Year 5 Estimated Outcome Amount: $140,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $400,364			

[28] http://archive.ahrq.gov/data/safetynet/billappb.htm
[29] http://archive.ahrq.gov/data/safetynet/billappb.htm

Category 3 Project Narrative – Pass 2
Seton Highland Lakes Hospital – 094151004.3.1

Outcome Domain: OD-2 Potentially Preventable Admissions
Outcome Measure Description: IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate
Unique RHP Outcome Identification Number: 094151004.3.1

Project Area, Option and Title: 094151004.2.1 - 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: the uninsured.
Performing Provider Name: Seton Highland Lakes Hospital
Performing Provider TPI #: 094151004

Outcome Measure Description:

- OD-2 Potentially Preventable Admissions
    - IT-2.11: Ambulatory Care Sensitive Conditions Admissions Rate

<u>Process Milestones:</u>

- 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-3: Develop and test data systems
    - P-5: Establish baseline rates for Target 1

<u>Outcome Improvement Targets for each year:</u>

- DY4:
    - IT-2.11: Ambulatory Care Sensitive Conditions Admission Rate
        - Decrease percentage of number of acute care hospitalizations for Program participants with ambulatory care conditions under age 75 by a certain percent of baseline to be identified in DY3.
- DY5:
    - IT-2.11: Ambulatory Care Sensitive Conditions Admission Rate
        - Decrease percentage of number of acute care hospitalizations for Program participants with ambulatory care conditions under age 75 by a certain percent of baseline to be identified in DY3.

Rationale:
Many of these patients entered our emergency department (ED) or otherwise sought care at Seton Highland Lakes (SHL) for conditions which could be treated most effectively in the ambulatory setting. One of the goals of this project is to reduce the Ambulatory Care Sensitive Conditions Admissions Rate for those patients less than 75 years of age using an effective care navigation program. The baseline data will be gathered from claims and electronic medical record data through the initial community needs assessment. The numerator will consist of the

total number of acute care hospitalizations for ambulatory sensitive conditions for patients under age 75 years. This will be based on the list of conditions developed by Billings et al. The denominator will be the mid-year population enrolled in the navigator program under the age of 75 years.

A collaborative care team of navigators, including community or Home Health workers, Licensed Nurses, and/or Case Managers will provide proactive care management, navigate patients to a medical home, perform home environment assessments, and provide medication management assistance. The care team will also provide education to enrolled patients regarding chronic conditions, disease prevention and medication management.

The program is designed to connect people to an appropriate healthcare setting and thereby reduce avoidable (ambulatory care sensitive) admissions. The Ambulatory Care Sensitive Conditions Admissions Rate for those less than 75 years of age will indicate the impact of the program on managing wellness in the enrolled population and navigating patients to the most appropriate healthcare setting. This ACSC rate will be determined by the end of DY3.

Outcome Measure Valuation:
Patient navigation presents a significant opportunity to manage healthcare conditions effectively and reduce the cost of preventable hospital admissions, readmissions and ED visits, save lives, and keep families healthy. Project valuation considered costs, cost avoidance, population impact, patient experience, the overall impact to the community, as well as the project's ability to transform the delivery of healthcare by providing the right care, at the right place, the right time, and in a cost efficient manner. SHL is projected to see more than 18,500 patients in its ED this year and admit over 1,250 to inpatient care. We estimate this project will result in approximately 300 fewer visits per year (including inpatients and outpatients) resulting in an approximate cost avoidance of $700,000. Final project valuation and funding distribution across categories was determined based on the valuation provisions in the Program Funding and Mechanics Protocol.

Patient navigation presents a significant opportunity to manage healthcare conditions effectively and reduce the cost of preventable hospital admissions, readmissions and ED visits, save lives and keep families healthy.

Seton Highland Lakes Hospital Category 3 Project 094151004.3.1 Related Category 2 Project - 094151004.2.1 (Project 2.9.1 - Pass 2)			
094151004.3.1	IT-2.11	Ambulatory Care Sensitive Conditions Admissions Rate	
Seton Highland Lakes Hospital			094151004
Related Category 1 or 2 projects:	094151004.2.1		
Starting Point/Baseline:	TBD in DY 3		
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**: Program implementation plan **Process Milestone1 Estimated Incentive Payment: $67,567** **Process Milestone 2** [P-3]: Develop and test systems to support Outcome Improvement Target 1 [IT-2.11] **Data Source:** Business Intelligence **Process Milestone 2 Estimated Incentive Payment**: **$67,568**	**Process Milestone 3** [P-3]: Develop and test data systems to support Outcome Improvement Target 1 [IT-2.11] **Data Source**: Business Intelligence **Process Milestone 3 Estimated Incentive Payment: $67,567** **Process Milestone 4** [P-2]: Establish baseline rate for Outcome Improvement Target 1 [IT-2.11] **Data Source**: Patient Records; Business Intelligence **Process Milestone 4 Estimated Incentive Payment: $67,568**	**Outcome Improvement Target 1** [IT-2.11]: Ambulatory Care Sensitive Conditions Admission Rate a. Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75. b. Denominator: Total mid-year population of program participants under age 75 **Improvement Target**: Decrease the percentage of acute care hospitalizations for Program participants with ambulatory care conditions under age 75 by a TBD percentage per baseline. **Data Source:** Patient Records; Business Intelligence **Outcome Improvement Target 1 Estimated Incentive Payment: $202,703**	**Outcome Improvement Target 2** [IT-2.11]: Ambulatory Care Sensitive Conditions Admission Rate a. Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75. b. Denominator: Total mid-year population of program participants under age 75 **Improvement Target**: Decrease the percentage of acute care hospitalizations for Program participants with ambulatory care conditions by a TBD percentage per baseline. **Data Source:** Patient Records; Business Intelligence **Outcome Improvement Target 2 Estimated Incentive Payment: $445,946**
Year 2 Estimated Outcome Amount: $135,135	**Year 3 Estimated Outcome Amount: $135,135**	**Year 4 Estimated Outcome Amount: $202,703**	**Year 5 Estimated Outcome Amount: $445,946**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $918,919			

Category 3 Project Narrative
St. David's Round Rock Medical Center - 020957901.3.1

Outcome Domain: OD 9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization
Unique RHP Outcome Identification Number: 020957901.3.1

Title of Category 1 or 2 Project: 020957901.1.1 - Community Clinic Services Project
Performing Provider Name: St. David's Round Rock Medical Center ("RRMC")
Performing Provider TPI #: 020957901

Outcome Measure Description:

- OD 9 Right Care, Right Setting
  - IT-9.2: ED Appropriate Utilization

Through RRMC's expansion of the available primary care services in Williamson County, RRMC expects a reduction in the use of the Emergency Department (ED) for non-emergent episodes stemming from diabetes, which is the target chronic condition RRMC will be measuring for this outcome. By the end of the Waiver (Demonstration Year or DY5), RRMC expects inappropriate diabetes related ED visits to be reduced by a percentage yet to be determined from the baseline established in DY2.

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 diabetes-related ED visits at RRMC

Outcome Improvement Targets for each year:

- DY4:
  - IT-9.2: Reduce ED visits to RRMC for diabetes-related conditions by X% over baseline (TBD). RRMC will determine the percentage target improvement using the baseline it establishes for diabetes-related ED visits, and the success and impact of the corresponding Category 1 project, with special attention to the increased number of diabetic patients seen through the Community Clinic Services Project.
- DY5:
  - IT-9.2: Reduce ED visits to RRMC for diabetes-related conditions by X% over baseline (TBD). RRMC will determine the percentage target improvement using the baseline it establishes for diabetes-related ED visits, and the success and impact of the corresponding Category 1 project, with special attention to the increased number of diabetic patients seen through the Community Clinic Services Project.

Rationale:
RRMC believes that creating expanded access to primary care in the community will reduce the systemic costs for expensive inpatient and/or emergency department services by allowing earlier diagnosis, treatment, and management of conditions before they reach an acute level. Between 2006 and 2010, Williamson County had $326,889,520 in charges for Potentially Preventable Admissions (PPAs) (RHP Plan, Section 3, Table 3-6), with especially high rates of PPAs for angina, bacterial pneumonia, COPD, diabetes, and urinary tract infections (RHP Plan, Section 3, Table 3-6). The conditions causing those preventable hospitalizations were each conditions that can be screened, treated, and/or managed by primary care physicians in the community, including diabetes.

From a population perspective, 16.5% of Williamson County's adult residents are uninsured and 10.7% of children are uninsured (RHP Plan, Section 3, Table 3-3), 5.5% live below poverty levels (RHP Plan, Section 3, Table 3-1), and 7.4% are unemployed. These groups have very little access to primary and preventative care, especially in circumstances where their household income is slightly above the thresholds for existing public assistance programs in the County. Thus, these patients are more likely to seek treatment in the ED where they perceive they will not be turned away and/or because they waited until treatable conditions became acute to seek treatment. RRMC believes that providing this population with expanded preventative and primary care, especially for those with manageable chronic conditions, like diabetes, will reduce inappropriate use of the ED, which will lead to better patient health outcomes and decreased institutional costs of providing healthcare.

RRMC will establish the actual percentage targets for improvement in inappropriate ED use to be established in DY3 for use in DYs 4 and 5.

Outcome Measure Valuation:
The valuation of each RRMC project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. RRMC considers this outcome to be of the utmost importance, as inappropriate use of the ED results in less availability and longer waits for patients with emergent conditions, is exponentially more expensive to provide, and does not result in the best possible health outcomes for patients. Thus, to reduce the inappropriate use of the ED will create benefit for emergent and non-emergent patients, as well as the EDs themselves.

St. David's Round Rock Category 3 Project - 020957901.3.1 Related Category 1 Project – 020957901.1.1 (Project Area 1.1.2)			
020957901.3.1	**IT-9.2**	**ED Appropriate Utilization**	
St. David's Round Rock			**020957901**
Related Category 1 or 2 projects:	**020957901.1.1**		
Starting Point/Baseline:	**To be developed in DY3**		
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:** Meeting minutes; materials; implementation plan **Process Milestone 1 Estimated Incentive: $393,120**	**Process Milestone 2** [P-2]: Establish baseline rates RRMC will determine the number of diabetes-related ED visits at its facility between 10/1/2012 and 9/30/2013 (DY2), which will be used to measure the improvement targets in DYs 4-5. **Data Source:** ER admission records **Process Milestone 2 Estimated Incentive Payment: $398,009**	**Outcome Improvement Target 1** [IT-9.2]: Reduce Emergency Department visits for target conditions. **Improvement Target:** ED visits to RRMC's ED for diabetes-related conditions will improve by X% (TBD). **Data Source:** ER admission records – **Outcome Improvement Target 1 Estimated Incentive Payment: $597,015**	**Outcome Improvement Target 2** [IT-9.2]: Reduce Emergency Department visits for target conditions. **Improvement Target:** ED visits to RRMC's ED for diabetes-related conditions will improve by X% (TBD). **Data Source:** ER admission records – **Outcome Improvement Target 2 Estimated Incentive Payment: $1,313,432**
Year 2 Estimated Outcome Amount: $393,120	**Year 3 Estimated Outcome Amount: $398,009**	**Year 4 Estimated Outcome Amount: $597,015**	**Year 5 Estimated Outcome Amount: $1,313,432**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $2,701,576			

Category 3 Project Narrative
Williamson County & Cities Health District 126936702.3.1

Outcome Domain: OD-6 Patient Satisfaction
Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: are getting timely care, appointments, and information
Unique RHP Outcome Identification Number: 126936702.3.1

Title of Category 1 or 2 Project: 126936702.1.1 – 1.1.2 Expanded Capacity for Access to Care
Performing Provider Name: Williamson County & Cities Health District
Performing Provider TPI #: 126936702

Outcome Measure Description:

- OD-6 Patient Satisfaction
  - IT-6.1: Getting timely care, appointments and information

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
  - P-3: Develop and test data systems

Outcome Improvement Targets for each Year:

- DY4:
  - IT-6.1: Increased percentage of patients are reporting they are getting timely care, appointments, and information by 10% above baseline
- DY5:
  - IT-6.1: Increased percentage of patients are reporting they are getting timely care, appointments, and information by 20% above baseline

Rationale:
Process milestones – P-1 through P-3 were chosen is the provision for a standardized survey instrument and data collection methodology for measuring patients' perspectives on care. In order to report accurate data and establish baselines, P-1 through P-3 must be approached in DY2 and DY3. By DY3, the establishment of baseline will be completed.

Satisfaction scores gathered from the patient satisfaction surveys will demonstrate improve utilization rates of clinical preventive services within the target population. Utilizing the CAHPS Consumer Assessment, we will be able to monitor and track experiences with providers and office staff. The scores will also drive the continuous quality improvement (CQI) process to ensure appropriate health related activities are suitable for the patients served and addressing

the issues of receiving health care in a timely fashion. Having the patients complete the satisfaction survey will enable WCCHD to share results with other local providers to make readily available appointment or walk-in schedules meet the need of targeted population.

Improvement target IT-6.1 was chosen for both DY4 and DY5 based on the timeframe in which intervention will occur and expectations met based on Healthy People 2020 objectives. The outcome measure being addressed will produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between healthcare institutions on domains that are important to consumers. Social determinants such as transportation, cultural issues, health literacy competency, and language barrier will affect a patient's show rate of appointments thus resulting in not receiving care in a timely manner.

Outcome Measure Valuation:
The valuation of this outcome measure takes into account the high need of the project, in that it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing preventive health services. It is based upon the premise that the diversion of inappropriate non-emergent care services through urgent and emergent care settings, to increase access points to timely and appropriate level of care, would improve patient care and satisfaction. For any project, there must be a system for development and evaluation of client response. DY2 will be dedicated to planning the project, identifying the current capacity and needed resources, engaging stakeholders, and determining timelines for implementation. This is a necessary step to establish the foundation of the project and protect its integrity. The valuation of this outcome measure takes into account the high value of the project, in that it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing preventive health services. By adding additional same or next day appointments and increasing health care personnel, the project seeks to provide 11,440 encounters in DY4 (2,640 over baseline) and 14,080 encounters in DY5 (5,280 over baseline). A fundamental way to determine whether the project is addressing and meeting the needs of the community is to query those who are directly impacted by the project. The integrity of this project is dependent upon evidence-based methodologies in determining patient satisfaction and improvement over time. A questionnaire must take into account several factors related to the population which is served; for example, the health literacy level and socioeconomic make-up of the clients served by this agency must be considered.

In DY3, establishing a baseline rate of satisfaction will help project planners to determine whether rates are improving at the desired levels throughout the project years. Additionally, it is of great value to test a new measurement tool in determining how increased patient satisfaction will be identified. By DY4, the outcome improvement target is to have at least a 10% increase in patient satisfaction, indicating an improvement and increased percentage of clients that report they are getting timely care, appointments, and information through this agency. In order to attain this goal, efforts must be placed on a system of patient survey delivery and completion in order to have as many clients involved in the process as possible. Finally, by the end of the final project year, DY5, the outcome improvement target is to have at least a 20% increase over baseline, in the same satisfaction domain as the previous year. This

cannot happen unless the resources exist to successfully allow for an increased clinic volume. For example, a clinic cannot increase hours unless there is an increase in available staff to serve clients. As access to preventive health services increases, the community benefit will increase. Increased access to a primary care setting, at a reduced cost to the client, can decrease the amount of uncompensated care dollars that currently plague the urgent and emergent care settings. Increased awareness of the expanded availability of preventive health services will lead to a decrease in delaying primary care, and consequently a decrease in health complications that lead to the need for urgent or emergent care. These considerations further justify the need for this type of project. Since little to no local funding exists for this type of service delivery, the delivery of this program and the outcome of increased patient satisfaction are directly dependent upon funding support from this Waiver.

Williamson County and Cities Health District Category 3 Project - 126936702.3.1 Related Category 1 Project - 126936702.1.1 (Project Area 1.1.2)			
126936702.3.1	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
Williamson County and Cities Health District			**126936702**
Related Category 1 or 2 projects:	**126936702.1.1**		
Starting Point/Baseline:	**8800 patients**		
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 evidence-based patient survey tool **Process Milestone 1 Estimated Incentive Payment: $7,984**	**Process Milestone 2** [P-2]: Establish baseline rates a. Numerator: Number of improvement in targeted patient satisfaction domain b. Denominator: Number of patients who were administered the survey **Data Sources:** Patient survey completion rates and results of surveys **Process Milestone 2 Estimated Incentive Payment: $48,483** **Process Milestone 3** [P-3]: Develop and test data systems **Data Source:** Data system **Process Milestone 3 Estimated Incentive Payment: $48,484**	**Outcome Improvement Target 1** [IT-6.1]: Increased percentage of patients are reporting they are getting timely care, appointments, and information **Improvement Target:** 10% increase, over baseline in percent improvement in targeted patient satisfaction domain based on the number of surveys completed **Data Source:** Patient survey **Outcome Improvement Target 1 Estimated Incentive Payment: $170,484**	**Outcome Improvement Target 2** [IT-6.1]: Increased percentage of patients are reporting they are getting timely care, appointments, and information **Improvement Target:** 20% increase, over baseline, in percent improvement in targeted patient satisfaction domain based on the number of surveys completed **Data Source:** Patient survey **Outcome Improvement Target 2 Estimated Incentive Payment: $316,240**
Year 2 Estimated Outcome Amount: $7,984	**Year 3 Estimated Outcome Amount: $96,967**	**Year 4 Estimated Outcome Amount: $170,484**	**Year 5 Estimated Outcome Amount: $316,240**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $591,675			

Category 3 Project Narrative
Williamson County & Cities Health District 126936702.3.2

Outcome Domain: OD-9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization
Unique RHP Outcome Identification Number: 126936702.3.2

Title of Category 1 or 2 Project: 126936702.1.2 – 1.6.2 Expanding Capacity of Prevention and Education to Rural Areas
Performing Provider Name: Williamson County & Cities Health District
Performing Provider TPI #: 126936702

Outcome Measure Description:

- OD-9 Right Care, Right Setting
  - IT-9.2: ED appropriate utilization

Reduce Emergency Department visits for target populations. Reduction in emergency department visits for target conditions.

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 Emergency Department visits for target conditions in Diabetes, Cardiovascular Disease /Hypertension, and Asthma, by 5% compared to baseline
- DY5:
  - IT-9.2: Reduce Emergency Department visits for target conditions in Diabetes, Cardiovascular Disease /Hypertension, and Asthma, by 10% compared to baseline

Rationale:
Process Milestones-P-1 and P-4 were chosen due to limited reports and resources currently available to measure and monitor timeliness of EMS transports for identified non-emergent services. In order to gather and report accurate data and establish baselines, P-1 and P-4 must be approached in DY2 and DY3. In DY3 Baseline data will be approached for both P-1 and P-4 rates.

Improvement targets were chosen for DY4 and DY5 based on the objectives from Healthy People 2020, timeframe of the intervention and expectations based on a similar project in North Texas. These outcome measures addressed are largely affected by social determinants, limited resources and access to care. For instance, transportation, cultural and behavioral issues, limited supplies and health literacy level will affect the patient's show rate of appointments, management of chronic disease and access to health care.

Project Valuation:
The valuation of this project takes into account the high need of the project, in that it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing preventive health services. This project seeks to increase the number of patient encounters from an initial baseline of 2,000 patients in DY3. Our goal is to increase our baseline by 10% in DY4 or 200 additional patients and 20% in DY5 or 400 additional patients. The process milestones and outcome measures identified above will validate through demonstration of: a) increased medical primary care visits b) care coordination c) decrease emergency department visits for non-emergency situations and d) decrease emergency medical services calls for non-emergent conditions. Current value for serving this population in the ED is increasing tremendously. The need to offer and provide services to underserved areas of the county and to frequent utilizers of the EMS system is a community need based on cost, access and literacy level of the targeted population. The estimated valuation of this project is $8.8 million and with the investment of $3.93 million (in Category 1) brings a cost saving to the healthcare system of $4.87 million. The return of investment on services provided will demonstrate a better quality of life for the population served.

Williamson County and Cities Health District Category 3 Project - 126936702.3.2 Related Category 1 Project – 126936702.1.2 (Project Area 1.6.2)			
126936702.3.2	**IT-9.2**	**ED Appropriate Utilization**	
Williamson County and Cities Health District			**126936702**
Related Category 1 or 2 projects: 1.6.2	**126936702.1.2**		
Starting Point/Baseline:	**To be developed in DY3**		
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 **Metrics:** Documentation of number of meetings **Baseline/Goals:** Produce a implementation plan for identified patient population **Data Source**: Documentation of meeting minutes and implementation plans **Process Milestone 1 Estimated Incentive Payment: $87,840**	**Process Milestone 2** [P-2]: Establish baseline rates **Metrics**: Documentation of baseline data **Baseline/Goals**: Produce baseline data to identify patient population to be targeted **Data Source**: ICare 2.0/emscharts system **Process Milestone 2 Estimated Incentive Payment: $184,114**	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization •Reduce Emergency Department visits for target conditions - Diabetes - Cardiovascular Disease - Hypertension - Asthma **Improvement Target:** 5% compared to baseline **Data Source:** ICare 2.0/emsCharts **Outcome Improvement Target 1 Estimated Incentive Payment: $185,968**	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization •Reduce Emergency Department visits for target conditions - Diabetes - Cardiovascular Disease -Hypertension - Asthma **Improvement Target:** 10% compared to baseline **Data Source:** ICC and emsCharts **Outcome Improvement Target 2 Estimated Incentive Payment: $249,508**
Year 2 Estimated Outcome Amount: $87,840	**Year 3 Estimated Outcome Amount: $184,114**	**Year 4 Estimated Outcome Amount: $185,968**	**Year 5 Estimated Outcome Amount: $249,508**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $707,430			

Category 3 Project Narrative
Williamson County & Cities Health District - 126936702.3.3

Outcome Domain: OD-11 Addressing Health Disparities in Minority Populations
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 Outcome Identification Number: 126936702.3.3

Title of Category 1 or 2 Project: 126936702.1.3 – 1.5.3 Data Collection
Performing Provider Name: Williamson County & Cities Health District
Performing Provider TPI #: 126936702

Outcome Measure Description:

- OD–11 Addressing Health Disparities in Minority Populations
  - 126936702.3.3 - IT-11.2: Improvement in disparate health outcomes for target population, including identification of the disparity gap

Numerator: # in target pop with disparate outcomes:
Denominator: Total eligible in target pop with and without disparate outcomes
Data Source: WCCHD EMR, ICare

Associated Category 3 Measures:

- OD–11: Addressing Health Disparities in Minority Populations
  - 126936702.3.4 - IT-11.3: Improve utilization rates of clinical preventive services in target population with identified disparity
  - 126936702.3.5 - IT-11.4: Improve patient satisfaction and/or quality of life scores in target population with identified disparity

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2: Establish baseline rates
- DY3:
  - P-3: Develop and test data systems
  - P-4: Complete establishing baseline rates

Outcome Improvement Targets for each Year:

- DY4:
  - IT-11.2: Improvement in disparate health outcomes for target population, including identification of the disparity gap, TBD%
- DY5:

- IT-11.2: Improvement in disparate health outcomes for target population, including identification of the disparity gap, TBD%

Rationale:
Improved data collection informs policy and programmatic decision making, and should improve the speed of translating data into action, addressing disparity gaps. Program activities such as promotional campaigns for preventing pertussis, encouraging regular check-ups and establishing a medical home, and making positive lifestyle changes all become more effective when targeted at high risk populations using appropriate language and being reflective of cultural differences. Improving communication and interviewing skills of frontline staff should lead to improved client satisfaction and improve the chance of a client returning to a clinic for preventative care rather than a hospital emergency room. The ongoing collection of valid REAL data is only a piece of a complicated system of care that must work in concert to reduce disparities. Because this project enhances the impact of other projects rather than bring about the changes to disparate outcomes directly, conservative declines of less than 10% were proposed for this project.

Improved data collection informs policy and programmatic decision making. This project supports other WCCHD project that directly impact disparity gaps.

Outcome Measure Valuation:
Advocates for improved health care strive to include and provide support to members of diverse communities. A key component for the success of this effort is the systematic collection of race and ethnicity data. Uniformly tracking race and ethnicity data provides organizations with important tools for determining the success of efforts to be inclusive of diverse communities in their area and reaching diversity goals. The analysis of collected data can help identify areas in need of improvement and can guide the development of targeted strategies to become more inclusive. This project's valuation is based on the apparent lack of awareness of health disparities and the significant costs associated with not addressing these disparities. Eliminating health disparities in minority populations would significantly lower both indirect and direct medical costs. With the shift to a higher percentage of minorities in Williamson County, the cost savings associated with addressing disparities is amplified.

Many organizations do not collect this data out of reluctance to ask people to identify their race/ ethnicity since they may feel that asking this question is intrusive and that it may alienate people. Several studies in the healthcare field have focused on race/ethnicity data collection since it is a key step towards improving quality of care for diverse communities. Unequal Treatment, an Institute of Medicine report, recommends data collection to address disparities of care. Studies also show that, contrary to a common concern, requesting race/ethnicity data does not necessarily deter people from accessing or staying in treatment. Researchers have found that explaining to the public why they are asked about their race and/or ethnicity increases a respondent's comfort in reporting. The Baker et al 2005 study of patient attitudes, 79.9% of participants somewhat or strongly agreed that hospitals and clinics should collect information on race and ethnicity. Hiring qualified staff, incorporating the appropriate and the

development and implementation of an Electronic Health Record will affect the outcome measures of this project.

Williamson County and Cities Health District Category 3 Project - 126936702.3.3 Related Category 1 Project – 126936702.1.3 (Project Area 1.5.3)			
126936702.3.3	**IT-11.2**	**Improvement in disparate health outcomes for target population, including identification of the disparity gap.**	
Williamson County and Cities Health District			**126936702**
Related Category 1 or 2 projects:	**126936702.1.3**		
Starting Point/Baseline:	**To be determined**		
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:** Meeting minutes and sign-in sheets **Process Milestone 1 Estimated Incentive Payment: $826**	**Process Milestone 2** [P-2]: Establish baseline rates **Data Source:** WCCHD EMR, ICare **Process Milestone 2 Estimated Incentive Payment: $3,152** **Process Milestone 3** [P-3]: Develop and test data systems **Data Source:** WCCHD EMR, ICare **Process Milestone 3 Estimated Incentive Payment: $3,152**	**Outcome Improvement Target 1** [IT-11.2]: Improvement in disparate health outcomes for target population, including identification of the disparity gap. a. Numerator: # in target pop with disparate outcomes, b. Denominator: Total eligible in target pop with and without disparate outcomes **Improvement Target 1:** Greater than TBD% decline from baseline **Data Source:** WCCHD EMR, ICare **Outcome Improvement Target 1 Estimated Incentive Payment: $9,456**	**Outcome Improvement Target 2** [IT-11.2]: Improvement in disparate health outcomes for target population, including identification of the disparity gap. a. Numerator: # in target pop with disparate outcomes b. Denominator: Total eligible in target pop with and without disparate outcomes **Improvement Target 2:** Greater than TBD% decline from baseline **Data Source:** WCCHD EMR, ICare **Outcome Improvement Target 2 Estimated Incentive Payment: $11,407**
Year 2 Estimated Outcome Amount: $826	**Year 3 Estimated Outcome Amount: $6,304**	**Year 4 Estimated Outcome Amount: $9,456**	**Year 5 Estimated Outcome Amount: $11,407**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $27,993			

Category 3 Project Narrative
Williamson County & Cities Health District 126936702.3.4

Outcome Domain: OD-11 Addressing Health Disparities in Minority Populations
Title of Outcome Measure (Improvement Target): IT-11.3 Improve utilization rates of clinical preventive services in target population with identified disparity.
Unique RHP outcome identification number(s): 126936702.3.4

Title of Category 1 or 2 Project: 126936702.1.3 – 1.5.3 Implement project to enhance collection, interpretation, and/or use of REAL data
Performing Provider Name: Williamson County & Cities Health District
Performing Provider TPI #: 126936702

Outcome Measure Description:

- OD-11: Addressing Health Disparities in Minority Populations
  - 126936702.3.4 - IT-11.3: Improve utilization rates of clinical preventive services in target population with identified disparity

Vulnerable populations are target, including low-income people, the uninsured, and racial and ethnic minorities
Numerator: Utilization rate by target population
Denominator: All members of target population eligible to receive clinical preventive services

<u>Associated Category 3 Measures:</u>

- OD-11: Addressing Health Disparities in Minority Populations
  - 126936702.3.3 - IT-11.2: Improvement in disparate health outcomes for target population, including identification of the disparity gap.
  - 126936702.3.5 - IT-11.4: Improve patient satisfaction and/or quality of life scores in target population with identified disparity

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 utilization

Outcome Improvement Target(s) for each Year:

- DY4:
  - IT-11.3: Improve utilization rates of clinical preventive services 20% improvement over baseline 59% (8800/14,872)
- DY5:

- IT-11.3: Improve utilization rates of clinical preventive services 25% improvement over baseline 59% (8800/14,872)

Rationale:
Improved data collection informs policy and programmatic decision making, and should improve the speed of translating data into action, raising utilization rates of clinical preventive services. Program activities such as promotional campaigns for preventing pertussis, encouraging regular check-ups and establishing a medical home, and making positive lifestyle changes all become more effective when targeted at high risk populations using appropriate language and being reflective of cultural differences. Improving communication and interviewing skills of frontline staff should lead to improved client satisfaction and improve the chance of a client returning to a clinic for preventative care rather than a hospital emergency room. The ongoing collection of valid REAL data is only a piece of a complicated system of care that must work in concert to utilization rates. Because this project enhances the impact of other projects rather that bring about the changes to utilization rates directly, conservative estimates of improving utilization rates of 25% by DY5 were proposed for this project.

Outcome Measure Valuation:
Advocates for improved health care strive to include and provide support to members of diverse communities. A key component for the success of this effort is the systematic collection of race and ethnicity data. Uniformly tracking race and ethnicity data provides organizations with important tools for determining the success of efforts to be inclusive of diverse communities in their area and reaching diversity goals. The analysis of collected data can help identify areas in need of improvement and can guide the development of targeted strategies to become more inclusive. This project's valuation is based on the apparent lack of awareness of health disparities and the significant costs associated with not addressing these disparities. Eliminating health disparities in minority populations would significantly lower both indirect and direct medical costs. With the shift to a higher percentage of minorities in Williamson County, the cost savings associated with addressing disparities is amplified.

Many organizations do not collect this data out of reluctance to ask people to identify their race/ethnicity since they may feel that asking this question is intrusive and that it may alienate people. Several studies in the healthcare field have focused on race/ethnicity data collection since it is a key step towards improving quality of care for diverse communities. Unequal Treatment, an Institute of Medicine report, recommends data collection to address disparities of care. Studies also show that, contrary to a common concern, requesting race/ethnicity data does not necessarily deter people from accessing or staying in treatment. Researchers have found that explaining to the public why they are asked about their race and/or ethnicity increases a respondent's comfort in reporting. The Baker et al 2005 study of patient attitudes, 79.9% of participants somewhat or strongly agreed that hospitals and clinics should collect information on race and ethnicity. Hiring qualified staff, incorporating the appropriate and the development and implementation of an Electronic Health Record will affect the outcome measures of this project.

Williamson County and Cities Health District Category 3 Project - 126936702.3.4 Related Category 1 Project – 126936702.1.3 (Project Area 1.5.3)			
126936702.3.4	**IT-11.3**	**Improve utilization rates of clinical preventive services in target population with identified disparity.**	
Williamson County and Cities Health District		**126936702**	
Related Category 1 or 2 projects:	**126936702.1.3**		
Starting Point/Baseline:	**59% (8800/14,872)**		
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:** Meeting minutes and sign-in sheets **Process Milestone 1 Estimated Incentive Payment: $826**	**Process Milestone 2**[P-3]: Develop and test data systems **Data Source:** OMS, WCCHD EMR, ICare **Process Milestone 2 Estimated Incentive Payment: $6,304**	**Outcome Improvement Target 1** [IT-11.3]: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure) a. Numerator: # in target pop utilizing clinical preventative services b. Denominator: Total eligible target pop **Improvement Target:** Greater than 20% improvement over baseline **Data Source:** WCCHD EMR, ICare **Outcome Improvement Target 1 Estimated Incentive Payment: $9,456**	**Outcome Improvement Target 2** [IT-11.3]: Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure) a. Numerator: # in target pop utilizing clinical preventative services b. Denominator: Total eligible target pop **Improvement Target:** Greater than 25% improvement over baseline **Data Source:** WCCHD EMR, ICare **Outcome Improvement Target 2 Estimated Incentive Payment: $11,407**
Year 2 Estimated Outcome Amount: $826	**Year 3 Estimated Outcome Amount: $6,304**	**Year 4 Estimated Outcome Amount: $9,456**	**Year 5 Estimated Outcome Amount: $11,407**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $27,993			

Category 3 Project Narrative
Williamson County & Cities Health District 126936702.3.5

Outcome Domain: OD-11 Addressing Health Disparities in Minority Populations
Title of Outcome Measure (Improvement Target): IT-11.4 Improve patient satisfaction and/or quality of life scores in target population with identified disparity
Unique RHP outcome identification number(s): 126936702.3.5

Title of Category 1 or 2 Project: 126936702.1.3 – 1.5.3 Implement project to enhance collection, interpretation, and/or use of REAL data
Performing Provider Name: Williamson County & Cities Health District
Performing Provider TPI #: 126936702

Outcome Measure Description:

- OD-11 Addressing Health Disparities in Minority Populations
  - 126936702.3.5 - IT-11.4: Improve patient satisfaction and/or quality of life scores in target population with identified disparity

Numerator: # of WCCHD minority clients providing overall positive rating of WCCHD services
Denominator: All minority clients

Associated Category 3 Measures:

- OD-11 Addressing Health Disparities in Minority Populations
  - 126936702.3.3 - IT-11.2: Improvement in disparate health outcomes for target population, including identification of the disparity gap
  - 126936702.3.4 - IT-11.3: Improve utilization rates of clinical preventive services in target population with identified disparity

Process Milestones:

- 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

Outcome Improvement Target(s) for each Year:

- DY4:
  - IT-11.4: Improve patient satisfaction and/or quality of life scores in target population with identified disparity by 3% improvement over baseline of 37.7% (3703/9807)

- DY5:
    - IT-11.4: Improve patient satisfaction and/or quality of life scores in target population with identified disparity by 5% improvement over baseline of 37.7% (3703/9807)

Rationale:
Through Data 101 and other customer service training client satisfaction should improve and help front line staff improve their data collection techniques in a sensitive culturally and language appropriate manner. Improved data collection informs policy and programmatic decision making, and should improve the speed of translating data into action. Program activities such as promotional campaigns for preventing pertussis, encouraging regular check-ups and establishing a medical home, and making positive lifestyle changes all have the potential to impact the quality of life for individuals and families in high risk populations. Using appropriate language and being aware of cultural differences communicates respect. Improving communication and interviewing skills of frontline staff should lead to improved client satisfaction and increase the likelihood of a client returning to a clinic for preventative care rather than going to a hospital emergency room. The ongoing collection of valid REAL data is only a piece of a complicated system of care that must work in concert to utilization rates. Because this project enhances the impact of other projects rather that bring about the changes to utilization rates directly, conservative estimates of improving utilization rates of no more than 10% were proposed for this project.

Outcome Measure Valuation:
Advocates for improved health care strive to include and provide support to members of diverse communities. A key component for the success of this effort is the systematic collection of race and ethnicity data. Uniformly tracking race and ethnicity data provides organizations with important tools for determining the success of efforts to be inclusive of diverse communities in their area and reaching diversity goals. The analysis of collected data can help identify areas in need of improvement and can guide the development of targeted strategies to become more inclusive. Eliminating health disparities in minority populations would significantly lower both indirect and direct medical costs. With the shift to a higher percentage of minorities in Williamson County, the cost savings associated with addressing disparities is amplified.

Unequal Treatment, an Institute of Medicine report, recommends data collection to address disparities of care. Studies also show that, contrary to a common concern, requesting race/ethnicity data does not necessarily deter people from accessing or staying in treatment. Researchers have found that explaining to the public why they are asked about their race and/or ethnicity increases a respondent's comfort in reporting. The Baker et al 2005 study of patient attitudes, 79.9% of participants somewhat or strongly agreed that hospitals and clinics should collect information on race and ethnicity. Hiring qualified staff, incorporating the appropriate and the development and implementation of an Electronic Health Record will affect the outcome measures of this project.

Williamson County and Cities Health District Category 3 Project - 126936702.3.5 Related Category 1 Project - 126936702.1.3 (Project Area 1.5.3)			
126936702.3.5	**IT-11.4**	**Improve patient satisfaction and/or quality of life scores in target population with identified disparity.**	
Williamson County and Cities Health District			**126936702**
Related Category 1 or 2 projects:	**126936702.1.3**		
Starting Point/Baseline:	**37.7% (3703/9807)**		
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:** Meeting minutes and evaluations; sign-in sheets **Process Milestone 1 Estimated Incentive Payment: $826**	**Process Milestone 2** [P-4]: Develop and test data systems **Data Source:** WCCHD Patient Satisfaction Database/Survey Records with the additional of REAL data elements and language appropriate tools. **Process Milestone 2 Estimated Incentive Payment: $6,304**	**Outcome Improvement Target 1** [IT-11.4]: Improve patient satisfaction and/or quality of life scores in target population with identified disparity a. Numerator: # of WCCHD minority Clients providing overall positive rating of WCCHD services b. Denominator: All minority clients **Improvement Target:** 3% improvement over baseline **Data Source:** WCCHD EMR **Outcome Improvement Target 1 Estimated Incentive Payment: $9,455**	**Outcome Improvement Target 2** [IT-11.4]: Improve patient satisfaction and/or quality of life scores in target population with identified disparity. a. Numerator: # of WCCHD minority Clients providing overall positive rating of WCCHD services b. Denominator: All minority clients **Improvement Target:** 5% improvement over baseline **Data Source:** WCCHD EMR, OMS **Outcome Improvement Target 2 Estimated Incentive Payment: $11,407**
Year 2 Estimated Outcome Amount: $826	**Year 3 Estimated Outcome Amount: $6,304**	**Year 4 Estimated Outcome Amount: $9,455**	**Year 5 Estimated Outcome Amount: $11,407**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $27,992			

Category 3 Project Narrative
Williamson County and Cities Health District - 126936702.3.6

Outcome Domain: OD-6 Patient Satisfaction
Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: are patients getting timely care, appointments, and information
Unique RHP Outcome Identification Number: 126936702.3.6

Title of Category 1 or 2 Project: 126936702.2.1 – 2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care.
Performing Provider Name: Williamson County & Cities Health District
Performing Provider TPI #: 126936702

Outcome Measure Description:

- OD-6 Patient Satisfaction
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores: getting timely care, appointments and information

This outcome measure is intended to show an improvement over baseline for the following patient satisfaction domain: whether patients are getting timely care, appointments, and information. The numerator for this measure is percent improvement in this targeted patient satisfaction domain. The data source is the patient survey. The denominator is the number of patients who were administered the survey.

This project will target identified populations within our community: those individuals with one or more chronic diseases (i.e. diabetes), women of child-bearing age at higher risk for late entry to prenatal care, and frequent users of the emergency department and/or hospital.

Process Milestone and Metrics:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation
- DY3:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation
  - P-3: Develop and test data systems

Outcome Improvement Targets for each Year:

- DY 4:
  - IT-6.1: Percent improvement over baseline of patient satisfaction survey scores in getting timely care, appointments and information. Approximately 1,040 individuals completing a patient survey will report satisfaction in receiving timely care,

appointments and information which is an improvement rate of 10% from the 10,400 of individuals serviced through the Patient Navigation system.

- DY 5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction survey scores in getting timely care, appointments and information; approximately 2,180 individuals completing a patient survey will report satisfaction in receiving timely care, appointments and information which is an improvement rate of 20% from the 10,900 individuals serviced through the Patient Navigation system.

Rationale:
This project is aimed at helping patients navigate the complex healthcare system by providing patient navigation to high-risk patients, who may have difficulty accessing timely care, appointments and information. Using the patient's own perception of getting timely care, appointments and information will be the most important measure to support, change and improve the patient navigation system, thereby improving health outcomes and decreasing cost.

The rationale/evidence for this measure is the provision of a standardized survey instrument and data collection methodology for measuring patients' perspectives of care. The survey is designed to produce comparable data that allows objective and meaningful comparisons between institutions on domains that are important to consumers.

Process milestones – P-1 and P-3 in DY2 and DY3 will be dedicated to planning the project, identifying the current capacity and needed resources, engaging stakeholders, and determining timelines for implementation. This is a necessary step to establish the foundation of the project and protect its integrity. In DY3, baseline rates for client satisfaction must be established to determine the starting point. Additionally, it is of great value to test a new measurement tool in determining how increased patient satisfaction will be identified.

Improvement measures in DY4 and DY5 will demonstrate that a total of 2,180 individuals completing a patient survey will report satisfaction in receiving timely care, appointments and information which is an improvement rate of 20% from the 10,900 individuals will receive services through the Patient Navigation system. Utilizing the CAHPS Consumer Assessment, we will be able to monitor and track experiences with providers and office staff. In order to attain this goal, efforts must be placed on the system of patient visit survey delivery and completion in order to have as many clients involved in the process as possible.

As access to health care navigation services increases, the community benefit will increase. Increased assistance with self-management of chronic illness (diabetes, for example) can lead to fewer medical visits and a reduction in inappropriate utilization of urgent and emergent care settings, and reduced health complications. Education and services related to assuring early entry into prenatal care and maintaining a healthy pregnancy can impact the rate of late entry

into care and reduce the number of pre-term births. These considerations further justify the need for this type of project.

Outcome Measure Valuation:
The valuation of this outcome measure takes into account the high value of the project, in that it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing health care services. The main way to determine whether the project is addressing and meeting the needs of the community is to query those who are directly impacted by the project. The integrity of this project is dependent upon evidence-based methodologies in determining patient satisfaction and improvement over time. A questionnaire must take into account several factors related to the population which is served; for example, the health literacy level and socioeconomic make-up of the clients served by this agency must be considered. The value estimated for this project is $844,629. This amount covers the cost in recruiting and hiring staff, enhancing current IT hardware in order to sustain upgrades to current systems, and development and implementation of an Electronic Health Record.

Williamson County and Cities Health District Category 3 Project 126936702.3.6 Related Category 2 Project – 126936702.2.1 (Project Area 2.9.1)			
126936702.3.6	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
Williamson County and Cities Health District			**126936702**
Related Category 1 or 2 projects:	**126936702.2.1**		
Starting Point/Baseline:	**8700**		
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 **Baseline/Goals:** By the end of this project year, to research an-evidenced based tool that accurately reflects agency services and impact of patients served through the Patient Navigation system. **Data Source**: Project planning documents, timeline, logic models, and top 2 evidenced based patient satisfaction survey tools **Process Milestone 1 Estimated Incentive Payment: $1,466**	**Process Milestone 2** [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation **Baseline/Goals:** By the end of this project year, to implement an-evidenced based tool that accurately reflects agency services and impact of patients served through the Patient Navigation system. **Data Source**: Project planning documents, timeline, logic models, selected patient satisfaction survey tool **Milestone2 Estimated Incentive Payment: $10,116** **Milestone 3** [P-3]: Develop and test	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information **Improvement Target:** Percent improvement over baseline of patient satisfaction scores: are getting timely care, appointments, and information. Approximately 1,040 individuals completing a patient satisfaction survey will report satisfaction in receiving time care, appointments and information which is an improvement rate of 10% from the 10,400 individuals provided with a patient navigation service. **Data Source:** Results of patient satisfaction surveys. **Outcome Improvement Target 1 Estimated Incentive Payment:**	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information **Improvement Target:** Percent improvement over baseline of patient satisfaction scores: are getting timely care, appointments, and information. Approximately 2,180 individuals completing a patient satisfaction survey will report satisfaction in receiving time care, appointments and information which is an improvement rate of 20% from the 10,900 individuals provided with a patient navigation service. **Data Source:** Results of patient satisfaction surveys. **Outcome Improvement Target 2 Estimated Incentive Payment: $40,464**

	data systems **Baseline/Goals:** To improve the quality of patient satisfaction scores in the domain of receiving care in a timely manner, an evidence based tool will be utilized. **Data Source:** Data system **Process Milestone 3 Estimated Incentive Payment: $10,116**	**$30,348**	
Year 2 Estimated Outcome Amount: $1,466	**Year 3 Estimated Outcome Amount: $20,232**	**Year 4 Estimated Outcome Amount: $30,348**	**Year 5 Estimated Outcome Amount: $40,464**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $92,510			

Category 3 Project Narrative - Pass 2
Williamson County and Cities Health District - 126936702.3.7

Outcome Domain: OD-6 Patient Satisfaction
Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: are getting timely care, appointments, and information
Unique RHP Outcome Identification Number: 126936702.3.7

Title of Category 1 or 2 Project: 126936702.2.2 – 2.6.1 Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population
Performing Provider Name: Williamson County & Cities Health District
Performing Provider TPI #: 126936702

Outcome Measure Description:

- OD-6 Patient Satisfaction
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores: are getting timely care, appointments, and information

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
  - P-3: Develop and test data systems

Outcome Improvement Target for each Year:

- DY4:
  - IT-6.1: Percent improvement over baseline of patient satisfaction survey scores in getting timely care, appointments and information. Approximately 2,100 individuals completing a patient survey will report satisfaction in receiving timely care, appointments and information which is an improvement rate of 5% from the 42,000 reached.

- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction survey scores in getting timely care, appointments and information; approximately 2,700 individuals completing patient a survey will report satisfaction in receiving timely care, appointments and information which is an improvement rate of 5% from the 54,000 reached.

Rationale:
The results gathered from the patient satisfaction surveys will impact the number of individuals' successfully accessing primary care appropriately. The scores will also drive the continuous quality improvement (CQI) process to ensure appropriate health related activities are suitable for the patients reached and addressing the issues of receiving health care in a timely fashion. Having the patients complete the satisfaction survey will enable WCCHD to share results with other local providers to make certain appointment schedules and self-management education meet the need for this population. By measuring improvement in utilization rate of clinical preventive services, we will be able to determine effective intervention and a positive impact on the community. WCCHD does not currently have a mechanism in place to capture such vital information. WCCHD aims to develop health promotion programs and increase access points to health promotion activities. Through these venues, WCCHD expects to disseminate patient satisfaction surveys. This particular domain is centered on patient satisfaction in getting timely care, appointments, and information. This project addresses three components of this domain; education, screening and timely access to health promotion and programs.

There are approximately 213,971 individuals within the targeted populations of chronic illness and women of child bearing age. By reaching over 25% or 54,000 of the targeted population by DY5, satisfaction survey results from at least 5% of the 54,000 (2700) will demonstrate an impact on the quality of health, understanding and satisfaction in receiving care within the healthcare system.

Process milestones – P-1 through P-3 were chosen as the provision for a standardized survey instrument and data collection methodology for measuring patients' perspectives on care. In order to report accurate data and establish baselines, P-1 through P-3 must be approached in DY2 and DY3. By DY3, the establishment of baseline will be completed.

Improvement target IT-6.1 was chosen for both DY4 and DY5 based on the timeframe in which intervention will occur and expectations met based on Healthy People 2020 objectives. The outcome measure being addressed will produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between healthcare institutions on domains that are important to consumers. Social determinants such as transportation, cultural issues, health literacy competency, and language barrier will affect a patient's show rate of appointments thus resulting in not receiving care in a timely manner. The above milestones and targets were also chosen based on the need for implementation of an evidence-based patient survey tool. Once those goals are reached and our related project interventions are implemented, we anticipate that we will be able to achieve an increase in patient satisfaction scores similar to other interventions which have produced similar results. Utilizing the CAHPS Consumer Assessment, we will be able to monitor and track experiences with providers and office staff. By DY4 and DY5, the outcome improvement target is to have an increase in patient satisfaction scores from targeted population completing the patient survey.

Outcome Measure Valuation:
As health disparities are identified, which impact the overall health of the community, the need for targeted health promotion campaigns increases. The goal of this project is to develop a team consisting of community health workers, case managers, health educators, marketing staff and health care professionals to promote preventive health awareness in the community to identified targeted populations, specifically women of child bearing age and individuals diagnosed with a chronic illness. For any project, there must be a system for development and evaluation of client response. DYs 2 and 3 will be dedicated to planning the project, identifying the current capacity and needed resources, engaging stakeholders, and determining timelines for implementation. This is a necessary step to establish the foundation of the project and protect its integrity. The valuation of this outcome measure takes into account the high value of the project, in that it will serve a significant number of residents in the community, specifically those that encounter barriers to accessing health promotion services. The main way to determine whether the project is addressing and meeting the needs of the community is to query those who are directly impacted by the project. The integrity of this project is dependent upon evidence-based methodologies in determining patient satisfaction and improvement over time. A questionnaire must take into account several factors related to the population which is served; for example, the health literacy level and socioeconomic make-up of the clients served by this agency must be considered.

Williamson County and Cities Health District Category 3 Project - 126936702.3.7 Related Category 2 Project – 126936702.2.2 (Project Area 2.6.1 – Pass 2)			
126936702.3.7	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**	
Williamson County and Cities Health District			**126936702**
Related Category 1 or 2 projects:	**126936702.2.2**		
Starting Point/Baseline:	**To be determined in DY3**		
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] (See page 363): Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Needs assessment and evidence-based patient survey tool **Process Milestone 1 Estimated Incentive Payment: $1,574**	**Process Milestone 2** [P- 2] (See page 363): Establish baseline rates **Data Source:** Patient survey completion rates and results of surveys **Process Milestone 2 Estimated Incentive Payment: $14,469** **Process Milestone 3** [P-3] (See page 363): Develop and test data systems **Data sources:** Data system **Process Milestone 3 Estimated Incentive Payment: $14,469**	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores - Increased percentage of patients are reporting they are getting timely care, appointments, and information **Improvement Target:** Percent improvement over baseline of patient satisfaction scores: getting timely care, appointments and information; approximately 2100 individuals completing patient survey will report satisfaction in receiving timely care, appointments and information which is an improvement rate of 5% from the 42,000 reached. **Data Source:** Patient survey **Outcome Improvement Target 1 Estimated Incentive Payment: $44,532**	**Outcome Improvement Target 2 [**IT-6.1]: Percent improvement over baseline of patient satisfaction scores - Increased percentage of patients are reporting they are getting timely care, appointments, and information **Improvement Target:** Percent improvement over baseline of patient satisfaction scores: getting timely care, appointments and information; approximately 2700 individuals completing patient survey will report satisfaction in receiving timely care, appointments and information which is an improvement rate of 5% from the 54,000 reached. **Data Source:** Patient survey **Outcome Improvement Target 2 Estimated Incentive Payment: $105,007**

Year 2 Estimated Outcome Amount: $1,574	**Year 3 Estimated Outcome Amount: $28,938**	**Year 4 Estimated Outcome Amount: $44,532**	**Year 5 Estimated Outcome Amount: $105,007**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $180,051			

Category 4 Population-Focused Improvements - Narratives & Tables

- **Little River Healthcare**
- **Scott & White Hospital – Llano**
- **Scott & White Memorial Hospital**
- **Seton Highland Lakes Hospital**
- **St. David's Round Rock Medical Center**

Category 4 Population-Focused Improvements
Little River Healthcare - 183086102

Performing Provider Name: Little River Healthcare
Performing Provider TPI #: 183086102
Related Category 1 or 2 Project: 183086102.1.1 – Expand Primary Care and 183086102.1.2– Expand Specialty Care
IGT Entity for DYs 1-5: Rockdale Hospital District

Domain 1: Potentially Preventable Admissions (8 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Little River Healthcare (LRH) will be expanding their existing Primary Care Capacity (#183086102.1.1) as well as improving Access to Specialty Care (#183086102.1.2) during the time frame of DYs 2-5. With the increase in primary care physicians, LRH will be able to expand its hours of operation (#183086102.1.1 P-4.1) and improve the access to primary care physicians (PCPs) with appointment times scheduled at the patients' convenience (I-11.3, I-11.1, and I-12.1). Having the ability and convenience of visiting an expanded number of PCPs will result in the admission rate for congestive heart failure, complications from diabetes, hypertension, and chronic obstructive pulmonary disease (COPD) becoming a potentially preventable admission (PPA) because of the potential for early diagnosis and treatment. In addition, due to patients' ability to make an appointment with the expanded base of PCPs, the admissions associated with pediatric asthma, and behavioral health and substance abuse will also become potentially preventable. As the expanded number of PCPs have appointments with patients, the PCP will also be able to consult with the at-risk patients on the benefits of receiving a bacterial pneumonia or influenza immunization. These immunizations will improve the patients' chances of not becoming ill and seeking admittance. Improving access to primary care and specialty care and screening is a key factor of early detection of chronic and potentially debilitating conditions as well as disease states that are a potentially preventable admission if detected and treated in the early stages or for which there is an immunization available.

The communication between primary and specialty care physicians in treating patients for PPAs will be facilitated by LRH's Electronic Hospital Record (EHR) system. This communication between physicians and the patient will result in a better patient experience, early treatment and positive outcomes.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$36,855	$44,651	$50,009	$131,516
IGT Required	$15,225	$18,445	$20,659	$54,329

The associated cost for completing this project include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains associated with our

projects. The costs include personnel that will need to be hired to effect the implementation of our plan and the on-going cost of personnel and technology to monitor and effect improved associated with each Domain. Such ongoing costs include but are not limited to training material, training personnel, training time, implementation material, implementation personnel, technology utilized to monitor outcomes as well as personnel used to monitor outcomes.

System Changes Necessary to Successfully Report Category 4

LRH is implementing a hospital-wide EHR which will be fully integrated within all Hospital systems during DY2. Current reporting mechanisms do not exist within the new EHR system to effectively report on the measures associated with the Category 4 Domains. LRH will be developing custom reporting capabilities so as to accurately and efficiently capture Category 4 measures. Once completed in DY3, LRH will work during all subsequent periods to continually improve performance over baseline as well as refine reporting capabilities.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

LRH will be expanding their existing Primary Care Capacity (#183086102.1.1) as well as improving Access to Specialty Care (#183086102.1.2) during the time frame of DYs 2-5. With the increase in primary care physicians, LRH will be able to expand its hours of operation (#183086102.1.1, P-4.1) and improve the access to PCPs with appointment times scheduled at the patients' convenience (I-11.3, I-11.1, and I-12.1) for follow-up appointments. As a result of the expanded appointment times those patients that are admitted for congestive heart failure, complications as the result of diabetes, stroke, and COPD, and subsequently discharged, will be more likely to seek continued and follow up treatment from the PCPs or a Specialty Care Physician (SCP), and increase their chances of not being readmitted within 30 days of discharge. Also, those individuals with behavioral health and substance abuse, pediatric asthma, as well as all other causes for admission that are subsequently released, will have a better chance at not being re-admitted within 30 days of discharge due to follow up physician visits and treatments. Also, and as detailed in the narrative for expanding existing primary care, (#183086102.1.1) LRH will be developing a house call program to more fully meet the needs of the community and patients with limited or no means of transportation to primary care clinics. The house call program will not only positively affect the care for primary care patients but also directly affect the follow up care of patients discharged from the inpatient and ED of the Hospital. This house call program will also improve patient access to SCPs that can provide treatment and consultation to those with specialty needs both before and after discharge (I-22.1). LRH's improved programs, access to primary care and SPCs, will reduce potentially preventable readmissions of patients within 30 days of discharge.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$36,855	$44,651	$50,009	$131,516
IGT Required	$15,225	$18,445	$20,659	$54,329

The associated cost for completing this project include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains associated with our projects. The costs include personnel that will need to be hired to effect the implementation of our plan and the on-going cost of personnel and technology to monitor and effect improved associated with each Domain. Such ongoing costs include but are not limited to training material, training personnel, training time, implementation material, implementation personnel, technology utilized to monitor outcomes as well as personnel used to monitor outcomes.

System Changes Necessary to Successfully Report Category 4

LRH is implementing a hospital-wide EHR which will be fully integrated within all Hospital systems during DY2. Current reporting mechanisms do not exist within the new EHR system to effectively report on the measures associated with the Category 4 Domains. Little River Healthcare will be developing custom reporting capabilities so as to accurately and efficiently capture Category 4 measures. Once completed in DY3, Little River Healthcare will work during all subsequent periods to continually improve performance over baseline as well as refine reporting capabilities.

Domain 3: Potentially Preventable Complications (64 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

LRH will be expanding their existing Primary Care Capacity (#183086102.1.1) as well as improving Access to Specialty Care (#183086102.1.2) during the time frame of DYs 2-5. With the increase in primary care physicians (P-5) LRH will be able to expand its hours of operation and improve the access to PCPs with appointment times scheduled at the patients' convenience (I-11.3, I-11.1, and I-12.1), for follow-up appointments. Also, and as detailed in the narrative for expanding existing primary care (project #183086102.1.1), LRH will be developing a house call program to more fully meet the needs of the community and patients with limited or no means of transportation to primary care clinics. The house call program will not only positively affect the care for primary care patients but also directly affect the follow up care of patients discharged from the inpatient and emergency department (ED) of the Hospital. This house call program will also improve patient access to specialty care physicians that can provide treatment and consultation to those with specialty needs both before and after discharge. With the increased and more convenient access to physicians, Potentially Preventable Complications (PPCs) such as septicemia, moderate and severe infections, post- operative infections and wound disruptions, and infections due to catheters have a better chance at prevention due to a patient seeking a physician or having a house call visit at the first sign of a PPC. In addition, the Fast Track triaged treatment schedule will enable the PCPs of the ED to see patients with critical care needs more quickly without the delay caused by over utilizing the ED. Thus as a related outcome, the ED will be more appropriately utilized (IT-9.2). Improving access to Specialty Care Providers (SCP's) (#183086102.1.2) will increase the number of cancer screenings (IT-12.1, IT-12.2, and IT-12.3) thus enabling an increase in specialty clinic hours and procedure hours (I-22.1). With the SCP's available, patients will be more likely to make an

appointment for PPCs such as obstetrical hemorrhages, lacerations, and trauma, as well as urinary tract infections. Also, as the result of having available a gastroenterologist for colorectal screening, PPCs such as gastrointestinal complications can be reduced. As more SCP's are made available to the residents of Milam County, cardiac complications, and congestive heart failure complications could also become a PPC. Improving patients' access to primary care and specialty care physicians, through scheduled appointments, triaged ED care, and house call visits will have a positive effect in reducing PPC's.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	NA	$44,651	$50,009	$94,661
IGT Required	NA	$18,445	$20,659	$39,104

The associated cost for completing this project include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains associated with our projects. The costs include personnel that will need to be hired to effect the implementation of our plan and the on-going cost of personnel and technology to monitor and effect improved associated with each Domain. Such ongoing costs include but are not limited to training material, training personnel, training time, implementation material, implementation personnel, technology utilized to monitor outcomes as well as personnel used to monitor outcomes.

System Changes Necessary to Successfully Report Category 4

LRH is implementing a hospital-wide EHR which will be fully integrated within all Hospital systems during DY2. Current reporting mechanisms do not exist within the new EHR system to effectively report on the measures associated with the Category 4 Domains. LRH will be developing custom reporting capabilities so as to accurately and efficiently capture Category 4 measures. Once completed in DY3, LRH will work during all subsequent periods to continually improve performance over baseline as well as refine reporting capabilities.

Domain 4: Patient-Centered Healthcare (2 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

LRH will be expanding their existing Primary Care Capacity (#183086102.1.1) as well as improving Access to Specialty Care (#183086102.1.2) during the time frame of DY 2-5. For those patients that are admitted to the hospital, their care and satisfaction with that care will be very important. Completed patient satisfaction surveys will be requested of all inpatients by DY3 with any necessary improvements documented in DYs 4-5 (I-11.1 and I-11.3, I-27.1). By increasing the PCPs and SCP's in the hospital, the patient should leave with a positive experience and be inclined to schedule any necessary follow up appointments at the patient's convenience. Along with obtaining a positive patient experience, the expanded capacity of PCPs and SPCs will effectively manage and reconcile any prescribed medications at the time of discharge. The patients will be instructed on the medications they are taking and what medications should not be taken. The expanded capacity for appointments for follow up visits

(P-4.1, P-11.1, and I-12.1) will help to enable the continued monitoring of prescribed medications. Also, and as detailed in the narrative for expanding existing primary care (project #183086102.1.1), LRH will be developing a house call program to more fully meet the needs of the community and patients with limited or no means of transportation to primary care clinics. The house call program will not only positively affect the care for primary care patients but also directly affect the follow up care of patients discharged from the inpatient and ED of the Hospital. As the result of a positive healthcare experience centered on the patient, the patient will be more willing and likely to continue a regimen of prescribed treatment and follow up visits or house calls, and have a better possibility of a positive outcome.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$36,855	$44,651	$50,009	$131,516
IGT Required	$15,225	$18,445	$20,659	$54,329

The associated cost for completing this project include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains associated with our projects. The costs include personnel that will need to be hired to effect the implementation of our plan and the on-going cost of personnel and technology to monitor and effect improved associated with each Domain. Such ongoing costs include but are not limited to training material, training personnel, training time, implementation material, implementation personnel, technology utilized to monitor outcomes as well as personnel used to monitor outcomes.

System Changes Necessary to Successfully Report Category 4

LRH is implementing a hospital-wide EHR which will be fully integrated within all Hospital systems during DY2. Current reporting mechanisms do not exist within the new EHR system to effectively report on the measures associated with the Category 4 Domains. LRH will be developing custom reporting capabilities so as to accurately and efficiently capture Category 4 measure. Once completed in DY3, LRH will work during all subsequent periods to continually improve performance over baseline as well as refine reporting capabilities.

Domain 5: Emergency Department (1 measure)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

LRH will be expanding their existing Primary Care Capacity (#183086102.1.1) as well as improving Access to Specialty Care (#183086102.1.2) during the time frame of DYs 2-5. The ED will have a Fast Track tiered triaged treatment program, as detailed in (#183086102.1.1), which will enable the ED to make a decision as to immediate treatment of the patient, transfer of patient to another facility, or treat patient as non-emergent. We anticipate this will allow the physicians to treat patients with critical care needs more quickly without delays associated with over utilization of the ED.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$36,855	$44,651	$50,009	$131,516
IGT Required	$15,225	$18,445	$20,659	$54,329

The associated cost for completing this project include the personnel and external resources we will utilize to establish a plan to measure and report on the 5 Domains associated with our projects. The costs include personnel that will need to be hired to effect the implementation of our plan and the on-going cost of personnel and technology to monitor and effect improved associated with each Domain. Such ongoing costs include but are not limited to training material, training personnel, training time, implementation material, implementation personnel, technology utilized to monitor outcomes as well as personnel used to monitor outcomes.

System Changes Necessary to Successfully Report Category 4

LRH is implementing a hospital-wide EHR which will be fully integrated within all Hospital systems during DY2. Current reporting mechanisms do not exist within the new EHR system to effectively report on the measures associated with the Category 4 Domains. LRH will be developing custom reporting capabilities so as to accurately and efficiently capture Category 4 measure. Once completed in DY3, LRH will work during all subsequent periods to continually improve performance over baseline as well as refine reporting capabilities.

Optional Domain 6: Children and Adult Core Measures (8 measures)

At this time, Little River Healthcare will not report on this optional domain.

Category 4: Population-Focused Measures Little River Healthcare – 183086102				
	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)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$74,250	$36,855		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		(2) April 1 – Sept 30	(2) April 1 – Sept 30	(2) April 1 – Sept 30
Domain 1 - Estimated Maximum Incentive Amount		$36,855	$44,651	$50,009
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		(2) April 1 – Sept 30	(2) April 1 – Sept 30	(2) April 1 – Sept 30
Domain 2 - Estimated Maximum Incentive Amount		$36,855	$44,651	$50,009
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			(2) April 1- Sept 30	(2) April 1 – Sept 30
Domain 3 - Estimated Maximum Incentive Amount			$44,651	$50,009
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		1/1/2013 – 12/31/2013	1/1/2014 – 12/31/2014	1/1/2015 – 12/31/2015
Planned Reporting Period: 1 or 2		(2) April 1 – Sept 30	(2) April 1 – Sept 30	(2) April 1 – Sept 30
Medication Management				
Measurement period for report		1/1/2013 – 12/31/2013	1/1/2014 – 12/31/2014	1/1/2015 – 12/31/2015
Planned Reporting Period: 1 or 2		(2) April 1 – Sept 30	(2) April 1 – Sept 30	(2) April 1 – Sept 30
Domain 4 - Estimated Maximum Incentive Amount		$36,855	$44,651	$50,009
Domain 5: Emergency Department				

Measurement period for report		1/1/2013 – 12/31/2013	1/1/2014 – 12/31/2014	1/1/2015 – 12/31/2015
Planned Reporting Period: 1 or 2		(2) April 1 – Sept 30	(2) April 1 – Sept 30	(2) April 1 – Sept 30
Domain 5 - Estimated Maximum Incentive Amount		$36,855	$44,651	$50,009
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	**$74,250**	**$184,275**	**$223,256**	**$250,047**

Category 4 Population-Focused Improvements
Llano Memorial Hospital (now Scott & White Hospital—Llano) - 020840701

Performing Provider Name: Llano Memorial Hospital (now Scott & White Hospital—Llano)
Performing Provider TPI #: 020840701
Related Category 1 or 2 Project: 020840701.2.1 - Patient Care Navigation and 020840701.2.2 – Sheriff Transport
IGT Entity for DYs 1-5: Llano County

Domain Descriptions:
This Category 2 project may impact Domain 1 and Domain 2 metrics. It is unlikely to impact Domain 3, 4 or 5 because all are related to ED and hospital processes not targeted by this project. Each is described in more detail below:

Domain 1: Potentially Preventable Admissions (8 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Our Category 2 project will use rapid cycle process improvement to reduce avoidable EMS and ED utilization in the target population selected by the QI team (after the initiation of the project). Many outpatient and community-based processes that impact potentially preventable EMS and ED utilization may also impact potentially preventable admissions defined in Domain 1. Given that EMS services and ED services come before hospital admission in the chain of services often utilized in the hospitalization process, it is likely that reductions in utilization of these early services will also reduce admission. The team will choose its tests of change once the project is launched. At that time, they will select processes to impact. The selection of those processes will influence which of these eight Domain 1 measures are most likely to be impacted by the project.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$8,444	$8,390	$8,390	$25,244
IGT Required	$3,488	$3,466	$3,466	$10,420

Domains were valued equally in each Demonstration Year. In each year, Category 4 reporting was valued at the minimum required (i.e., 5% of total project value in DY2, 10% DY3, DY4, DY5) because a) the minimum percentages will provide sufficient resources to gather and report required data, and b) valuing reporting requirements at a minimum leaves the maximum percent of total project value available to run the Category 2 project and meet our Category 3 metrics. The QI team will have access to the data reports to use as they monitor the ongoing impact of their iterative tests of change.

System Changes Necessary to Successfully Report Category 4:
Personnel will be added to our quality reporting team to gather or extract and then report the required Category 4 data. Current data systems at the hospital require relatively more chart extraction than at other hospitals in the Scott & White System. The majority of personnel time will therefore be dedicated to on-site data extraction. Additional personnel time will be spent at the healthcare system level, cleaning, processing and reporting on data.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Rapid cycle process improvement efforts are unlikely to impact Domain 2.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$8,444	$8,390	$8,390	$25,244
IGT Required	$3,488	$3,466	$3,466	$10,420

Valuation was calculated the same was for all domains (see Domain 1).

System Changes Necessary to Successfully Report Category 4:
Necessary system changes are the same for all domains (see Domain 1).

Domain 3: Potentially Preventable Complications (64 measures)
- See Category 4 of the RHP Planning Protocol for all 64 measures

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Our Category 2 project is unlikely to directly impact potentially preventable complications in the hospital setting because the focus will be on preventing EMS and ED utilization rather than changing hospital processes after admission.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	NA	$8,390	$8,390	$16,780
IGT Required	NA	$3,466	$3,466	$6,932

Valuation was calculated the same was for all domains (see Domain 1).

System Changes Necessary to Successfully Report Category 4:
Necessary system changes are the same for all domains (see Domain 1).
Domain 4: Patient-Centered Healthcare (2 measures)
- Patient Satisfaction
- Medication Management

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Domain 4 measured are tied to hospital processes, which will not be changed in this project. Our Category 2 project is therefore unlikely to impact Domain 4.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$8,444	$8,390	$8,390	$25,244
IGT Required	$3,488	$3,466	$3,466	$10,420

Valuation was calculated the same was for all domains (see Domain 1).

System Changes Necessary to Successfully Report Category 4:
Necessary system changes are the same for all domains (see Domain 1).

Domain 5: Emergency Department (1 measure)
- Admit decision time to ED departure time for admitted patients

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Domain 5 is tied to ED processes, which are not likely to be targeted in this project because the focus will be reducing EMS utilization and ED admits. Our Category 2 project is therefore unlikely to impact Domain 5.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$8,444	$8,390	$8,390	$25,244
IGT Required	$3,488	$3,466	$3,466	$10,420

Valuation was calculated the same was for all domains (see Domain 1).

System Changes Necessary to Successfully Report Category 4:
Necessary system changes are the same for all domains (see Domain 1).

Optional Domain 6: Children and Adult Core Measures (8 measures)
At this time, Scott & White Hospital – Llano will not report on this optional domain.

Category 4: Population-Focused Measures Scott & White Hospital--Llano – 020840701				
	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)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$10,630	$8,444		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$8,444	$8,390	$8,390
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$8,444	$8,390	$8,390
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$8,390	$8,390
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		9/1/2012-8/31/2013	9/1/2013-8/31/2014	9/1/2014-8/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		9/1/2012-8/31/2013	9/1/2013-8/31/2014	9/1/2014-8/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$8,444	$8,390	$8,390
Domain 5: Emergency Department				
Measurement period for report		9/1/2012-8/31/2013	9/1/2013-8/31/2014	9/1/2014-8/31/2015
Planned Reporting Period: 1 or 2		2	2	2

Domain 5 - Estimated Maximum Incentive Amount		$8,444	$8,390	$8,390
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	**$10,630**	**$42,220**	**$41,950**	**$41,950**

Category 4 Population-Focused Improvements
Scott & White Memorial Hospital

Performing Provider Name: Scott & White Memorial Hospital
Performing Provider TPI #: 137249208
Related Category 1 or 2 Project: 137249208.2.1 - Patient Navigation
IGT Entity for DYs 1-5: Bell County

Domain 1: Potentially Preventable Admissions (8 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Potentially preventable admissions may be impacted by meeting patient needs before they experience exacerbations requiring hospitalization. It is possible, although not likely, that hospital-level potentially preventable admissions reported for Domain 1 will show a decrease during project years due to the impact of the program, depending on the size of the project population relative to the hospital's overall patient population and the degree to which the targeted population makes up those at highest risk for admission among the full population.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$17,036	$17,036	$17,036	$51,108
IGT Required	$6,849	$6,848	$6,848	$20,545

Total Category 4 value for each year was calculated as the minimum required for Category 4 reporting in order to preserve maximum value for project implementation. Each domain was valued equally in each year, where applicable, to avoid emphasis on reporting one domain over the others requested in Category 4. Because the target population for this patient navigator program is only a subset of the large patient population at the participating provider site and because the navigator program is dedicated to serving a population in the county defined by payor and risk rather than site, we do not necessarily expect large impacts on the domains at the participating provider site. Instead, our goal is to reduce utilization across the sites in the County.

System Changes Necessary to Successfully Report Category 4:
Most processes are in place to gather raw data required for reporting in each domain. Additional personnel will be added to the healthcare system to process those data and prepare/submit reports required for Category 4.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Potentially preventable readmissions (PPRs) may be impacted for patients in the patient navigator program due to improved access of patients to social and health services needed after hospital discharge. It is possible, although not likely, that hospital-level PPRs reported for Domain 1 will show a

decrease during project years due to the impact of the program, depending on the size of the project population relative to the hospital's overall patient population and the degree to which the targeted population makes up those at highest risk for readmission among the full population.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$17,036	$17,036	$17,036	$51,108
IGT Required	$6,849	$6,848	$6,848	$20,545

As described above, the minimum allowable Category 4 value was assigned to preserve value for program implementation. Within each year, value was divided equally among domains to avoid over-emphasis on any one domain set requested.

System Changes Necessary to Successfully Report Category 4:
Most processes are in place to gather raw data required for reporting in each domain. Additional personnel will be added to the healthcare system to process those data and prepare/submit reports required for Category 4.

Domain 3: Potentially Preventable Complications (64 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
This patient navigator program is unlikely to impact potentially preventable inpatient complications because the focus will be in the community/outpatient setting.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	NA	$17,036	$17,036	$34,072
IGT Required	NA	$6,848	$6,848	$13,696

As described above, the minimum allowable Category 4 value was assigned to preserve value for program implementation. Within each year, value was divided equally among domains to avoid over-emphasis on any one domain set requested.

System Changes Necessary to Successfully Report Category 4:
Most processes are in place to gather raw data required for reporting in each domain. Additional personnel will be added to the healthcare system to process those data and prepare/submit reports required for Category 4.

Domain 4: Patient-Centered Healthcare (2 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
This patient navigator program is unlikely to impact inpatient patient-centered healthcare as currently described in HHSC documents because the program focus will be in the community/outpatient setting.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$17,036	$17,036	$17,036	$51,108
IGT Required	$6,849	$6,848	$6,848	$20,545

As described above, the minimum allowable Category 4 value was assigned to preserve value for program implementation. Within each year, value was divided equally among domains to avoid over-emphasis on any one domain set requested.

System Changes Necessary to Successfully Report Category 4:
Most processes are in place to gather raw data required for reporting in each domain. Additional personnel will be added to the healthcare system to process those data and prepare/submit reports required for Category 4.

Domain 5: Emergency Department (1 measure)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
This patient navigator program is unlikely to impact the Emergency Department (ED) domain as currently defined by HHSC because the domain is limited to admit decision time. The program will not change ED processes for necessary admissions.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$17,036	$17,036	$17,036	$51,108
IGT Required	$6,849	$6,848	$6,848	$20,545

As described above, the minimum allowable Category 4 value was assigned to preserve value for program implementation. Within each year, value was divided equally among domains to avoid over-emphasis on any one domain set requested.

System Changes Necessary to Successfully Report Category 4:
Most processes are in place to gather raw data required for reporting in each domain. Additional personnel will be added to the healthcare system to process those data and prepare/submit reports required for Category 4.

Optional Domain 6: Children and Adult Core Measures (8 measures)
At this time, Scott & White Memorial Hospital will not report on this optional domain.

Category 4: Population-Focused Measures Scott & White Memorial – 137249208				
	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)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$42,591	$17,036		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$17,036	$17,036	$17,036
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$17,036	$17,036	$17,036
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$17,036	$17,036
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		9/1/2012-8/31/2013	9/1/2013-8/31/2014	9/1/2014-8/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		9/1/2012-8/31/2013	9/1/2013-8/31/2014	9/1/2014-8/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$17,036	$17,036	$17,036

Category 4: Population-Focused Measures Scott & White Memorial – 137249208				
	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)**
Domain 5: Emergency Department				
Measurement period for report		9/1/2012-8/31/2013	9/1/2013-8/31/2014	9/1/2014-8/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$17,036	$17,036	$17,036
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	**$42,591**	**$85,182**	**$85,180**	**$85,180**

Category 4 Population-Focused Improvements
Seton Highland Lakes Hospital

Performing Provider Name: Seton Highland Lakes Hospital
Performing Provider TPI: 094151004
Related Category 1 or 2 Project: 094151004.2.1 - Patient Care Navigation
IGT Entity for DYs 1-5: Burnet County

Domain 1 - Potentially Preventable Admissions (8 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5
Because IT-2.11 -- Ambulatory Care Sensitive Conditions Admission Rate is the Category 3 Outcome Measure for this project, Potentially Preventable Admissions (PPAs) are expected to be substantially impacted by this project, Patient Navigation (#094151004.2.1), for the population being served. Likewise, Category 2 Improvement Measure I-6.1, which refers enrollees into a primary care setting and empanelment to a medical home is aimed at managing health care in the most appropriate setting and is anticipated to reduce the incidence PPAs of program enrollees. Seton Highland Lakes (SHL) used the primary diagnosis of all of the indigent and charity assistance patients against the Ambulatory Care Sensitive Conditions (ACSC) document listed in the Companion Documents. Nearly 10% (146 of 1,482) of the SHL service area indigent and charity care encounters from September 2011-August 2012 are considered ambulatory sensitive admissions when compared to the data provided by ACSC from the Canadian Institute of Health Information. The ability for this project to have a statistically significant impact on the whole community's rates of PPAs has not been determined; it is likely dependent on the percentage of the community represented by this project and the current level of healthcare utilization for the project's participants.

To the extent that the target population has the chronic conditions specifically called out in this domain (Congestive Heart Failure, Diabetes, Behavioral Health and Substance Abuse, Chronic Obstructive Pulmonary Disease or Asthma in Adults, Hypertension, or Pediatric Asthma), these specific indicators will be more or less impacted. Analysis of the target population's clinical profile in the initial needs assessment will determine the extent to which these conditions apply and will determine if the measures are statistically significant.

The remaining measures in this domain related to Bacterial pneumonia immunization and Influenza Immunization will both be impacted via the one-on-one in-home meetings and navigation services to be provided to these patients. At the same time, the hospital already has systems in place to identify every inpatient's need for these immunizations and to administer them if appropriate.

Valuation/Rationale

	DY3	DY4	DY5	Total DY3-5
Total Value	$27,027	$27,027	$27,027	$81,081
IGT Required	$11,165	$11,165	$11,165	$33,495

The valuation of Category 4 for each Demonstration Year is based on the minimum amounts permitted by the protocol, i.e. 5% in DY3 and 10% in DYs 4 & 5 of the total project value. Provider anticipates this amount will be sufficient to report the data required. Recognizing the shared and related provider data systems expected to be developed and/or utilized for the reporting of these measures; domains were valued equally in each Demonstration Year.

System Changes Necessary to Successfully Report Domain:
Although HHSC will make these data available for Medicaid HMO encounters, the Seton Healthcare Family is developing a network-wide data warehouse and supporting business intelligence reporting tools to be able to calculate and track these measures on a regular basis. A health information exchange is also being deployed to assist caregivers in real time with information about patients' histories.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
The Patient Navigator model that will be utilized by this project (#094151004.2.1) is intended to help guide persons to the most appropriate care setting for their needs. For patients who are admitted to the hospital, this will include assistance with linkage to appropriate outpatient care follow-up, teaching on self-care and disease management, and other supportive services that should help to avoid Potentially Preventable Readmissions (PPRs) for the population being served. Like Domain 1, these Domain 2 measures are also related to the Category 3 Outcome Measure IT-2.11 (Ambulatory Care Sensitive Conditions Admission Rate) and the Category 2 Improvement milestones I-6.1 (referral into a primary care setting and empanelment to a medical home).

To the extent that the target population is hospitalized for the conditions specifically called out in this domain (Congestive Heart Failure, Diabetes, Behavioral Health and Substance Abuse, Chronic Obstructive Pulmonary Disease, Stroke, or Pediatric Asthma), these specific indicators will be more or less impacted. Analysis of the target population's hospitalization experience will determine the extent to which these conditions apply and will determine if the measures are statistically significant.

The All-Cause Readmission Rate will be applicable to all project participants who are hospitalized. However, the ability for this project to have a statistically significant impact on the whole hospital's rate of PPRs has not been determined; it is likely dependent on the percentage of the hospital's discharges represented by the project's participants. Certainly, applicable learnings from the project will be adopted by the hospital as part of ongoing performance improvement initiatives. This could lead to a more substantial impact.

Valuation/Rationale

	DY3	DY4	DY5	Total DY3-5
Total Value	$27,027	$27,027	$27,027	$81,081
IGT Required	$11,165	$11,165	$11,165	$33,495

See Valuation/Rationale under Domain 1.

System Changes Necessary to Successfully Report this Domain:
Although HHSC will make these data available for Medicaid HMO encounters, the Seton Healthcare Family is developing a network-wide data warehouse and supporting business intelligence reporting tools to be able to calculate and track these measures on a regular basis for patients seen in Seton hospitals. For readmissions, in particular, this will make it possible to track patients admitted initially to Seton Highland Lakes and then readmitted to any Seton hospital. A health information exchange is also being deployed to assist caregivers in real time with information about patients' histories.

Domain 3: Potentially Preventable Complications (64 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
Potentially Preventable Complications (PPCs) are not expected to be explicitly impacted via this project (#094151004.2.1). However, there are other quality improvement efforts being conducted by the hospital toward this end.

Valuation/Rationale

	DY3	DY4	DY5	Total DY3-5
Total Value	NA	$27,027	$27,027	$54,054
IGT Required	NA	$11,165	$11,165	$22,330

See Valuation/Rationale under Domain 1.

System Changes Necessary to Successfully Report this Domain:
Although HHSC will make these data available for Medicaid HMO encounters, the Seton Healthcare Family is developing a network-wide data warehouse and supporting business intelligence reporting tools to be able to calculate and track these measures on a regular basis for patients seen in Seton hospitals. A health information exchange is also being deployed to assist caregivers in real time with information about patients' histories.

Domain 4: Patient-Centered Healthcare (2 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
The Patient Navigator model that will be utilized by this project (#094151004.2.1) will provide support for patients while they are in the hospital and when they leave the hospital. Thus,

patients who are admitted to the hospital might be expected to respond favorably to their hospital experience, particularly their care upon leaving the hospital. They will also be well educated regarding their discharge medication lists and instructions. Category 2 Milestone 8 will include reporting of the type of navigation services provided (P-5.1). These services may include education related to medication usage.

These measures will be applicable to all project participants who are hospitalized. However, the ability for this project to have a statistically significant impact on the whole hospital's patient satisfaction and medication reconciliation rate has not been determined; it is likely dependent on the percentage of the hospital's discharges represented by the project's participants. Certainly, applicable learnings from the project will be adopted by the hospital as part of ongoing performance improvement initiatives.

Valuation/Rationale

	DY3	DY4	DY5	Total DY3-5
Total Value	$27,027	$27,027	$27,027	$81,081
IGT Required	$11,165	$11,165	$11,165	$33,495

See Valuation/Rationale under Domain 1.

System Changes Necessary to Successfully Report this Domain:
SHL currently contracts with an outside vendor to conduct patient satisfaction surveys, including the HCAHPS measures. If it is necessary to isolate the surveys of project participants, we will work with our vendor to create this capability. Regarding medication reconciliation, our audit process will be revised to accommodate reporting this measure.

Domain 5: Emergency Department (1 measure)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
ED through-put time is not expected to be explicitly impacted via this project. However, there are other quality improvement efforts being conducted by the hospital toward this end.

Valuation/Rationale

	DY3	DY4	DY5	Total DY3-5
Total Value	$27,027	$27,027	$27,027	$81,081
IGT Required	$11,165	$11,165	$11,165	$33,495

See Valuation/Rationale under Domain 1.

System Changes Necessary to Successfully Report this Domain:
Seton Highland Lakes' electronic medical record has the capacity to capture these data. The appropriate reports will be written to aggregate and report out this metric.

Optional Domain 6: Children and Adult Core Measures (8 measures)
At this time, Seton Highland Lakes Hospital will not report on this optional domain.

Category 4: Population-Focused Measures Seton Highland Lakes Hospital – 094151004				
	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)**
Capability to Report Category 4 (Semi-annual reporting periods 1: (October 1 – March 31) or 2: (April 1 – September 30)	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$67,568	$27,027		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$27,027	$27,027	$27,027
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$27,027	$27,027	$27,027
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$27,027	$27,027
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$27,027	$27,027	$27,027
Domain 5: Emergency Department				
Measurement period for report		4/1/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive		$27,027	$27,027	$27,027

Amount				
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	**$67,568**	**$135,135**	**$135,135**	**$135,135**

Category 4 Population-Focused Improvements
St. David's Round Rock Medical Center - 020957901

Performing Provider Name: St. David's Round Rock Medical Center
Performing Provider TPI #: 020957901
Related Category 1 or 2 Project: 020957901.1.1– Expand Primary Care
IGT Entity for DYs 1-5: Williamson County

Domain 1: Potentially Preventable Admissions (8 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
St. David's Round Rock Medical Center (RRMC) will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions (PPAs), which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. RRMC expects that its provision of expanded primary care services through existing local clinics (#020957901.1.1) will reduce the number of PPAs over the life of the Waiver. More specifically, RRMC hopes that patients with chronic diseases will be better able to engage in self-management goals and activities of daily living with the support, education, and services that primary care providers participating with RRMC in this project can offer to a currently underserved patient population. Specifically, this reporting domain will be affected by RRMC's Category 1 milestones in DYs 4-5, which RRMC expects to result in a 505 person increase in the number of individuals participating in the Community Clinic Services Project over the number of individuals enrolled at the start of DY4. The additional volume of patients with access to primary care is expected to impact the number PPAs of at RRMC because more patients will receive preventative/timely care before their health condition becomes acute and requires hospitalization.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$79,602	$79,602	$79,602	$238,806
IGT Required	$32,000	$32,000	$32,000	$96,000

The value RRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in Williamson County will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Between 2006-2010, there were 12,078 potentially preventable hospitalizations in Williamson County (with total charges of $326,889,520), and 8,832 of those hospitalizations were linked to manageable chronic diseases that RRMC intends to address with its project to expand access to primary care (see Table 3-6 of this Plan).

System Changes Necessary to Successfully Report Category 4

RRMC is in the process of evaluating the necessary changes, updates, and/or improvements to its existing reporting capabilities and systems, if any for this domain, to prepare for the reporting requirements in DYs 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

RRMC will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. RRMC expects that its provision of expanded primary care services through existing local clinics (#020957901.1.1) will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of potentially preventable readmissions (PPR). Additionally, RRMC's Category 3 Outcome Measure (Right care, right setting: emergency department (ED) appropriate utilization) relates to this reporting domain because patients who are readmitted to the hospital often enter through the ED when their chronic condition worsens subsequent to discharge. Expanded access to primary care and support at local clinics should have a positive impact on the rate of readmissions to the hospital through the ED. Specifically, this reporting domain will be affected by RRMC's Category 1 milestones in DYs 4-5, which RRMC expects to result in a 505 person increase in the number of individuals participating in the Community Clinic Services Project over the number of individuals enrolled at the start of DY4. The additional volume of patients with access to primary care after discharge from an inpatient stay is expected to impact the number of PPRs at RRMC because more uninsured patients will receive the provider support and management they need in the community to avoid relapsing into a state requiring re-hospitalization.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$79,602	$79,602	$79,602	$238,806
IGT Required	$32,000	$32,000	$32,000	$96,000

The value RRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs in Williamson County will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Between 2006-2010, Williamson County was charged for 12,078 potentially preventable hospitalizations (at a cost of $326,889,520), with 8,832 of those hospitalizations being linked to manageable chronic diseases that RRMC intends to address with its project to expand access to primary care (see Table 3-6 of this Plan).

System Changes Necessary to Successfully Report Category 4
RRMC is in the process of evaluating the necessary changes, updates, and/or improvements to its existing reporting capabilities and systems, if any for this domain, to prepare for the reporting requirements in DYs 3-5.

Domain 3: Potentially Preventable Complications (64 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
RRMC will report on the 64 measures in this domain in an effort to understand the most prevalent causes of potential preventable complications (PPCs) and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and RRMC is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. RRMC intends for its Category 1 project milestones (#020957901.1.1) in DYs 4-5 (to expand the volume of primary care provided in participating local clinics) to reduce the number of hospital visits at RRMC, which would reduce the strain on RRMC's hospital resources, including staff, space, and equipment. With the reduction in avoidable hospital visits, RRMC can redirect its efforts to making the changes and/or improvements necessary to reduce the number of PPCs during the life of the Waiver.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	NA	$79,602	$79,602	$159,204
IGT Required	NA	$32,000	$32,000	$64,000

The value RRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of PPCs. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

System Changes Necessary to Successfully Report Category 4
RRMC is in the process of evaluating the necessary changes, updates, and/or improvements to its existing reporting capabilities and systems, if any for this domain, to prepare for the reporting requirements in DYs 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)
Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:
RRMC will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well the hospital is serving its patients. How a patient perceives his/her care often affects that patient's willingness to engage in follow-up, self-management, and honest interactions with practitioners. As a consequence of patient dissatisfaction, patients may experience negative health outcomes and become even more disillusioned with the healthcare delivery system. RRMC is committed to preventing this from happening. Additionally, medication management is a primary function that the hospital's providers need to engage in with patients to avoid readmissions,

complications, and to promote improved health outcomes outside of the hospital setting. RRMC expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with RRMC's Category 1 project to expand primary care access (#020957901.1.1) because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management). The milestones in DYs 4-5 should lead to an increase in uninsured patients' access to primary care services upon discharge, which should increase patient satisfaction with the healthcare delivery system. Medication management best practices that patients learn in the hospital will be reinforced by the primary care providers in local clinics; this may improve the rate of medication management during future stays at the hospital, may reduce admissions, and benefit patients.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$398,011	$398,011	$398,011	$1,194,033
IGT Required	$32,000	$32,000	$32,000	$96,000

The value RRMC placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from RRMC and how well RRMC performs its function of promoting medication management. RRMC is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Between 2006-2010, Williamson County was charged for 12,078 potentially preventable hospitalizations (at a cost of $326,889,520), with 8,832 of those hospitalizations being linked to manageable chronic diseases (see Table 3-6 of this Plan). Prevalent chronic disease in Williamson County is costly to patients' health and to the delivery system, and RRMC believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community.

System Changes Necessary to Successfully Report Category 4

RRMC is in the process of evaluating the necessary changes, updates, and/or improvements to its existing reporting capabilities and systems, if any for this domain, to prepare for the reporting requirements in DYs 3-5.

Domain 5: Emergency Department (1 measure)

Relationship to Categories 1-3 and Expected Domain Improvements DYs 2-5:

RRMC will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. RRMC is committed to reducing its ED admission decision time to ED departure if it is not within the recommended less than 1 hour threshold. This reporting domain ties in with RRMC's Category 3 outcome to reduce inappropriate use of the ED; one cause of extended ED departure times results from an overcrowded ED. RRMC intends to expand access to primary care for patients who currently are unable to access primary care due to their financial situation, which RRMC

expects will reduce the number of inappropriate ED visits. Specifically, RRMC expects a measurable reduction in the number of ED visits by diabetes patients in the community under its Category 3 project (the exact amount of which is to be determined in DY3), which will have a beneficial impact on the efficiency of running the ED and effecting quick decision-time to ED departure for emergent patients in the ED.

Valuation and Rationale:

	DY3	DY4	DY5	Total DY3-5
Total Value	$79,603	$79,603	$79,603	$238,809
IGT Required	$32,000	$32,000	$32,000	$96,000

The value RRMC 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 with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress.

System Changes Necessary to Successfully Report Category 4

RRMC is in the process of evaluating the necessary changes, updates, and/or improvements to its existing reporting capabilities and systems, if any for this domain, to prepare for the reporting requirements in DYs 3-5.

Optional Domain 6: Children and Adult Core Measures (8 measures)

At this time, St. David's Round Rock Medical Center will not report on this optional domain.

Category 4: Population-Focused Measures St. David's Round Rock – 020957901				
	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)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$196,560	$79,602		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$79,602	$79,602	$79,602
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$79,602	$79,602	$79,602
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$79,602	$79,602
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		Oct. 1-Sept 30	Oct. 1-Sept. 30	Oct. 1-Sept. 30
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Oct. 1-Sept. 30	Oct. 1-Sept. 30	Oct. 1-Sept. 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$79,602	$79,602	$79,602
Domain 5: Emergency Department				
Measurement period for report		Oct. 1-Sept 30	Oct. 1-Sept. 30	Oct. 1-Sept. 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$79,603	$79,603	$79,603

OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	**$196,560**	**$398,011**	**$398,011**	**$398,011**

Section VI. RHP Participation Certifications

TAMHSC would like to sincerely thank the organizations, stakeholders, and waiver participants in RHP 8 for their time, dedication, and hard work throughout this process. RHP 8 is fortunate to have so many entities that are committed to working collaboratively, improving health delivery systems, and impacting the health of residents in RHP 8.

All RHP Participants outlined in this plan to be providing State match and/or receiving pool payments do, through their signature herein, certify this RHP Plan.

All parties signing below agree that this Regional Healthcare Partnership 8 Plan may be executed and certified via electronic signature and in any number of counterparts, each of which when executed and delivered shall constitute an original of this certification. It is further agreed that all the counterparts shall together constitute the same agreement and serve as a fully certified and signed original of this Regional Health Partnership 8 Plan for submission to the State of Texas Health and Human Services Commission and the United States Centers for Medicare and Medicaid Services.

By my signature below, I certify the following facts:

- 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.

Signature	Name	Organization	Type
	Mr. E.J. "Jere" Pederson *Acting President* *Acting Vice Chancellor for Health Affairs*	TAMHSC (Anchor)	Academic Health Science Center
	Hon. Jon H. Burrows *County Judge*	Bell County	County
	Ms. Bonnie Scurzi *Interim District Director*	Bell County Public Health District	Local Health Department

By my signature below, I certify the following facts:

- 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.

Signature	Name	Organization	Type
	Ms. Andrea Richardson *Executive Director*	Bluebonnet Trails Community Services	Local Mental Health Authority
	Hon. Donna Klaeger *County Judge*	Burnet County	County
	Ms. Ingrid Whipple *CEO*	Cedar Crest Hospital & RTC	Hospital
	Mr. Brad Holland *CEO*	Cedar Park Regional Medical Center	Hospital
	Mr. Dion White *CEO*	Center for Life Resources	Local Mental Health Authority
	Mr. Eldon Tietje *CEO*	Central Counties Services	Local Mental Health Authority
	Mrs. Linda J. Werlein *Executive Director*	Hill Country MHDD	Local Mental Health Authority
	Hon. Wayne L. Boultinghouse *County Judge*	Lampasas County	County
	Mr. Jeff Madison *CEO*	Little River Healthcare	Hospital
	Hon. Wayne A. Brascom *County Judge*	Llano County	County
	Mr. Mike Jenkins *President*	Llano County Hospital Authority	Hospital District
	Mr. Kevin A. Leeper *CEO*	Llano Memorial Hospital/ Scott & White Llano	Hospital

By my signature below, I certify the following facts:

- 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.

Signature	Name	Organization	Type
	Mr. Victor Lawhorn *Vice President/CFO*	Metroplex Health System	Hospital
	Mr. Terry Browning *Finance Committee Chairman*	Rockdale Hospital District	Hospital District
	Mr. Victor Lawhorn *Vice President/CFO*	Rollins Brook Community Hospital	Hospital
	Mr. Shahin Motakef *CEO*	Scott & White Memorial Hospital	Hospital
	Mr. Ernie Bovio *CEO*	Scott & White Hospital - Round Rock	Hospital
	Ms. Michelle Robertson *President, CEO North Operating Group, Seton Family of Hospitals*	Seton Highland Lakes Hospital	Hospital
	Ms. Michelle Robertson *President, CEO North Operating Group, Seton Family of Hospitals*	Seton Medical Center Williamson	Hospital
	Ms. Cindy Sexton *Division Vice President & CFO*	St. David's Round Rock Medical Center	Hospital
	Hon. Cynthia Long *County Commissioner*	Williamson County	County
	Dr. Chip Riggins *Executive Director & Health Authority*	Williamson County and Cities Health District	Local Health Department