Texas Healthcare Transformation and Quality
Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

February 12, 2013

Region 10 RHP

RHP Lead Contact: David Salsberry
1500 S. Main St.
Fort Worth, TX 76104
rhp@jpshealth.org
(817) 927-1611

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Section I. RHP Organization

Section I. RHP Organization

Below is a list of RHP participants in Region 10 by type: Anchor, Intergovernmental Transfer (IGT) Entity, Performing Provider, Uncompensated Care (UC)-only hospital, and other stakeholder.

RHP Participant Type	Texas Provider Identifier	Texas Identification Number	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Anchoring Entity						
Public Hospital	126675104	17560004399150	Non-State Public	JPS Health Network	David Salsberry	1500 S. Main St. Fort Worth, TX 76104 DSalsberry@jpshealth.org (817) 927.1611
IGT Entities						
County	N/A	17560009353011	Non-State Public	Ellis County, Texas	Judge Carol Bush	Ellis County Courthouse 101 W. Main St., Waxahachie, TX 75165 countyjudge@co.ellis.tx.us (972) 825-5011
CMHC	127373205	17512419767000	Non-State Public	Helen Farabee Centers	Roddy Atkins	1000 Brook Wichita Falls, TX 76301 AtkinsR@helenfarabee.org (940) 397-3101
Public Hospital	126675104	17560004399150	Non-State Public	JPS Health Network	David Salsberry	1500 S. Main St. Fort Worth, TX 76104 DSalsberry@jpshealth.org (817) 927.1611
CMHC	121988304	17528338233000	Non-State Public	Lakes Regional MHMR Center	John P. Delany	400 Airport Rd. Terrell, TX 75160 JOHND@LRMHMRC.ORG (972) 524.4159 x1150
CMHC	081599501	17512494562008	Non-State Public	MHMR of Tarrant County	Susan Garnett	3840 Hulen Street, N. Tower Fort Worth, TX 76107 susan.garnett@mhmrtc.org (817) 569-4512
CMHC	130724106	17515321002000	Non-State	Pecan Valley	Donna Gilmore	2101 W. Pearl St., P.O. Box 729

RHP Participant Type	Texas Provider Identifier	Texas Identification Number	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
			Public	Centers for Behavioral and Developmental Healthcare		Granbury, TX 76048 dgilmore@pecanvalley.org (817) 579-4414
County	N/A	17460457280003	Non-State Public	Somervell County, Texas	Judge Mike Ford	107 N.E. Vernon Glen Rose, TX 76043 cojudge@co.somervell.tx.us (254) 897-2322
County	022817305	17560011706006	Non-State Public	Tarrant County Public Health	Doug Fabio Marsha Gillespie	1101 S. Main Street Fort Worth, TX 76196 dfabio@tarrantcounty.com (817) 321-5316 (817) 321-5335
Academic Health Science Center	138980111	37637637630001	Non-State Public	University of North Texas Health Science Center	Jeanie Foster	3500 Camp Bowie Blvd. Fort Worth, TX 76107 Jeanie.foster@unthsc.edu (817) 735-0217
Non-State Public	130606006	17512504501003	Private	Wise Regional Health System	Paul Aslin	2000 South FM 51 Decatur, TX 76234 paslin@wiseRegional.com (940) 626-3863
Public Hospital	121800004	12715721325001	Non-State Public	Glen Rose Medical Center	Kelly Van Zandt	1021 Holden St. Glen Rose, TX 76043-4937 kvanzandt@grmf.org (254) 897-2215
County	N/A	75139762200201	Non-State Public	Hood County Hospital District	Darrell Cockerham	100 E. Pearl St. Granbury, TX 76048 dcockerham@co.hood.tx.us (817) 579-3200
County	N/A	17560010922019	Non-State Public	Navarro County	H.M. Davenport, Jr.	300 West Third Avenue, Suite 102 Corsicana, Texas 75110 hdavenport@navarrocounty.org (903) 654-3025

RHP Participant Type	Texas Provider Identifier	Texas Identification Number	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Performing Providers						
Private Hospital	135036506	17510084308016	Private	Baylor All Saints Medical Center Fort Worth	Fred Savelsbergh	3600 Gaston Ave. Wadley Tower Suite 150 Dallas, TX 75246 fredsa@baylorhealth.edu (214) 820-3724
Private Hospital	021184901	17520516463324	Private	Cook Children's Medical Center	Larry Tubb	801 Seventh Ave. Fort Worth, TX 76104 Larry.Tubb@cookchildrens.org (682) 885-1430
Private Hospital	138910807	17508006289000	Private	Children's Medical Center (Dallas)	Ray Dziesinki	1935 Medical District Drive Dallas, TX 75235 hilda.sallack@childrens.com 214-456-1542
Private Hospital	121822403	16217894027001	Private	Ennis Regional Medical Center	Edwina Miner	2201 West Lampasas Ennis, TX 75119 Edwina.Miner@LPNT.net (469)-256-2155
Public Hospital	216719901	12715721325001	Non-State Public	Glen Rose Medical Center	Kelly Van Zandt	1021 Holden St. Glen Rose, TX 76043-4937 kvanzandt@grmf.org (254) 897-2215
CMHC	127373205	17512419767000	Non-State Public	Helen Farabee Center	Raymond Atkins	1000 Brook Wichita Falls, TX 76301 AtkinsR@helenfarabee.org (940) 397-3143
Private Hospital	020950401	16216822011001	Private	- Medical Center of Arlington	Kathleen Sweeney	6565 N. MacArthur Blvd. Suite #350 Irving, TX 75039 Kathleen.Sweeney@HCAHealthcare.com (972) 401-8757
Private Hospital	094105602	16216822052000	Private	- North Hills Hospital	Kathleen Sweeney	6565 N. MacArthur Blvd. Suite #350

RHP Participant Type	Texas Provider Identifier	Texas Identification Number	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
						Irving, TX 75039 Kathleen.Sweeney@HCAHealthcare.com (972) 401-8757
Private Hospital	094193202	16216822029005	Private	- Plaza Medical Center Fort Worth	Kathleen Sweeney	6565 N. MacArthur Blvd. Suite #350 Irving, TX 75039 Kathleen.Sweeney@HCAHealthcare.com (972) 401-8757
Public Hospital	126675104	17560004399150	Non-State Public	JPS Health Network (JPS)	David Salsberry	1500 S. Main St. Fort Worth, TX 76104 DSalsberry@jpshealth.org (817) 927.1611
Physician Group	162334001	11616766869150	Non-State Public	JPS Physician Group	Tammy Walsh	1500 S. Main St. Fort Worth, TX 76104 TWalsh@jpshealth.org (972) 672-9885
CMHC	121988304	17528338233000	Non-State Public	Lakes Regional MHMR Center	John P. Delaney	400 Airport Rd. Terrell, TX 75160 JOHND@LRMHMRC.ORG (972) 524.4159 x1150
Private Hospital	186221101	17508006610011	Private	Methodist Mansfield Medical Center	Brenda Lockey	1441 N. Beckley Avenue Dallas, TX 75205 Brenda.lockey@mhd.com (214) 947-4578
CMHC	081599501	17512494562008	Non-State Public	MHMR of Tarrant County	Susan Garnett	3840 Hulen Street, N. Tower Fort Worth, TX 76107 Susan.garnett@mhmrtc.org (817) 569-4512
CMHC	130724106	17515321002000	Non-State Public	Pecan Valley Centers for Behavioral and Developmental Healthcare	Donna Gilmore	2101 W. Pearl St., P.O. Box 729 Granbury, TX 76048 dgilmore@pecanvalley.org (817) 579-4414
County Public Health	022817305	17560011706006	Non-State	Tarrant	Doug Fabio	1101 S. Main Street

RHP Participant Type	Texas Provider Identifier	Texas Identification Number	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
			Public	County Public Health	Marsha Gillespie	Fort Worth, TX 76196 dfabio@tarrantcounty.com (817) 321-5316 and (817) 321-5335
Private Hospital	130614405	17509728055003	Private	Texas Health Arlington Memorial Hospital	Kirk King	800 W. Randol Mill Rd. Arlington, TX 76012 kirkking@texashealth.org (817) 960-6539
Private Hospital	109574702	14526946208000	Private	- Huguley Memorial Medical Center	Ken Finch	801 South Freeway Fort Worth, TX 76028 Ken.finch@ahs.org (817) 551-2704
Private Hospital	127304703	17517485862003	Private	Texas Health Harris Methodist Hospital Azle	Bob Elizey	108 Denver Trail Azle, TX 76020 bobelizey@texashealth.org (817) 444-8780
Private Hospital	131036903	17519778504006	Private	Texas Health Harris Methodist Hospital Cleburne	Blake Kretz	201 Walls Dr. Cleburne, TX 76033 blakekretz@texashealth.org (817) 641-2551
Private Hospital	112677302	17560017430011	Private	Texas Health Harris Methodist Hospital Fort Worth	Lillie Biggins	301 Pennsylvania Avenue Fort Worth, TX 76104 Lilliebiggins@texashealth.org (817) 250-2079
Private Hospital	136326908	17514387269011	Private	Texas Health Harris Methodist Hospital Hurst Euless Bedford	Deborah Paganelli	1600 Hospital Pkwy Bedford, TX 76022 deborahpaganelli@texashealth.org (817) 848-4607
Private Hospital	120726804	17526788579002	Private	Texas Health Harris	Brett McClung	6100 Harris Pkwy Fort Worth, TX 76132

RHP Participant Type	Texas Provider Identifier	Texas Identification Number	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
				Methodist Hospital Southwest Fort Worth		Brett McClung@texashealth.org (817) 433-6551
Private Hospital	121794503	17517522532004	Private	Texas Health Harris Methodist Hospital Stephenville	Chris Leu	411 N. Belknap Stephenville, TX 76401 christopherleu@texashealth.org (254) 965-1508
Academic Health Science Center	138980111	37637637630001	Non-State Public	University of North Texas Health Science Center	Geoffrey Scarpelli	3500 Camp Bowie Blvd. Fort Worth, TX 76107 Geoffrey.scarpelli@unthsc.edu (817) 735-5030
Non-State Public	130606006	17512504501003	Private	Wise Regional Health System	Paul Aslin	2000 South FM 51 Decatur, TX 76234 paslin@wiseRegional.com (940) 626-3863
Private Clinic	206106101	12632953654006	Private	Wise Clinical Care Associates	Paul Aslin	2000 South FM 51 Decatur, TX 76234 paslin@wiseRegional.com (940) 627-5921
UC-only Hospitals						
Private Hospital	112701102	16217624283002	Private	Navarro Regional Hospital	Xavier Villarreal	3201 West Highway 22 Corsicana, TX 75110 Xavier.villarreal@navarrohospital.com (903) 654-6805
Private Hospital	197807401	12700163889002	Private	North Texas Community Hospital	Paul Aslin	2000 South FM 51 Decatur, TX 76234 paslin@wiseRegional.com (940) 626-3863
Public Hospital	094178302	17526820174002	Private	Lake Granbury Medical Center	Noe Gutierrez Jr.	1310 Paluxy Rd. Granbury, TX 76048 noe_gutierrez@chs.net 817-579-2953

RHP Participant Type	Texas Provider Identifier	Texas Identification Number	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Private Hospital	127262703	17517771196004	Private	Baylor Regional Medical Center at Grapevine	Fred Savelsbergh	3600 Gaston Ave. Wadley Tower Suite 150 Dallas, TX 75246 fredsa@baylorhealth.edu (214) 820-3724
Private Hospital	135223905	17518441393001	Private	Baylor Medical Center at Waxahachie	Fred Savelsbergh	3600 Gaston Ave. Wadley Tower Suite 150 Dallas, TX 75246 fredsa@baylorhealth.edu (214) 820-3724
Other Stakeholders						
County Medical Associations/Societies				Tarrant County Medical Society	Brian Swift	555 Hemphill St. Fort Worth, TX 76104 bswift@tcms.org (817) 732-2825
Other significant safety net providers within the Region (specify type)						
Free Clinic				HOPE Clinic	Mackie Owens	411 East Jefferson Street Waxahachie, Texas 75165 mackieowens@hopeclinicelliscounty.com (972) 923-2440
Local Behavioral Health Authority				North Texas Behavioral Health Authority	Alex Smith	1201 Richardson, Suite #270 Richardson, TX 75080 alsmith@ntbha.org (214) 366-9407
Behavioral Health Provider				Recovery Resource Council	Ronna Huckabee	2700 Airport Freeway Fort Worth, TX 76111 R.Huckaby@recoverycouncil.org (817) 332-6329
Others (specify type, e.g., advocacy groups, associations)						

RHP Participant Type	Texas Provider Identifier	Texas Identification Number	Ownership Type	Organization Name	Lead Representative	Lead Representative Contact Information
Ambulance Service				MedStar EMS	Matt Zavadsky	551 E. Berry St. Fort Worth, TX 76110 mzavadsky@medstar911.org (817) 927-9620

Section II. Executive Overview of RHP Plan

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The Region 10 Regional Healthcare Partnership (RHP) is the result of a shared commitment by the Region's providers to a community-oriented, Regional health care delivery system focused on the triple aims of improving the experience of care for patients and their families, improving the health of the Region, and reducing the cost of care without compromising quality. Region 10's Delivery System Reform Incentive Program (DSRIP) plan is the essential blueprint for improved individual and population health at a lower cost, delivered more efficiently. Because our plan has been enriched by and reflects the input and work of all Regional stakeholders and providers, we are confident that it will be an effective and meaningful tool for coordinated health care planning and delivering improved Regional health outcomes at lower cost.

Region 10 Vision and Goals for Delivery System Transformation

Our shared vision is a transformed Regional delivery system that actively collaborates across all nine counties to provide integrated and coordinated care. Region 10 RHP will achieve this goal by operating at all times in a manner that is:

- **Transparent:** Decision-making process takes place in the public eye and processes are clear to participants;
- **Collaborative:** Developing the RHP plan and making decisions through a collaborative process that reflects the needs of the Region's communities and input of stakeholders; and
- **Accountable:** Holding all stakeholders to common performance standards, deliverables and timelines.

Our governance approach fosters the health care provider buy-in necessary for lasting delivery system change. By coming together as a Region to improve individual and population health outcomes, Region 10 RHP participating providers have made the first critical steps toward a health care delivery system that is:

- **Patient-Centered:** Improving patient care and experience through a more efficient, patient-centered and coordinated system; and
- **Value-driven:** Increasing the value of care delivered to patients, community, payers and other stakeholders by improving individual and population health.

Region 10 RHP conducted stakeholder surveys, assessed provider readiness, collected and analyzed relevant data about the Region, and engaged in exploratory conversations with a wide range of Regional stakeholders to inform its decision-making activities. The Region 10 RHP synthesized this information into a community health needs assessment shared with all RHP participants and the public through open-access committee meetings, online postings, webinars, and County Visioning sessions. These findings resulted in Region 10 RHP's delivery reform objectives:

- Connect providers across the Region for improved coordination and communication;
- Empower individuals and families to manage and improve their health;
- Provide a robust and comprehensive set of services improving the physical health, behavioral health and general well-being of Region 10 residents at an affordable cost;

- Expand access to primary care and ambulatory care to serve more patients, particularly through medical homes offering ongoing routine care in a timely manner; and,
- Expand access to behavioral health services.

The Region 10 Healthcare Environment

More than two million people (2.4m) lived in Region 10 in 2011. Nearly two-thirds of these individuals (62%) are working-age adults. Of the remainder, 11% are elderly and 28% are children. Regional growth over the Waiver period is projected at nearly 10 % (9.4) to 2.7 million residents regionally. Tarrant County, which includes Fort Worth Metropolitan Statistical Area, serves as the Region's urban center and will see the most significant growth in population on an absolute basis. Region 10 is predominantly White (58%), Hispanic (24%), and African-American (12%) – less diverse than the state overall, but more diverse than the nation. Region 10 also has a slightly more educated population than the state overall, but a less educated population than the national average. An estimated 13% of the Region's residents live at or below the federal poverty level, lower than both the rate for Texas (17%) and for the nation (14%).

While Region 10 has some of Texas' strongest and most highly regarded provider systems, it also has a historically fragmented Regional delivery system with significant gaps in capacity, primary care access, behavioral health services and specialty care access. These health care access problems disproportionately impact the Region's socioeconomically disadvantaged, underserved, uninsured and rural residents. Across the Region, there are 46 acute care hospitals (most are private) and 3,721 physicians (1,512 primary care[i] providers and 2,209 specialty providers). The Region has 6,491 acute care licensed beds and 170 psychiatric care licensed beds. Region 10 also has four community mental health centers (CMHCs) and one federally qualified health center (FQHC).

Provider distribution mirrors overall population density, with the majority of providers located in Tarrant County's major urban center, Fort Worth. The Region's wide geographic footprint (7,221 square miles) combined with unevenly distributed providers and health care resources make the system's endemic access problems even more serious and profound for individuals in outlying rural counties, particularly those who are low-income and uninsured.

Key Health Challenges in Region 10

Region 10 residents face many health challenges, including high rates of one or more chronic conditions and behavioral health issues; gaps in ability to manage communicable diseases; lack of access to healthy foods; lack of patient education on self-managing their health conditions; and lack of ongoing relationships with health care providers. Further, Region 10's population, particularly its low-income, elderly, pediatric, disabled, and rural residents, struggle with major health care access barriers caused by very limited public transportation availability.

Low-income and uninsured residents who lack the financial wherewithal to pay for preventive and routine health care often defer medical care at earlier stages in a disease process and instead present later in the course of the disease with more acute health care needs. These financially driven barriers have also created a shortage of specialists in high-demand specialties, and overuse of emergency departments for routine health care needs more appropriately addressed in

lower cost primary care settings. These inefficiencies can lead to avoidable negative outcomes experienced by individuals and families in the Region. In summary, the Region's residents are sicker and experience many more adverse events that cost more to treat than they would in a more organized delivery system.

Developing Projects for Systems Transformation

Region 10 RHP was developed through an intentional and collaborative process of organizing, learning, assessment and planning inclusive of all participants and the public, including elected officials. The RHP Anchor (Tarrant County Hospital District d/b/a JPS Health Network) worked with all stakeholders to create a governance structure that ensured all perspectives were incorporated into plan development and prioritization decisions. The planning team reached out to performing providers and other knowledgeable stakeholders at every step in the process. Our commitment is demonstrated by our attendance at all Texas Health and Human Services Commission (HHSC) forums including Anchor calls, Executive Waiver Committee meetings, and the Waiver Summit, and ongoing direct participation and engagement with HHSC.

Region 10 RHP shared the community health needs assessment with all Regional performing providers to encourage them to develop projects tailored to address their communities' needs. Additionally, guidance was provided to performing providers in terms of the partnership's collective mission and the transformative overarching goals of DSRIP. Direct and individual technical assistance was provided to each performing provider through office hours, individual and group meetings, and by phone and email, throughout the project planning process. The RHP Anchor has offered all of the Region's performing providers multiple opportunities to submit projects to ensure they had adequate time for revisions after receiving feedback. Dedicated financial expertise has been provided for UC tool completion and DSRIP project valuation. The Anchor has also disseminated all protocols and information from the Texas HHSC (CMS), including timely updates about revised or additional guidance, to all performing providers on a routine and timely basis. Numerous tools – such as valuation principles and methodologies, crosswalks and summary tables – were provided to help providers with project development. Updates were provided frequently to ensure their accuracy.

The Region selected Pass 1 projects through a three-step process: first, holding an initial dialogue between each interested performing provider and their IGT entity; secondly, direct interaction with performing providers and IGT entities to foster and enhance DSRIP project and funding protocol understanding as CMS and HHSC developed program content and requirements; thirdly, holding a final discussion that included a review of each project's adherence to the Anchor Checklist items and helped identify various types of collaborative opportunities for participating providers. The Region welcomed Pass 2 as a second opportunity for both existing and new providers, including Region 10 medical groups not affiliated with the University of North Texas, to develop additional high-impact projects that contribute to our Region's delivery system improvement. The large number of Region 10 participants brought into the RHP has yielded a set of projects that significantly exceeds the required minimum number project threshold for a Tier 2 Region. In summary, this plan is the culmination of a lengthy and inclusive system transformation planning process and represents our Region's firm commitment to significantly improved access to the right services, in the right setting, at the right time and at lower cost for all residents.

Summary of Categories 1-2 Projects

Project Title	Brief Project Description	Related Category 3 Outcome Measure	Estimated Incentive Amount (DSRIP) for DYs 2-5
Category 1: Infrastructure Development			
021184901.1.1 Establish 1 additional Cook Children's pediatric neighborhood clinic in an identified area of need Cook Children's Medical Center 021184901	Expand pediatric primary care by adding 1 additional clinic	021184901.3.1 IT-9.2 Improve ratio of NHC visits to ED visits	$9,858,155
021184901.1.2 Develop 1 additional Cook Children's pediatric urgent care clinic Cook Children's Medical Center 021184901	Establish 1 additional pediatric urgent care which will see increased visits annually	021184901.3.2 IT-9.2 ED appropriate utilization	$8,577,338
021184901.1.3 Increase, expand and enhance oral health services (Establish one new Cook Children's pediatric dental clinic) Cook Children's Medical Center 021184901	Establish pediatric dental clinic which will see increased visits annually	021184901.3.3 IT-7.2 Oral caries	$6,092,739
-022817305.1.1 Region 10 RHP HIE Tarrant County Public Health 022817305	Improve Region 10 participants' communication	-022817305.3.1 IT-5.1 Improve cost savings 022817305.3.2 IT-5.2 Per episode cost of care 022817305.3.3 IT-5.3 Other outcome improvement target	$6,201,850
022817305.1.2- (Pass 2) Expansion of primary care capacity-TB clinic expansion Tarrant County Public	Expansion of TB clinical hours to increase patient access during non-traditional hours	022817305.3.15 IT-5.1 Cost of Care: improved cost	$6,060,164

Health 022817305		savings 022817305.3.18 IT-2.14 Other Admission Rate: Decrease in Tuberculosis hospital admissions with improved LTBI treatment access and case management. 022817305.3.20 IT-12.6 Improved patient treatment access	
081599501.1.1 Increase behavioral health clinic hours MHMR of Tarrant County 081599501	Expand behavioral health services and access	081599501.3.1 IT-9.2 ED appropriate utilization	$18,607,526
081599501.1.2 (Pass 3) Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system MHMR of Tarrant County 081599501	Develop behavioral health crisis stabilization services for patients with Intellectual and Developmental Disabilities, Autism Spectrum Disorder and Mental Health diagnosis (IDD/ASD/MH), or have other co-occurring disorders and/or medical needs	081599501.3.6 IT-6.1 Percent improvement over baseline of patient satisfaction scores 081599501.3.13 IT-9.2 ED Appropriate Utilization 081599501.3.14 IT-2.13 Other Admissions Rate	$15,206,473
121822403.1.1 Expand primary care capacity in Ennis Regional Medical Center primary service area Ennis Regional Medical Center 121822403	Increase access to primary care services	121822403.3.1 IT-9.2 ED appropriate utilization	$888,964
121988304.1.1 Crisis respite – behavioral support wraparound program Lake Regional MHMR Center 121988304	Establish a crisis alternative placement program	121988304.3.1 IT-6.1 Improve patient satisfaction scores	$6,475,705

121988304.1.2 Introduce, expand or enhance telemedicine/telehealth Lakes Regional MHMR Center 121988304	Expand access to behavioral health services	121988304.3.2 IT-6.1 Improve patient satisfaction scores	$1,782,072
121988304.1.3 (Pass 2) Depression/trauma counseling centers Lakes Regional MHMR Center 121988304	Develop and establish a behavioral health Depression/Trauma Clinic for individual with mental health needs.	121988304.3.3 IT-10.1 Quality of Life	$2,768,494
126675104.1.1 Behavioral health expanding hours JPS Hospital 126675104	Increase patient visits and hours of operation, establish urgent outpatient consult service	126675104.3.1 IT-1.18 Follow-up after hospitalization 126675104.3.2 IT-9.2 ED appropriate utilization	$6,459,097
126675104.1.2 Call center JPS Hospital 126675104	Decrease utilization of ED for preventable ambulatory care conditions	126675104.3.3 IT-3.1 All-cause 30-day readmission rate 126675104.3.4 IT-9.2 ED appropriate utilizations	$24,590,515
126675104.1.3 Expanded specialty care JPS Hospital 126675104	Incorporate ophthalmologist into primary care	126675104.3.5 IT-1.12 Diabetes care 126675104.3.6 IT-5.3 Reduce cost of care for inpatients with primary or secondary diagnosis of pressure ulcer 126675104.3.51 IT-1.1 3rd next available appointment	$11,354,152
126675104.1.4 PHP JPS Hospital 126675104	Operate 4 partial hospitalization programs and/or intensive outpatient programs	126675104.3.7 IT-1.18 Follow up after hospitalization for mental illness 126675104.3.8	$12,492,408

		IT-3.8 Behavioral health/substance abuse 30-day readmission rate 126675104.3.9 IT-9.2 Reduce ED visits	
126675104.1.5 (Pass 2) Innovation and Transformation Center JPS Hospital 126675104	Establish a System Transformation Center to be the central authority for organizing, evaluating and documenting change efforts.	126675104.3.36 IT-4.2 Central line-associated bloodstream infections 126675104.3.37 IT-4.3 Catheter-associated urinary tract infections 126675104.3.38 IT-4.4 Surgical site infections 126675104.3.39 IT-4.5 Patient fall rate 126675104.3.40 IT-4.6 Hospital acquired deep vein thrombosis	$16,322,709
127304703.1.1 Walk-in Care Center Texas Health Harris Methodist Hospital Azle 127304703	Create walk-in primary care/non-emergency care clinic	127304703.3.1 IT-9.2 ED appropriate usage	$371,360
127373205.1.1 Substance abuse expansion Helen Farabee Centers 127373205	Establish substance abuse division	127373205.3.1 IT-10.1 Improve quality of life	$1,323,234
127373205.1.2 Improve access to specialty care Helen Farabee Centers 127373205	Increase number of daily psychiatric evaluations	127373205.3.2 IT-10.1 Improve quality of life	$265,003
130606006.1.2 (Pass 3b) Expand pediatric primary care (WRHS DC Collaboration Project) Wise Regional Health System 130606006	Expand the capacity of pediatric primary care in Wise County through a collaboration between Wise Regional Health System and Children's Medical Center in Dallas	130606006.3.7 IT-9.2 ED appropriate utilization 130606006.3.8 IT-1.1 Third next available	$12,551,370

		appointment	
130724106.1.1 Expand specialty care capacity Pecan Valley Centers 130724106	Provide increased psychiatric services to individuals requesting routine behavioral services	130724106.3.1 IT-9.2 ED appropriate utilization	$11,330,564
130724106.1.2 (Pass 2) Extending services beyond normal business hours Pecan Valley Centers 130724106	Increase access for behavioral health patients by remain open pass normal business hours	130724106.3.3 IT-6.1 Percent improvement over baseline for patient satisfaction	$4,807,273
131036903.1.1 Johnson County Hope Clinic and APRN Urgent Care Clinic Texas Health Harris Methodist Hospital Cleburne 131036903	Increase HOPE clinic resources, improve access to care for patients, and augment access for under insured	131036903.3.1 IT-9.2 ED appropriate utilization	$874,050
135036506.1.1 Expand existing primary care capacity Baylor All Saints Medical Center Fort Worth 135036506	Open PCMH/primary care services to new patients	135036506.3.1 IT-1.7 BP control 135036506.3.2 IT-6.1 Improve patient satisfaction: wait times 135036506.3.3 IT-6.1 Improve patient satisfaction: phone response 135036506.3.4 IT-12.1 Breast cancer screening 135036506.3.5 IT-12.5 Influenza vaccination	$2,815,668
135036506.1.2 Improve access to specialty care Baylor All Saints Medical Center Fort Worth 135036506	Expand specialty care services and referrals to increase access to specialty care and procedures/ diagnostics	135036506.3.6 IT-11.1 Asthma Management in Underserved Population 135036506.3.7 IT-12.2 Cervical cancer screenings 135036506.3.8 IT-12.3 Colorectal cancer screening	$2,310,294
138910807.1.1 (Pass 2)	Expand capacity by	138910807.3.1	$1,057,500

Expand pediatric primary care Children's Medical Center of Dallas 138910807	increase clinic hour and number of staffs	IT-9.2 ED appropriate utilization	
138910807.1.2 (Pass 2) Implement and Utilize Pediatric-Specific Disease management System Functionality Children's Medical Center of Dallas 138910807	Expand Children's medical Center certified disease management programs at primary care and school-based settings	138910807.3.2 IT-9.3 Pediatric and young adult asthma emergency visits	$2,115,000
138910807.1.3 (Pass 2) Enhance community-based settings where behavioral health services may be delivered in underserved areas Children's Medical Center of Dallas 138910807	Expand pediatric behavioral health capacity in the Children's primary care setting	138910807.3.3 IT-1.18 Follow up after hospitalization for mental illness	$1,057,500
138980111.1.1 Telemedicine for children recovering from severe burns University of North Texas Health Science Center (UNTHSC) 138980111	Provide telemedicine services for children	138980111.3.1 IT-1.1 Decrease third next available appointment 138980111.3.2 IT-6.1 Patient satisfaction 138980111.3.3 IT-9.2 ED appropriate utilization 138980111.3.4 IT-10.1 Improve quality of life	$1,093,219
138980111.1.2 Community-based primary care for the elderly University of North Texas Health Science Center (UNTHSC) 138980111	Increase primary care services to Medicaid-eligible elders and reduce readmission rates	138980111.3.-40 IT-2.1-2 Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions 138980111.3.6 IT-3.1 Reduce all-cause 30-day readmission rates	$19,992,974

		138980111.3.7 IT-6.1 Patient satisfaction 138980111.3.8 IT-10.1 Improve quality of life	
138980111.1.3 Expand existing primary care capacity (Expanding geriatric primary care and consultative services to Medicaid-eligible elders) University of North Texas Health Science Center (UNTHSC) 138980111	Increase access to geriatric primary care	138980111.3.-41 IT-2.1-2 Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions 138980111.3.11 IT-6.1 Improve patient satisfaction 138980111.3.10 IT-3.1 Reduce all-cause 30-day readmission rate 138980111.3.12 IT-12.4 Pneumonia vaccinations	$6,381,163
138980111.1.4 Training primary care workforce in evolving Health care delivery models) University of North Texas Health Science Center (UNTHSC) 138980111	Improve pneumococcal and pneumonia vaccinations, reduce ED visits	138980111.3.13 IT-9.2 ED appropriate utilization -138980111.3.42 - IT-11.3 -Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. 138980111.3.15 IT-12.4 Pneumonia vaccinations	$6,051,102
138980111.1.5 Community health worker network University of North Texas Health Science Center (UNTHSC) 138980111	Expand primary care training	138980111.3.16 IT-6.1 Increase patient satisfaction 138980111.3.17 IT-10.1 Improve quality of life	$19,813,826
138980111.1.6 (Pass 2)	Create a mobile mental	138980111.3.33	$19,999,997

Community-based behavioral healthcare for depressed Medicaid elders and near elders University of North Texas Health Science Center (UNTHSC) 138980111	health team to provide behavioral health services for depression to Medicaid eligible elders and near elders	IT-10.1 Quality of Life 138980111.3.34 IT-6.1 Percent improvement over baseline of patient satisfaction score (4) patient's involvement in shared decision making 138980111.3.43 IT-1.8 Depression management: screening and treatment plan clinical depression 138980111.3.44 IT-1.9 Depression management remission at 12 months	
138980111.1.7 (Pass 2) Expansion of Plaza/UNTHSC/TCOM Family Medicine Residency program University of North Texas Health Science Center (UNTHSC) 138980111	Increase primary care providers through expanding the 4-4-4 Plaza Hospital/UNTHSC Family Medicine Residency Program to a 6-6-6 program	138980111.3.35 IT-14.6 Percent of trainees who have spent at least 5 years living in a health-professional shortage area or medically underserved area 138980111.3.36 IT-14.7 Percent of trainees who report that they plan to practice in HPSAS or MUAS based on a systematic survey 138980111.3.37 IT-14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey	$11,830,226
138980111.1.8 (Pass 3) Managing chronically ill Medicaid patients using interventional telehealth University of North Texas Health Science Center (UNTHSC) 138980111	Use telehealth monitoring system to manage chronically ill adult patients discharged from hospitals in RHP 10	138980111.3.38 IT-10.1 Quality of Life 138980111.3.39 IT-10.2 Activities of daily living	$20,000,000

162334001.1.1 (Pass 2) Expand pain management care services JPS Health Network Physician Group 162334001	Increase access to specialized pain management	162334001.3.1 IT-2.13 Other admission rate – primary diagnosis code of pain 162334001.3.2 IT-4.10 Other outcome improvement target – Reduce ALOS for Oncology inpatient 162334001.3.3 IT-9.2 ED appropriate utilization	$14,664,582
216719901.1.1 Expand primary care capacity Glen Rose Medical Center 216719901	Reduce readmissions to GRMC by increasing physician office visits	216719901.3.1 IT-3.1 Reduce all-cause 30-day readmission	$402,243
Category 2: Program Innovation and Redesign			
020950401.2.1 Redesign to improve patient experience Medical Center of Arlington 020950401	Rise in percentile on CMA HCAPS grand composite scores	020950401.3.1 IT-6.1 Improve patient satisfaction	$1,824,718
020950401.2.2 Apply process improvement methodology to improve quality/efficiency Medical Center of Arlington 020950401	Increase compliance in identification/diagnosing and application of sepsis bundles	020950401.3.2 IT-4.8 Reduce sepsis mortality 020950401.3.3 IT-4.9 Decrease average length of stay	$3,671,468
020950401.2.3 Implement/expand care transition programs Medical Center of Arlington 020950401	Register patients identified as high risk for readmission in registry	020950401.3.4 IT-3.2 Reduction in CHF readmissions	$841,652
022817305.2.1 Implement innovative evidence-based strategies to reduce low birth weight and preterm birth (FIMR) Tarrant County Public Health 022817305	Reduce low birth weight in target population by implementing 3 key recommendations in hospitals in Tarrant County	022817305.3.19 -IT-8.4 Preterm births	$13,173,706
022817305.2.2	Reduce STD rates in		$5,015,792

PRIDE Program Tarrant County Public Health 022817305	Arlington and Tarrant county	022817305.3.5 IT-11.1 Improvement in clinical indicator	
022817305.2.3 STD/HIV testing and disease intervention Tarrant County Public Health 022817305	Measurable reduction in STD infection rates	022817305.3.6 IT-11.1 Improvement in clinical indicators – Gonorrhea and Chlamydia 022817305.3.7 IT-11.1 Improvement in clinical indicators – Minority Syphilis	$2,903,343
022817305.2.4 Tarrant County chronic disease self-management program (CDSMP) Tarrant County Public Health 022817305	Provide Tarrant county citizens with CHW benefits and CDSMP	022817305.3.8 IT-2.3 Reduce hypertension admissions	$2,597,849,
022817305.2.5 TB medication Tarrant County Public Health 022817305	Decrease number of individuals who refuse treatment or are 'lost'	-022817305.3.9 IT-12.6 LTBI treatment completion increase 022817305.3.17 IT-2.14 Other Admissions Rate	$1,149,150
022817305.2.8 (Pass 3) Tobacco Cessation Tarrant County Public Health 022817305	Educate and facilitate Tarrant County residents to utilize tobacco cessation treatment program	022817305.3.16 IT-10.1 Quality of Life	$19,999,998
081599501.2.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting MHMR of Tarrant County 081599501	Increase clients at detoxification unit	081599501.3.2 IT-6.1 Increase patient satisfaction 081599501.3.12 IT-9.2 ED Appropriate Utilization	$12,065,652
081599501.2.2 Integrate primary and behavioral health care services MHMR of Tarrant County	Establish primary care capacities, and treatment plan with primary care and behavioral health	081599501.3.3 IT-1.7 Controlling high blood pressure	$20,000,000

081599501		081599501.3.7 IT-1.10 Diabetes Care; HbA1c poor control (>9.0%) – NQF 0059 081599501.3.8 IT-9.2 ED Appropriate Utilization – All ED Visits	
081599501.2.3 RN care management MHMR of Tarrant County 081599501	Increase referrals and access to primary care, reduce ED use	081599501.3.4 IT-10.1 Improve quality of life 081599501.3.15 IT-9.2 ED Appropriate Utilization 081599501.3.16 IT-2.13 Other Admissions Rate	$19,224,968
081599501.2.4 (Pass 2) Substance Use Disorder (SUD) outpatient integration MHMR of Tarrant County 081599501	Expand existing MHMRTC SUD outpatient program to 11 mental health sites in the MHMRTC network.	-081599501.3.9 IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. 081599501.3.10 IT-9.2 ED appropriate utilization addiction severity 081599501.3.11 IT-10.7 Functional status assessment for	$17,154,265
094105602.2.1 Apply process improvement methodology to improve quality/efficiency North Hills Hospital 094105602	Increase compliance in identification/diagnosis of patients with sepsis, increase compliance with sepsis bundles application	094105602.3.1 IT-4.8 Sepsis mortality 094105602.3.2 IT-4.9 Average length of stay	$1,458,139
094193202.2.1 Redesign to improve patient experience Plaza Medical Center Fort Worth	Increase percentile on CMA HCAPS grand composite scores	094193202.3.1 IT-6.1 Patient satisfaction	$3,836,901

094193202			
094193202.2.2 Apply process improvement methodology to improve quality/efficiency Plaza Medical Center Fort Worth 094193202	Increase compliance in identification/diagnosis of sepsis, increase compliance with sepsis bundles application	094193202.3.2 IT-4.8 Sepsis mortality IT-4.9 094193202.3.3 Average length of stay	$1,536,513
109574702.2.1 CHF project THR – Huguley Memorial Medical Center 109574702	Improve health of patients with CHF	109574702.3.1 IT-3.2 CHF 30-day readmission	$290,112
109574702.2.2 Apply process improvement methodology to improve quality/efficiency – sepsis THR – Huguley Memorial Medical Center 109574702	Reduce the number of sepsis-related deaths	109574702.3.2 IT-4.8 Sepsis mortality 109574702.3.3 IT-4.9 Average length of stay	$666,988
112677302.2.1 Redesign the outpatient delivery system to coordinate care for patients with diabetes Texas Health Harris Methodist Hospital Fort Worth 112677302	Partner with primary care clinicians to improve outpatient diabetes education	112677302.3.4 IT-1.10 Reduction from baseline 112677302.3.5 IT-3.3 Reduction from baseline	$971,228
112677302.2.2 Heart failure clinic Texas Health Harris Methodist Hospital Fort Worth 112677302	Prevention of potentially avoidable heart failure readmissions	112677302.3.6 IT-2.1 Decrease HF admission 112677302.3.7 IT 3.2 CHF 30 days readmission rate	$1,415,617
112677302.2.3 Establish/expand a patient care navigation program Texas Health Harris Methodist Hospital Fort Worth 112677302	Assign nurse case managers to lead process to reduce inappropriate ED utilization	112677302.3.8 IT-9.2 Improvement from baseline	$7,660,302
112677302.2.4 Sepsis Texas Health Harris Methodist Hospital Fort Worth 112677302	Implementation of sepsis resuscitation bundle	112677302.3.9 IT-4.8 Decrease sepsis mortality rate 112677302.3.10	$6,803,213

		IT-4.9 Decrease average length of stay	
112677302.2.5 Wellness for life mobile health services Texas Health Harris Methodist Hospital Fort Worth 112677302	Create a mobile health service	112677302.3.11 IT-12.1 Breast cancer screening 112677302.3.12 IT-12.2 Cervical cancer screening 112677302.3.13 IT-12.3 Fecal oral blood test	$3,970,344
120726804.2.1 Redesign the outpatient delivery system to coordinate care for patients with diabetes Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804	Partner with primary care clinicians to improve outpatient diabetes patient education	120726804.3.1 IT-1.10 Diabetes care 120726804.3.2 IT-3.3 Reduction from baseline	$107,392
120726804.2.2 Sepsis Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804	Implementation of sepsis resuscitation bundles	120726804.3.3 IT-4.8 Sepsis mortality 120726804.3.4 IT-4.9 Average length of stay	$1,189,472
120726804.2.3 Identify frequent ED utilizers and use navigators as part of a preventable ED reduction program Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804	Develop and expansion of ED liaison collaboration	120726804.3.5 IT-9.2 ED appropriate utilization	$1,468,048
120726804.2.4 NTSP extensivist clinic Texas Health Harris Methodist Hospital Southwest Fort Worth 120726804	Apply the extensivist chronic care model to patients with chronic conditions (CHF, MI)	120726804.3.6 IT-2.1 Reduction in CHF readmissions 120726804.3.7 IT-3.2 Reductions in CHF readmissions 120726804.3.8 IT-3.5 Acute Myocardial Infarction	$2,833,053

		(AIM) 30 day readmission rate	
121794503.2.1 Redesign the outpatient delivery system to coordinate care for patients with diabetes Texas Health Harris Methodist Hospital Stephenville 121794503	Partner with primary care clinicians to improve outpatient diabetes education	121794503.3.1 IT-1.10 Diabetes care 121794503.3.2 IT-3.3 Diabetes 30-day readmission	$83,381
126675104.2.1 Diabetes JPS Hospital 126675104	Establish chronic care model for patients with diabetes	126675104.3.10 IT-1.10 Diabetes care 126675104.3.11 IT-1.11 Diabetes care 126675104.3.12 IT.1.13 Diabetes care	$28,479,904
126675104.2.2 PCMH JPS Hospital 126675104	Decrease avoidable ED admissions by implementing a patient-centered medical home in JPS' primary care sites	126675104.3.13 IT-2.12 Reduce ACSC admissions 126675104.3.14 IT-12.1 Increase compliance 126675104.3.15 IT-12.2 Cervical cancer screening	$31,974,525
126675104.2.3 Homeless Connect JPS Hospital	Station multidisciplinary team on the street to provide care to homeless populations to reduce admissions and improve chronic care conditions	126675104.3.16 IT-1.10 Diabetes care 126675104.3.17 IT-1.18 Increase access to follow-up after hospitalization 126675104.3.18 IT-9.2 ED appropriate utilization	$2,374,283
126675104.2.4 CHF Program JPS Hospital 126675104	Establish dedicated CHF clinic	126675104.3.19 IT-3.2 Reduce CHF 30-day readmissions	$1,072,454

		126675104.3.20 IT-6.1 Patient satisfaction scores	
126675104.2.5 Care transitions JPS Hospital 126675104	Develop standardized clinical protocols to improve care following inpatient/ED visits by connecting patients with access to key resources	126675104.3.21 IT-3.1 All-cause 30-day readmission rate 126675104.3.22 IT-9.2 ED utilization	$8,415,894
126675104.2.6 Integrated behavioral health care JPS Hospital 126675104	Embed 5 behavioral health care managers	126675104.3.23 IT-1.8 Depression management screening 126675104.3.24 IT-1.10 Diabetes care 126675104.3.25 IT-1.11 Diabetes care	$15,451,704
126675104.2.7 Discharge management JPS Hospital 126675104	Implement discharge management program	126675104.3.26 IT-3.8 Behavioral health/substance abuse readmission 126675104.3.27 IT-9.1 Decrease mental health admissions criminal justice 126675104.3.28 IT-9.2 ED appropriate utilization	$10,592,107
126675104.2.8 MedStar patient navigation JPS Hospital 126675104	Expand 911 Nurse Triage program and MedStar CHF program	126675104.3.29 IT-3.2 Reduction CHF readmission -126675104.3.52 IT-2.11 Ambulatory care sensitive conditions admission rate	$4,814,232
126675104.2.9 Virtual psychiatric JPS Hospital 126675104	Increase adherence to guidelines for specific behavioral health conditions	126675104.3.31 IT-1.8 Depression management 126675104.3.X IT-1.9 Depression management	$27,703,074
126675104.2.10 Community Connect	Provide care to underserved population	126675104.3.32 IT-1.10	$4,017,533

JPS Hospital 126675104		Diabetes care 126675104.3.33 IT-9.2 ED appropriate utilization	
126675104.2.11 Patient experience: JPS Cares JPS Hospital 126675104	Establish a patient experience team to improve patient satisfaction scores	126675104.3.34 IT-6.1 Patient satisfaction	$8,436,908
126675104.2.12 Sepsis JPS Hospital 126675104	Increase compliance with application of sepsis bundles	126675104.3.35 IT-4.9 ICU length of stay 126675104.3.53 IT-4.8 Sepsis Resuscitation and Management: Reduce Mortality	$31,974,525
126675104.2.13 (Pass 2) Palliative Program JPS Hospital 126675104	Implement a comprehensive palliative care consultation program for patients with serious or life-threatening illnesses.	126675104.3.41 IT-13.1 Pain assessment 126675104.3.42 IT-13.2 Treatment preferences 126675104.3.43 IT-5.1 Improved Cost Savings	$20,289,785
126675104.2.14 (Pass 2) Integrated care model with outcome based payments JPS Hospital 126675104	Establish an integrated care model with outcome based payments	126675104.3.44 IT-5.1 Improved cost savings	$22,287,553
126675104.2.15 (Pass 2) Journey to Life: prenatal care and healthy babies initiative JPS Hospital 126675104	Provide Perinatal Services Program for low-income women of childbearing age in Tarrant County	126675104.3.45 IT-8.1 Timeliness of prenatal/postnatal care 126675104.3.46 IT-9.2 ED appropriate utilization	$17,463,621
126675104.2.16 (Pass 2) School Based Care JPS Hospital 126675104	Expand chronic disease management services in schools to serve underserved children and adolescents.	126675104.3.47 IT-9.3 Pediatric/Young adult asthma emergency department visits 126675104.3.48 IT-3.11	$811,373

		Other 30 day readmission rate	
126675104.2.17 (Pass 3) Develop rehab transition process for JPS Connection patients JPS Hospital 126675104	Refer rehabilitation-eligible individuals from JPS Connection to HealthSouth	126675104.3.49 IT-4.9 Average length of stay 126675104.3.50 IT-6.1 Percent improvement over baseline of patient satisfaction scores (5) overall health status/functional status	$9,178,153
127304703.2.1 Health education and lifestyles program and the chronic disease self-management program Texas Health Harris Methodist Hospital Azle 127304703	Establish HELP to offer team-based outpatient care to patients	127304703.3.2 IT-9.2 ED appropriate utilization	$1,060,197
127373205.2.1 Implement whole health peer support Helen Farabee Centers 127373205	Hire 2 peer providers to implement whole health planning	127373205.3.3 IT-10.1 Improve quality of life	$661,039
127373205.2.2 (Pass 2) Virtual Psychiatric Consultation Helen Farabee Centers 127373205	Provide psychiatric telephone consultation to primary care physicians	127373205.3.4 IT-9.4 Other outcome improvement target – number of telephonic psychiatric consultations	$754,096
130606006.2.1 Design, implement, and evaluate research-supported and evidence-based interventions tailored toward individuals in the target population (WRHS NTCH BH/SA Collaboration Project) Wise Regional Health System 130606006	Develop and implement IOP that meets patient needs, and reduce unnecessary admissions and services	130606006.3.1 IT-2.4 Reduce behavioral health/substance abuse admission rates 130606006.3.2 IT-10.1 Improve quality of life	$8,510,410
130606006.2.2 (Pass 3) Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions	Redesign current concept of the hospital admission and discharge process	130606006.3.5 IT-3.1 All cause 30 day readmission rate 130606006.3.6 IT-2.1	$2,868,548

Wise Regional Health System 130606006		Congestive heart failure admission	
130614405.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases (diabetes) THR – Arlington Memorial Hospital 130614405	Increase number of referrals and maintain HbA1c below 9.0 for program participants	130614405.3.1 IT-1.10 Diabetes care 130614405.3.2 IT-3.3 Reduce diabetes 30-day readmission rate	$462,721
130614405.2.2 Improving management of heart failure in patients and preventing readmission THR – Arlington Memorial Hospital 130614405	Improve health of patients with heart failure and a reduction in HF patient admissions	130614405.3.3 IT-2.1 Reduce CHF admission rate 130614405.3.4 IT-3.2 Reduce CHF 30-day readmission rate	$761,102
130614405.2.3 Implement evidence-based disease prevention program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth. THR – Arlington Memorial Hospital 130614405	Develop a prenatal clinic run by advance practice nurses to reduce low birth weight births	130614405.3.5 IT-8.2 Reduce percentage of low birth weight births 130614405.3.6 IT-8.3 Reduce number of early elective deliveries	$2,851,216
130614405.2.4 Establish/expand a patient care navigation program THR – Arlington Memorial Hospital 130614405	Reduce inappropriate ED utilization or hospitalization	130614405.3.7 IT-9.2 ED appropriate utilization	$5,011,564
130724106.2.1 Integrate primary care into behavioral health care clinics Pecan Valley Centers 130724106	Integrate primary and behavioral health services in three community sites	130724106.3.2 IT-6.1 Patient satisfaction	$3,008,248
135036506.2.1 Expand chronic care management models Baylor All Saints Medical Center Fort Worth 135036506	Increase patients served with better clinical outcomes	135036506.3.9 IT-1.10 HbA1c control 135036506.3.10 IT-1.11 Diabetic patients to have BP control 135036506.3.11	$2,508,834

		IT-1.13 Foot exam	
-135036506.2.4 (Pass 3b) Develop care management function that integrates primary and behavioral health needs of individuals Baylor All Saints Medical Center Fort Worth 135036506	Unduplicated patients will receive behavioral health services	135036506.3.16 IT-11.1 Diabetes bundle -135036506.3.17 IT-11.3 Improve utilization of preventive services	$2,418,588
-135036506.2.5 (Pass 3b) Establish/expand a patient care navigation program Baylor All Saints Medical Center Fort Worth 135036506	Increase patients served, and increase confirmed appointments within 14 days post discharge	135036506.3.18 IT-5.1 Improve cost savings -135036506.3.19 IT-9.2 ED utilization	$2,292,244
136326908.2.1 Diabetes management program Texas Health Harris Methodist Hospital Hurst Euless Bedford 136326908	Establish program to transition ED patients to primary care providers, and decrease length of stay for diabetes inpatients	136326908.3.1 IT-1.10 Diabetes care: HbA1c poor control 136326908.3.2 IT-3.3 Diabetes 30 days readmission rate	$231,706
136326908.2.2 Expand chronic care management models: redesign the outpatient delivery system to coordinate care for patients with chronic disease (CHF) Texas Health Harris Methodist Hospital Hurst Euless Bedford 136326908	Develop process to identify heart failure patients and improve health via reduction in acute readmission	136326908.3.3 IT-3.2 Decrease CHF readmission rate	$231,954
136326908.2.3 Expand chronic care management model Texas Health Harris Methodist Hospital Hurst Euless Bedford 136326908	Develop care management program for behavioral health and primary care	136326908.3.4 IT-3.8 Decrease BH/SA readmission rate	$2,272,147
136326908.2.4 Establish patient care navigation program Texas Health Harris	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized	136326908.3.5 IT-9.2 ED appropriate utilization	$1,592,699

Methodist Hospital Hurst Euless Bedford 136326908	health care (the seniors, self-pay, frequent flyers chronically ill and the mentally ill)		
138910807.2.1 (Pass 2) Enhance Medical Homes Children's Medical Center of Dallas 138910807	Develop and implement a medical home team-based approach to care	138910807.3.4 IT-9.2 ED appropriate utilization	$1,057,500
138980111.2.1 Promoting physical and mental health among at-risk, underserved African-American pre-teen girls in Tarrant County University of North Texas Health Science Center (UNTHSC) 138980111	Development and implementation of program to increase access to disease prevention services by program participants	138980111.3.18 IT-10.1 Improve quality of life	$2,092,876
138980111.2.2 Improving primary care clinical processes to reduce hospitalization risk University of North Texas Health Science Center (UNTHSC) 138980111	Reduce flu, pneumonia, COPD, and asthma admission rates	138980111.3.19 IT-2.5 Reduce COPD admission rate 138980111.3.20 IT-2.6 Reduce adult asthma admission rate 138980111.3.21 IT-2.10 Reduce flu and pneumonia admission rate	$919,602
138980111.2.3 Asthma 411 University of North Texas Health Science Center (UNTHSC) 138980111	Provide a school-based program for asthma	138980111.3.22 IT-3.11 Reduce potentially preventable readmissions 138980111.3.23 IT-9.3 Reduce pediatric/young adult asthma ED visits	$169,983
138980111.2.4 Tarrant County preconception and perinatal health promotion initiative University of North Texas Health Science Center (UNTHSC) 138980111	Development and implementation of preconception/perinatal health program to reduce preconception/ interconception health risks for participants	138980111.3.25 IT-8.2 Reduce percentage of low birth weight births 138980111.3.26 IT-8.9 Interpregnancy interval/ birth spacing	$20,000,000

138980111.2.5 Discharge planning and care coordination for Medicaid eligible elders University of North Texas Health Science Center (UNTHSC) 138980111	Reduce all-cause readmissions, improve quality of life scores, and decrease falls	138980111.3.28 IT-3.1 Reduce all-cause readmission rate 138980111.3.29 IT-10.1 Improve quality of life -138980111.3.45 -IT-4.5 Patient Fall Rate	$7,800,499
138980111.2.6 Health navigation and incentives for dual diagnosis patients University of North Texas Health Science Center (UNTHSC) 138980111	Reduce preventable admissions, and reduce alcohol/drug use problems	138980111.3.31 IT-10.1 Increase quality of life scores 138980111.3.32 IT-1.9 Decrease depression readmission	$10,626,887
186221101.2.1 Establish a patient care navigation program Methodist Mansfield Medical Center 186221101	Develop patient navigators to engage and guide patients through integrated health care delivery systems	186221101.3.1 IT-9.2 Decrease ED usage 186221101.3.2 IT-3.1 Decrease all-cause 30-day readmission rates	$1,793,834
186221101.2.2 Expand chronic care management models Methodist Mansfield Medical Center 186221101	Develop and implement chronic disease management interventions	186221101.3.3 IT-1.11 Decrease diabetic inpatients 186221101.3.4 IT-1.10 Decrease diabetic inpatients 186221101.3.5 IT-3.3 Decrease readmissions	$729,914
206106101.2.1 (Pass 2) Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards (WCCA PCMH) Wise Clinical Care Associates 206106101	Change the care delivery model of three primary care clinics within Wise Clinical Care Associates into patient centered medical homes.	206106101.3.1 IT-1.10 Diabetes Care: HbA1c poor control 206106101.3.2 IT-6.1 Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate	$18,143,252

216719901.2.1 (Pass 2) Becoming a facility with the "culture of always" Glen Rose Medical Center 216719901	Develop a process to incorporate patient satisfaction into every employee's every day function	216719901.3.2 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$134,852

Section III. Community Needs Assessment

Section III. Community Health Needs Assessment

Region 10 RHP's Community Health Needs Assessment (CHNA) offers Regional data and related county-specific health needs information to inform the selection of the delivery system reform projects that will effectively transform the health care experiences of our Region's residents by addressing unmet needs and contributing to overall population health improvements. This section summarizes Region 10's most pressing community health needs and the societal and market contexts in which they have developed. It also underscores the connections between the projects proposed by the participating providers listed in Section II and the Region's most serious community health needs, which are: (1) access to primary and specialty care, particularly in underserved areas of the Region and for low-income residents; (2) access to behavioral health resources and integration of behavioral and physical health care services; (3) improved primary care management and self-management of chronic care conditions; and (4) better overall coordination and service integration across the Region's providers.

Methodology

Region 10 RHP's CHNA includes both qualitative and quantitative data. Our primary data collection activities included stakeholder surveys and provider readiness assessments. Additionally, the RHP plan team reviewed and incorporated relevant and appropriate prior existing sub-Regional community health needs assessments. We also collected secondary data from national and state sources to create a full community profile that includes birth and death characteristics, indicators of health care access, chronic disease prevalence rates, as well as demographic variables affecting Regional health such as insurance status, socioeconomic status and educational attainment level. Some data is presented in this section with comparisons to state and national data, framing the scope of an issue as it relates to individual counties and the Region. (*Please see Appendix D for all supplemental materials related to this Community Health Needs Assessment.)*

COMMUNITY PROFILE

Region 10 consists of nine contiguous counties in north central Texas. It is characterized by one urban center surrounded by a number of rural and suburban communities. This Region has a significant geographic footprint, spanning 7,221 square miles. Region 10's nine counties are: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant and Wise. *(See Appendix D-1.1 for a map of Region 10. Additional count- specific information can also be found in Appendix D-4.)*

Demographics: Population by Age Cohort

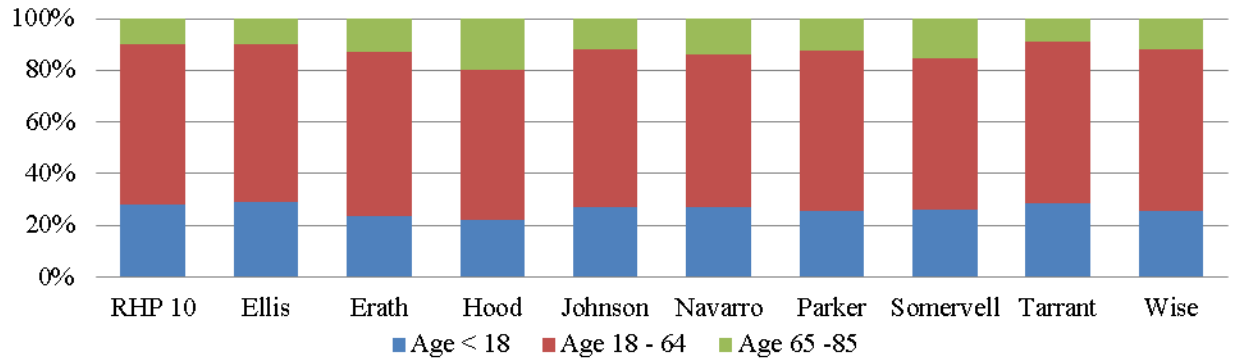
Region 10 had a population of 2,444,642 in 2011. The majority of Region 10 residents are working-age adults (62% ages 18-64). The remaining population is made up of seniors (11% of total Regional population) and children (28% of Regional total population). Region 10 is similar to the rest of Texas in terms of its 18-and-under proportion of total residents with the exception of Hood, Somervell and Navarro Counties. Hood County trends significantly older, with a larger proportion of seniors (20.1%), offset by a smaller adult population (57.8%) and child population (22.1%). Both Somervell and Navarro also have higher proportions of elderly residents than the

rest of the Region, but lower than that for Hood County. In Somervell, the senior population is 15.5% of the total population, with a smaller proportion of working-age adults (58.3%) and a child population similar to the Region (26.2%). Navarro's proportion of elderly residents is similar to Somervell's with seniors representing 14.0% of its population; working-age adults and children represent 59.1% and 26.9% of the county respectively. Tarrant and Ellis Counties have slightly higher proportions of children as a percentage of their total county population (28.4% and 29.4%, respectively) than the rest of the Region.

By 2016, the Region is projected to see its population grow by an estimated 9.4% to a Regional total of 2,674,022 people (60.7% adults ages 18-64; 27.8% children ages 0-18; and 11.5% seniors ages 65 and older). This projected growth is unevenly spread across the counties: Ellis and Parker counties will see the greatest population growth (13.9% and 11.2%, respectively). Erath and Navarro will see a much lower rate of growth than the rest of the Region (3.9% and 4.3%, respectively). The other five counties in Region 10 are projected to have population growth similar to that of the Region as a whole.

Overall, Region 10's elderly population (65 and older) is anticipated to grow more rapidly as a percentage of total population than its working-age adults and children (*Figure 1*). The highest percentages of elderly are projected for Ellis and Parker counties at a rate of 32% for both counties, compared with the Region-wide estimate of 26%. In contrast, Erath and Navarro counties' elderly populations as a percentage of total county population will grow much less than the rest of the Region (12% and 13%). *(Please see Appendix D-1.2, 1.3 and 1.4 for summary data tables of Region 10's population, including projected population growth.)*

Figure 1: Age Distribution of Region 10 Counties in 2011



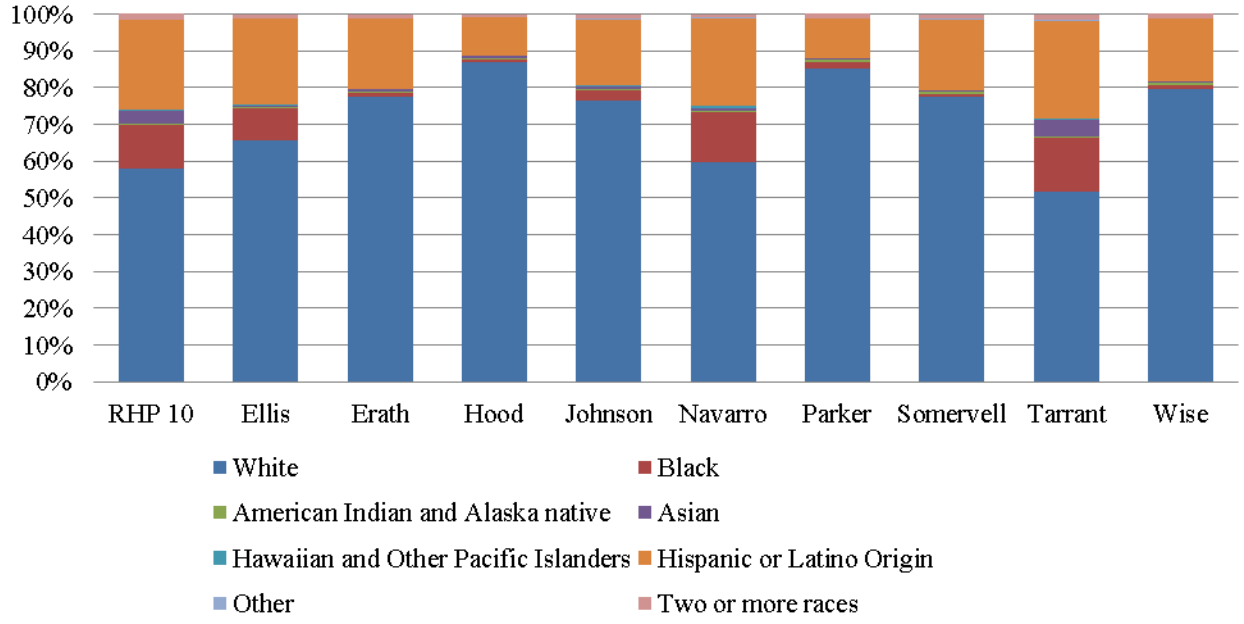
Source: Thomson Reuters 2011

Demographics: Population by Race and Ethnicity

Region 10's population is predominantly White (57.9%), Hispanic (24.4%), and African-American (11.9%). The Region is less diverse than the state, but more diverse than the nation. Region 10 also has a smaller proportion of Hispanic residents than the state (24.4% versus 40%), but the Region's Hispanic population is still a significantly larger proportion of total population than nationally. Hispanics and other minorities are projected to have higher population growth rates over time. Much of Region 10's racial diversity is concentrated in Ellis, Navarro and

Tarrant counties. Of Region 10's remaining six counties, Hood and Parker counties are the least diverse at 87.1% and 85.3% White, respectively *(Figure 2)*.

Figure 2: Race/Ethnicity Distribution of Region 10 Counties in 2010

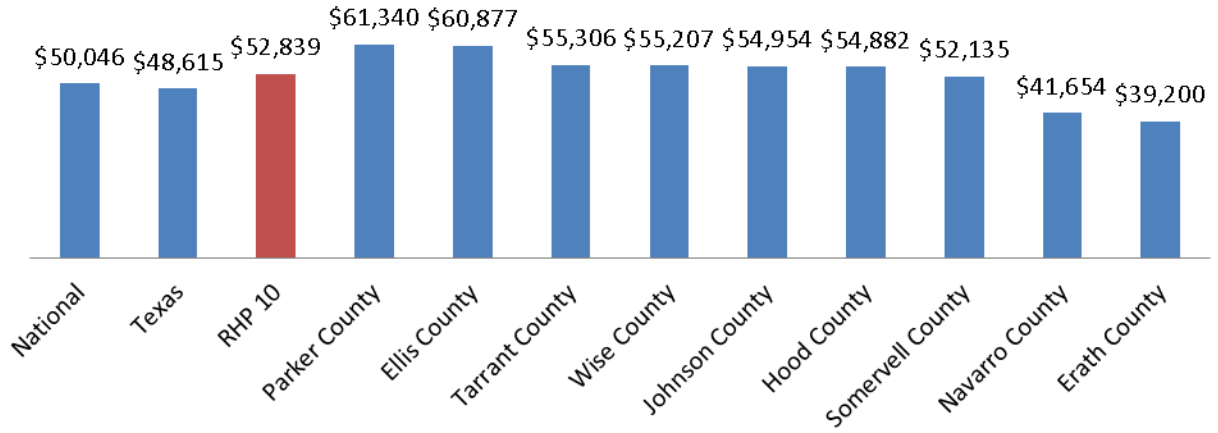


Source: Thomson Reuters, 2011

Demographics: Household Income

Region 10 has a higher per capita income than Texas or the nation with a median household income of $52,839 per year, compared to $48,615 median state income and $50,046 national median income *(Figure 3)*. The wealthiest counties in Region 10 are Ellis and Parker, which have higher median household incomes of $60,877 and $61,340, respectively. Conversely, Erath and Navarro are the Region's least affluent counties with median household incomes of $39,200 and $41,654, respectively.

Figure 3: Median Household Income of Region 10 Counties in 2011

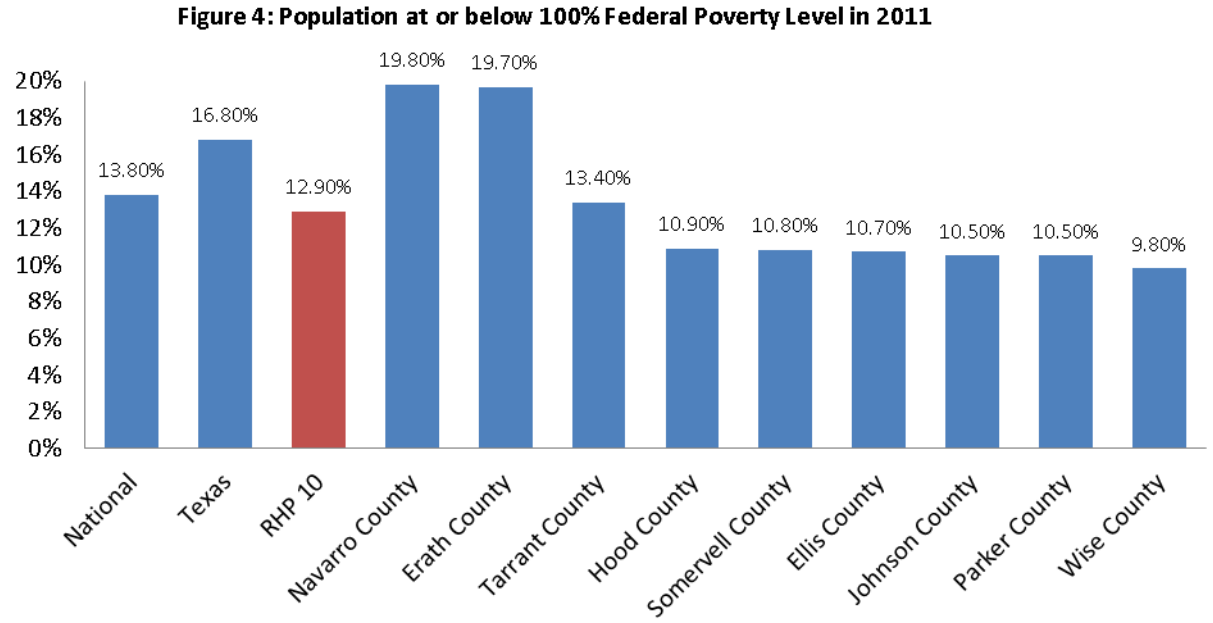


Source: Thomson Reuters, 2011

Demographics: Population Living in Poverty

Poverty is highly correlated with poorer health status and poorer health outcomes. Empirical research has demonstrated conclusively that people living on limited incomes are likely to forego visits to the doctor in order to meet their more pressing financial responsibilities, such as food and housing.[ii] Low-income wage earners are less likely to be covered by an employer's health insurance program, and even if they are covered, they are often less able to pay for premiums or out-of-pocket expenses.

Analysis of the Regional and county populations at or below the federal poverty level (FPL) mirrors the findings of the median household income analysis above *(Figure 4)*.[iii] Overall, Region 10 has fewer people living in poverty than the rest of Texas and the nation as a percentage of the total Regional population. However, the poorest Region 10 residents tend to be concentrated in a few counties and specific communities within the remainder of the Region. Erath and Navarro counties contain the highest relative percentage of population living in poverty with almost 20% of each county's population at or below 100% of the federal poverty level.

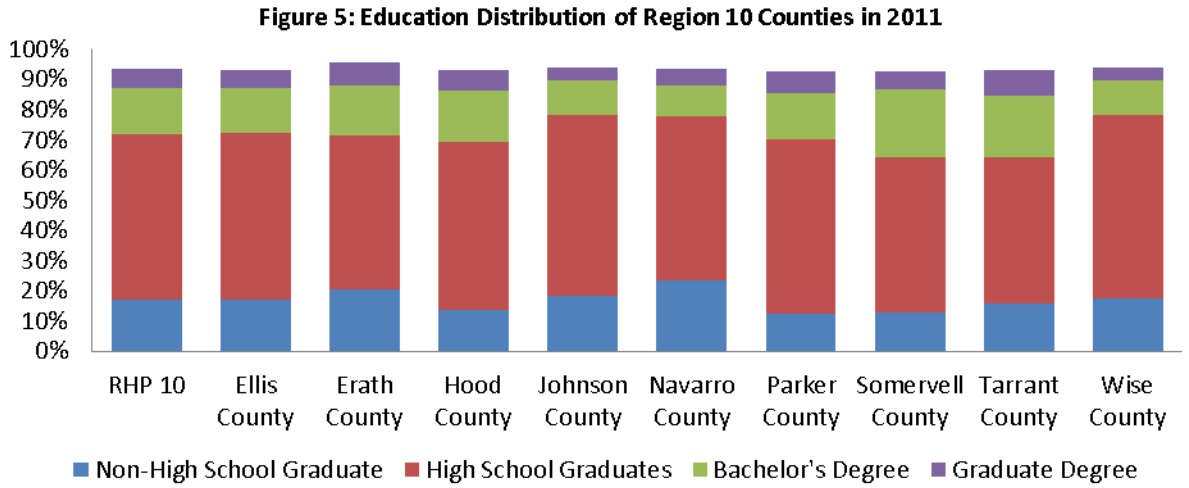


Notes: FPL 2011: $10,890 for an individual, or $22,350 for a family of four
Source: Texas Association of Counties, HealthData.Gov – Health Resources County Comparison Tool

Demographics: Education Level

Educational attainment level is another demographic variable that correlates strongly with overall health status as well as poverty level. Low levels of formal education are often cited as a major indicator of poor health. Lack of education is a formidable barrier to securing living-wage and higher-wage jobs, and further increases an individual's probability of living in poverty, being uninsured and having children who grow up in poverty.

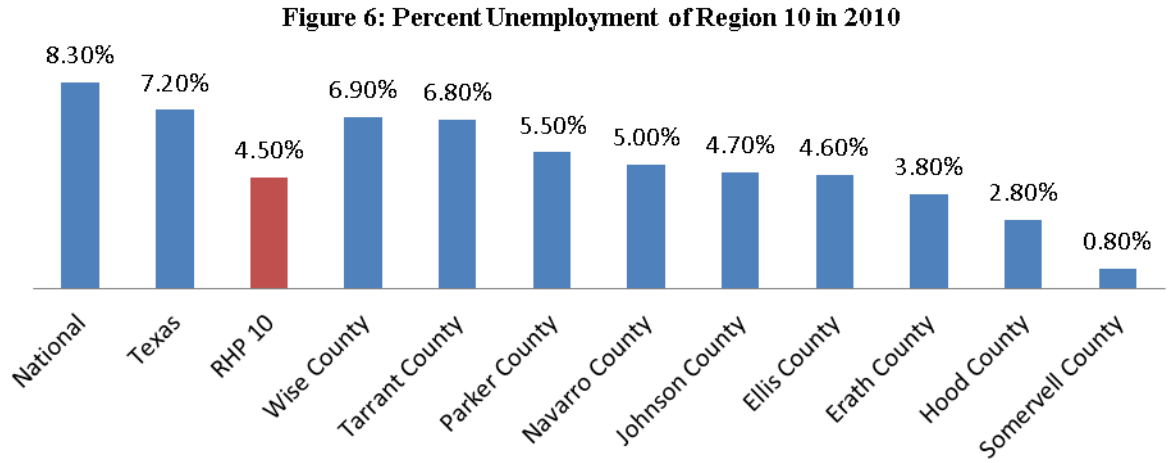
Those with low levels of formal education and literacy are less likely to understand how personal behavior and lifestyle can affect health status and health outcomes. Educational attainment level is also related to a person's ability to understand medical information and recognize early symptoms of disease. While Region 10 has a smaller percentage of adults without a high school diploma (16.9%) than the rest of Texas, the proportion of the Region's population without a diploma is higher than the national rate of 14.4% *(Figure 5)*. Reflecting the correlations that exist between poverty level and education, Navarro and Erath counties contain the highest percentages of population that did not complete a high school education (23.6% and 20.5%, respectively), while the most affluent counties – Hood, Parker and Somervell – have the smallest proportions of residents without a high school diploma (13.8%, 12.6% and 12.7%, respectively).



Source: U.S. Census 2011

Demographics: Employment

Generally, the Region has a higher rate of employed residents than the rest of the state and the nation (4.5% unemployment in Region 10 versus 7.2% and 8.3% unemployment for Texas and U.S., respectively) *(Figure 6)*. Tarrant and Wise counties have the Region's highest unemployment rates at (6.8% and 6.9%, respectively). Somervell has a significantly lower unemployment rate 0.8%) than the rest of Region



10.

Source: Texas Department of State Health Services, United States Census Bureau

Insurance Status

Being uninsured is a major barrier to accessing primary and preventive care in Region 10. People without insurance tend to be working-age adults with less secure employment, lower wage levels, and pre-existing conditions. When individuals defer care because of cost concerns they are more likely to seek care when symptoms have become more severe and receive care in more expensive, acute and emergent care settings. Individuals who defer care also have a greater likelihood of poor long-term outcomes.

Put simply, uninsured patients tend to use hospital emergency departments and urgent care centers as a last resort, rather than managing their health through more cost-effective primary care clinics and physician offices. This unmanaged, episodic and health-event driven approach to seeking care has both serious financial cost implications at the county, Regional and national levels as well as potentially devastating health consequences for individuals.[IV]

Region 10's 2010 uninsured rate of 18% is closer to the national uninsured rate of 15.5% than Texas' statewide rate of 23.7% *(Figure 7).* More of Region 10's residents have private insurance than the rest of Texas (51.2%) or the nation (54%). The Region's public coverage rates are 11% for Medicaid, 8.9% for Medicare and 1.4% for the dually enrolled. The highest rates of uninsured residents are found Erath and Navarro Counties (30.2% and 28.0%, respectively) commensurate with the counties' higher rates of poverty and lower median household incomes than the rest of Region 10.

Figure 7: Uninsured vs. Insured, 2011

	Total Uninsured	Total Insured	Private: Employer Sponsored Insurance	Private: Direct Insurance	Medicaid	Medicare	Other Insurance
U.S.	15.5%	84.5%	49.0%	5.0%	16.0%	12.0%	2.5%
Texas	24.7%	76.3%	45.0%	4.0%	16.0%	9.0%	2.3%
Region 10	**18.0%**	**82.0%**	**55.3%**	**5.3%**	**11.1%**	**8.9%**	**1.4%**
Ellis	13.5%	86.5%	59.1%	5.7%	10.5%	9.7%	1.5%
Erath	36.5%	63.5%	35.7%	3.5%	10.6%	11.9%	1.8%
Hood	13.5%	86.5%	51.4%	5.1%	8.8%	19.6%	1.6%
Johnson	14.0%	86.0%	56.7%	5.5%	11.0%	11.4%	1.4%
Navarro	31.1%	68.9%	34.0%	3.3%	15.7%	12.8%	3.1%
Parker	13.6%	86.4%	60.4%	5.9%	8.7%	10.5%	0.9%
Somervell	14.2%	85.8%	55.5%	5.5%	11.2%	12.4%	1.2%
Tarrant	18.5%	81.5%	55.6%	5.4%	11.4%	7.9%	1.2%
Wise	16.1%	83.9%	56.8%	5.5%	9.7%	10.8%	1.1%

Source: U.S. Census Bureau, Thompson Reuters 2011

The proportion of Region 10 residents who remain uninsured in 2016 is projected to drop to 11.3%. Of those who will be newly insured, an estimated 58.1% will be covered by direct or employer-sponsored private insurance, while an estimated additional 15.7% of Region 10 residents will receive coverage through Medicaid and 10.2% through Medicare. These projections, however, are highly dependent on various federal and state policy and market factors, including availability and affordability of insurance products offered in the local market, impact of any potential state or federal health insurance exchange, and whether or not the state moves forward with a Medicaid expansion.

HEALTH CARE INFRASTRUCTURE AND ENVIRONMENT

(See Appendix D-2 for additional information regarding Region 10's health care infrastructure.)

Facilities and Health Care Workforce

Region 10's health care infrastructure consists of 46 acute care hospitals (the majority of which are privately owned), two psychiatric hospitals and 3,726 physicians *(Figure 8)*. The Region has a total of 6,491 acute care licensed beds and 170 psychiatric care licensed beds. The Region's provider options also include four MHMRs and one FQHC. *(See Appendix D-5 for a list of health care facilities by county.)*

Providers are most concentrated within Tarrant County and particularly in Fort Worth, Region 10's major urban center. The vast geographic expanse of Region 10 and the high level of provider concentration within Tarrant County combine to create serious specialty and primary care access barriers for many individuals in the Region's rural counties.

Figure 8: Acute Care Resources, 2009

	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Acute Care Hospitals	46	2	1	1	1	1	1	1	36	2
Investor Owned Hospitals	28	1	0	1	0	1	1	0	24	0
Non-Profit Hospitals	18	1	1	0	1	0	0	1	12	2
Psychiatric Hospitals	2	0	0	0	0	0	0	0	2	0
Acute Care Licensed Beds	6,491	129	98	83	137	162	99	16	5,583	184
Psychiatric Care Licensed Beds	170	0	0	0	0	0	0	0	170	0

Source: Health Resources County Comparison Tool, Health Indicators Warehouse, Texas Department of State Health Services

The most frequent inpatient services for Region 10 in 2011 were obstetrics, internal medicine, cardiology, pulmonology, general surgery and orthopedics, according to Thomson Reuters. The Region's top outpatient services were laboratory services, internal medicine, physical therapy, diagnostic radiation, psychiatry and pulmonology.

Overall Regional physician demand is projected to increase by 30% over the five-year Waiver period. Demand for various specialties and types of providers is projected to increase anywhere from 22% to 36%, according to Thomson Reuters. The greatest demand increases are expected for obstetrics/gynecology, vascular medicine, cardiology, oncology/hematology and nephrology *(See Appendix D-2.1: for a table of Provider Supply and Demand by Specialty).*

Medically Underserved Areas and Health Professional Shortage Areas

Five of Region 10's counties – including Tarrant County, the Region's most populous county – are at least partially designated by the U.S. Health and Human Services Agency as Medically

Underserved Areas (MUAs). Ellis, Erath, Johnson and Navarro are the Region's other MUA counties.

Four of Region 10's nine counties are also designated as partial primary care Health Professional Shortage Areas (HPSAs). Additionally, Tarrant, Wise and Ellis Counties are federal dental health professional shortage areas. Perhaps most alarming, all but one of Region 10's counties are federally designated mental health provider shortage areas (only Johnson County is not a MHPSA). These findings correlate with the Stakeholder Surveys and Providers Readiness Assessments Region 10 conducted as part of RHP plan development[v] (*Figure 9*).

Figure 9: Health Professional Shortage Areas by County

HPSA Category	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Primary Care	x				x			x	x
Dental Care	x							x	
Mental Health	x	x	x		x	x	x	x	x

Source: Region 10 Stakeholder Survey, Health Professional Shortage Areas

Health Care Infrastructure: Performing Provider Readiness Assessment

Region 10 RHP created and fielded a readiness assessment tool to assess current health care delivery competencies, capabilities and gaps with relation to integrated care delivery and population health management for all major providers within each county and across the Region. All providers participating in the DSRIP program completed this assessment. Region 10 also asked major health care providers and stakeholders in each Region 10 county not actively participating in DSRIP (e.g.,, hospitals, MHMRs, medical groups, independent physician associations, public health clinics and ambulance companies) to complete the assessment. Survey respondents assessed and specified gaps and needs in the Region's health care infrastructure across five domains:

1) Population health management,
2) Provider capacity,
3) Functional patient care teams,
4) Use of health information technology (HIT), and
5) Care coordination abilities.

Figure 10 shows respondents' assessment of system gaps and needs in each Region 10 County. ("Yes" indicates a gap exists.) We received a total of 15 responses, representing the majority of the Region 10 RHP performing providers.

Figure 10: Delivery Gaps Identified by the Performing Provider Readiness Assessments, 2012

PPRA Domain	Need(s) Identified								
	Erath	Ellis	Hood	Johnson	Somervell	Tarrant	Wise	Navarro	Parker
Population Health	Yes	No	Yes	No	No	Yes	No	*	*

Provider Capacity	Hospital Provider	No	Yes	Yes	No	No	Yes	No	*	*
	MHMR	Yes	Yes	No	No	No	Yes	No	*	*
	Physician Organization	*	*	*	*	*	*	*	*	*
	Other	*	*	*	*	*	*	*	*	*
Functional Patient Care Teams		Yes	No	Yes	Yes	Yes	Yes	Yes	*	*
Use of HIT		Yes	Yes	No	No	No	Yes	No	*	*
Care Coordination		Yes	Yes	Yes	Yes	Yes	Yes	Yes	*	*

*No assessments received.

Stakeholder Surveys

Region 10 RHP also conducted a stakeholder survey. The stakeholder survey collected qualitative data and feedback on the following:

1) Access to care,
2) Care coordination and
3) Community health.

The Region collected surveys over a period of one month via a Web-based survey tool for a total of 191 stakeholder responses. *(See Appendix D-2.2 for a PowerPoint Discussion of Stakeholder Responses and Results).*

Access to Care

Most survey respondents agreed that routine hospital services, routine primary/preventive care and routine specialty care were "difficult" to access. Mental/behavioral health care services were identified as the most difficult for low-income patients to access, while emergency services were consistently noted as the least difficult to access. The same access barriers were identified for all types of care:

- Lack of coverage/financial hardship (consistently the most frequently cited barrier);
- Difficulty navigating system/lack of awareness of available resources; and
- Lack of provider capacity.

Care Coordination

Top barriers to effective care coordination (between providers and systems) cited by survey respondents were the complexity of coordination, lack of staff, lack of financial integration, fragmented service systems and practice norms that allow providers to work in silos. Most respondents said they did not believe that low-income patients could:

- Choose and establish a relationship with a primary care provider;
- Access private primary care providers;
- Access community health centers, free clinics or public clinics; and
- Access behavioral/mental health providers.

Community Health

Region 10's most prevalent conditions are diabetes, obesity, hypertension, heart failure and chronic obstructive pulmonary disease (COPD), survey respondents reported. Survey respondents also reported that the conditions contributing most to preventable hospitalizations in Region 10 are hypertension, uncontrolled diabetes, COPD, congestive heart failure and diabetes short-term complications (in decreasing order of importance). Respondents reported that behavioral health, substance abuse and insufficient access to care were the top issues to target for population health improvement. Respondents reported that Region 10 residents were most likely to get their health education and health information from friends and family, the Internet and their doctor.

Key Survey Takeaways

Respondents overwhelmingly listed a lack of coverage and/or financial hardship as the most significant barrier to care for low-income patients. Survey respondent write-in comments also cited an overuse of emergency department services and patient inability to access primary and preventive care (due to difficulty navigating the system and a lack of capacity). Most respondents also indicated that the Region's primary care providers, hospitals and specialists were not coordinating care effectively.

Other Major Delivery System Reform Initiatives

We have identified several federal initiatives in which Region 10 providers participate. The majority of these are related to diabetes, cancer and infectious diseases. One of our participating providers, Baylor Health Systems, collaborates with AHRQ, NCI, and the National Institute of Allergy and Infectious Diseases on vaccine research, and diabetes and health care quality initiatives. Another Region 10 participating provider, The University of North Texas Health Science Center, works with several federal agencies on Alzheimer's, education and health disparities research. Another Region 10 participating provider, Tarrant County Department of Public Health, is a consortium member of the North Texas Accountable Healthcare Partnership, a recipient of HITECH funds awarded to 12 Regional HIEs in the state of Texas. We will provide in our final and complete RHP Plan submission a comprehensive listing of all participating providers' federal initiative involvement based on the list specified in the DSRIP Companion Document issued on October 15, 2012. *(See Appendix D-6 for the draft survey questionnaire sent to all Region 10 participating providers to develop a complete list of each provider's federal initiative participation activities.)*

KEY HEALTH CHALLENGES

Population health statistics for Region 10 residents reveal important trends and opportunities for delivery system improvement. The most important of these statistical trends are summarized below. *(See Appendix D-3 for additional information, including summary data tables.)*

Region 10 RHP Pregnancy and Birth-Related Statistics

Teen pregnancy increases the risk of poor health outcomes for both young mothers and their children. Pregnancy and delivery negatively impact a teenager's health both directly and indirectly and often result in long-term negative consequences including increased risk of poverty and low socioeconomic status. Babies born to teen mothers are more likely to be born preterm and/or low birth weight; much of this increased risk is attributable to delayed onset of

prenatal care. For this reason, Healthy People 2020 stresses the importance of responsible sexual behavior to reduce unintended pregnancies and the number of births to adolescent females.

Region 10 fares slightly better than the state overall in its teen pregnancy rate (4.3% versus 4.9%) and the incidence of low birth weight babies (7.2% versus 8.4%). However, Region 10 has a slightly lower rate of early (first trimester) prenatal care than the state overall (58.1% versus. 60.1%). Navarro and Somervell Counties have Region 10's highest teen pregnancy rates (6.2% and 5.4% compared with the Regional average of 4.3%). Navarro and Tarrant Counties have the Region's highest percentages of low birth weight babies and its lowest rates of early prenatal care.

Morbidity and Mortality

Cancer and obesity are Region 10's most common morbidity factors. Hood and Navarro Counties have the Region's highest cancer rates. Obesity rates are statistically the same across all nine counties in Region 10 at around 26 to 29 persons per 100,000. Johnson County has the Region's highest rate of diabetes at 10.0 per 100,000. Tarrant County has the Region's highest HIV rate, though small sample sizes reduce the precision of county-level HIV statistics across the Region.

Cardiovascular disease is the number one killer in Region 10 (4,931 deaths in 2011). Cancer is Region 10's second most frequent cause of death (3,668 deaths in 2011). These two causes of death are also the two highest for Texas overall.

Preventable Hospitalization

Region 10's preventable hospitalization rate of 931 per 100,000 persons is lower both than the state's average of 5,923 per 100,000 and the national average of 1,433 per 100,000. Navarro County's preventable hospitalization rate is the Region's highest (17 per 1,000 population), followed by Johnson County (14 per 1,000 population). Region 10's most prevalent cause of preventable hospitalization is congestive heart failure (195 per 1,000 Medicare enrollees), closely followed by anginas without procedures (190 per 1,000 Medicare enrollees).

Access to Care

County Health Ranking surveys place difficulties in accessing care due to lack of insurance coverage at the top of health care problems. Although the county-level information is difficult to interpret with certainty because of variations in county response levels, it appears that Johnson and Ellis Counties reported the greatest access problems throughout the Region *(Figure 11).*

Overall Region 10 performs at or slightly better than the rest of the state in providing diabetes and mammography screenings. Within the Region, Wise County and Navarro County have the lowest screening levels for diabetes and mammography and are below both state and national average screening rates. Wise County's diabetes screening rate is 76%, compared with the statewide and national rates of 84% and 80%, respectively. Navarro County has the Region's lowest mammography screening rate at 55%, compared with statewide and national rates of 60% and 59%, respectively.

Figure 11: Utilization of Health Services, 2011

	U.S.	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Access to Care	*	*	16%	18%	N/A	15%	22%	N/A	12%	N/A	16%	15%
Emergency Department Visits	*	*	1,093,860	74,949	22,748	23,994	68,934	17,199	44,794	5,708	798,904	36,630
Diabetic Screening	89%	80%	84%	80%	81%	87%	89%	82%	79%	92%	82%	76%
Mammography Screening	74%	59%	60%	59%	59%	47%	73%	55%	53%	56%	62%	46%

* Data unavailable
Source: County Health Rankings, 2011

Communicable Diseases

In general, Region 10 has lower rates of communicable disease than the rest of the state, although prevalence rates for Region 10's Somervell County are statistically questionable because of its small population size. Specifically, Region 10 has lower AIDS rates (3.4), tuberculosis rates (2.3) and whooping cough rates (10.3) than the state. However, Region 10 has a much higher rate for chicken pox infections (26.3%) versus the overall rate in Texas of 17.9%. Tarrant County has the Region's highest TB infection rate. Johnson, Navarro and Tarrant Counties have the Region's highest rates of AIDS infections (6.1, 7.9 and 6.1, respectively). Hood County had the Region's highest chicken pox and whooping cough infections.

Sexually Transmitted Diseases

Region 10 generally has lower reported sexually transmitted disease rates (STDs) than the overall state rates. Region 10 has lower rates of syphilis (2.7 versus 4.9 per 100,000) and gonorrhea (99.0 versus 504.1 per 100,000) than the state overall. Conversely, Region 10 has a higher rate of chlamydia infections than the state overall (533.7 versus 467.3 per 100,000).

Ellis County had the Region's highest infection rates for syphilis, gonorrhea and chlamydia. Ellis and Tarrant Counties had the Region's highest syphilis infection rates (10 and 8.3 respectively). However, these rates are still significantly lower than the national average. Ellis, Navarro and Tarrant Counties have the Region's highest gonorrhea infection rates (504.1, 141.4 and 139.0, respectively). Ellis County also had a chlamydia infection rate roughly five times higher than the rest of the Region.

Health Outcomes

As previously noted, county-specific health outcomes are difficult to assess because of small sample sizes in a few counties (Somervell and Navarro). However, the County Health Rankings data set indicates that Region 10's population self-reported having fewer poor or fair health days than the rest of the state (17% versus 19%). Johnson County has the Region's highest percentage of respondents reporting poor or fair health and the highest reported levels of poor mental health days. Hood County respondents have the Region's highest reported number of poor physical health days.

Health Behaviors

The Region's top identified health behaviors negatively impacting and influencing health outcomes are adult obesity (30%) and physical inactivity (28%). These behaviors are followed by smoking (19%) and excessive drinking (15%). Counties appeared to have fairly comparable levels for these behaviors. Johnson County had the Region's highest rates for nearly all harmful health behaviors: adult smoking, adult obesity, physical inactivity and excessive drinking. Navarro, Parker and Wise also had slightly higher adult obesity rates than the state (See County Health Rankings).

Access to Healthy Foods

The Region fares slightly better than the state overall in terms of access to healthy foods in poor communities (10% versus 12%). Residents in Ellis and Johnson counties have the worst access to healthy foods in poor communities, but their rates are still significantly better than the statewide average. Overall Region 10 has fast food restaurant access rates similar to the statewide average. Johnson County has the Region's highest percentage of fast food restaurants at 60%.

Conclusions

While on average Region 10 fares as well as or slightly better than the rest of the state on many health need indicators, the poorest and most vulnerable residents of Region 10 live in communities struggling with very significant levels of unmet health care need. Through DSRIP, Region 10 RHP is committed to a revitalized community-oriented Regional health care delivery system focused on the triple aims of improving the experience of care for all patients and their families, improving the health of the Region's population, and reducing the cost of care without compromising quality with a particular focus on the community health needs of our most vulnerable residents.

SUMMARY TABLE OF COMMUNITY NEEDS

The table below provides a concise summary of the community needs we have outlined in Section III. *(See Appendix D for additional detail and contextual data).* The DSRIP projects proposed by Region 10 RHP participating providers have been selected to address many of the health care challenges outlined in this CHNA and highlighted in the summary table below.

Identification Number	Brief Description of Community Needs Addressed Through RHP Plan	Data Source for Identified Need
CN.1	**Lack of provider capacity.** Patients find difficulty in navigating the system and have noted the difficulty in finding a provider, particularly Medicaid providers. Five counties are recognized as medically underserved areas.	Stakeholder Survey, Texas CHS, County 2010 Health Rankings, Providers Readiness Assessments, Health Professional Shortage Areas
CN.2	**Shortage of primary care services** (e.g., pediatric, prenatal,	Health Professional Shortage

Identification Number	Brief Description of Community Needs Addressed Through RHP Plan	Data Source for Identified Need
	family care). Four counties have such shortages.	Areas
CN.3	**Shortage of specialty care.** The Region is facing a 22-36% growth in provider demand, across all specialties. The specialties with the greatest growth in demand are obstetrics/gynecology**,** vascular health, urology, hematology/oncology, cardiology, and nephrology.	Health Professional Shortage Areas
CN.4	**Lack of access to mental health services.** All but one county in Region 10 are recognized as health professions shortage areas for mental health providers.	Health Resources County Comparison Tool, Health Indicators Warehouse, Texas Dept. of State Health Services
CN.5	**Insufficient integration of mental health care in the primary care medical care system.** Community stakeholders cite a need to achieve better integration of primary and behavioral health services in the primary care setting.	Stakeholder surveys
CN.6	**Lack of access to dental care.** Two of the 9 counties are nationally recognized with a shortage of dental providers.	Health Professional Shortage Areas.
CN.7	**Need to address geographic barriers that impede access to care**. There is a skewed distribution of providers in Region 10, with most located in the major urban centers, particularly Fort Worth, Tarrant County. Individuals from rural counties have difficulty with access to care, especially specialty care.	Health Resources County Comparison Tool, Health Indicators Warehouse, Texas Dept. of State Health Services
CN.8	**Lack of access to health care due to financial barriers (i.e., lack of affordable care).** Providers overwhelmingly list lack of coverage/financial hardship as a major barrier for low-income patients.	U.S. Census Bureau, County Health Rankings Survey
CN.9	**Need for increased geriatric, long-term, and home care resources (e.g., beds, Medicare providers).** Region 10's population is projected to grow 9% by 2016, with a 26% increase in the senior population (ages 65+). Three counties have senior populations of between 14-20% of total population.	Thomson Reuters, 2011
CN.10	**Overuse of emergency department (ED) services.** Demand for ED visits is on the rise and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow. As a Region, there were 1.1 million visits to hospital EDs in 2010, with a rate of 447.5 visits per 1,000 persons. The 2007 national ED visit rate was 390.5 per 1,000 persons, increasing 23% since 1997, but lower than the ED visit rate of Region 10.	Stakeholder Survey, Texas CHS, 2010 County Health Rankings, UCSF Trends and Characteristics of U.S. Emergency Department Visits, 1997-2007
CN.11	**Need for more care coordination.** All counties identified it as a system cap and need. Barriers include complexity of coordination, lack of staff, lack of financial integration, fragmented system service, and practicing in silos. Providers did not feel there was strong care coordination between primary care providers, hospitals, and specialists.	Region 10 Stakeholder Survey
CN.12	**Need for more culturally competent care to address unmet needs (e.g., Latino-population need care, translators, translated-materials).** Over 40% of the Region's population is not Caucasian, and nearly one-quarter are Hispanic or Latino origin. Hispanic and minority populations have higher growth rates than the White population. Research shows that culturally competent care shows better health outcomes.	American Fact Finder 2010 Census Data, U.S. Census Bureau

Identification Number	Brief Description of Community Needs Addressed Through RHP Plan	Data Source for Identified Need
CN.13	**Necessity of patient education programs.** Many community residents lack basic health literacy.	U.S. Census, National Adult Literacy Survey (NALS)
CN.14	**Lack of access to healthy foods.** The Region and the state has more than double the percentage of all restaurants that are fast food establishments compared to the nation.	Community Health Rankings
CN.15	**Need for more education, resources and promotion of healthy lifestyles (free and safe places to exercise, health screenings, health education, healthy environments, etc.).** Top identified health behaviors impacting and influencing health outcomes in Region 10 are adult obesity (30%) and physical activity (28%). Region had a lower rate of health screening rate than nation and state.	County Health Rankings, 2010
CN.16	**Higher incidence rates of syphilis and chlamydia.** Two counties have higher rates of syphilis than the state. One county had significantly higher rate of chlamydia, while entire Region 10 has higher rate than the state and nation.	Texas CHS
CN.17	**Incomplete management of varicella (chicken pox) cases.** Region 10 has poor rates of some chicken pox, with nearly a 50% higher rate than national average (with rate of 26.3 compared to 17.9 per 100,000, respectively).	Texas CHS, Centers for Disease Controls and Preventions
CN.18	**Incomplete management of pertussis (whooping cough) cases.** The Region has nearly a 50% higher rate than state, with rate of 10.3 compared to 5.54 per 100,000, respectively).	Texas CHS, Centers for Disease Controls and Preventions
CN.19	**Need for more and earlier onset of prenatal care.** Nearly 60% of Region 10 mothers access prenatal care within first trimester, compared with 71% national rate. Region 10 has higher teen birth rates than the national average, while also having a lower rate of low birth weight.	Texas CHS
CN.20	**Improved Public Health Surveillance to Promote Individual and Population Health.** West Nile and other disease outbreaks locally highlight areas in the local public health surveillance system that are unaddressed.	Texas DSHS and National Electronic Disease Surveillance System (CDC)
CN.21	**High tuberculosis (TB) prevalence** and low treatment completion rates of latent tuberculosis infection (LTBI) LTBI treatment	Healthy People 2020
CN.22	**Inadequate health IT infrastructure** and limited interoperability to support information sharing between providers hinders care coordination.	Region 10 RHP Community Health Needs Assessment, Regional Stakeholder Survey Summary, June 2012

Section IV. Stakeholder Engagement

SECTION IV. STAKEHOLDER ENGAGEMENT

Region 10 created a two-pronged planning, development and engagement outreach effort for the entire nine-county area. Ongoing collaborative communication between the RHP Anchor, county governments, other IGT entities, and all participating providers was the first major stakeholder engagement focus. This included the development of a formal governance structure, regular meetings, a weekly newsletter, webinars and additional communications as needed. Through this process, unparalleled in the history of the Region, providers and county leaders were able to work as a team to identify, define and develop transformative projects that mesh and collectively address Regional needs. The second major Regional engagement focus was to include and seek input from ***all*** Regional stakeholders, including those not directly involved in Regional health care delivery but possessing valuable knowledge and Regional insight to help identify our Region's highest priority areas of unmet health care need and how best to meet them.

RHP PARTICIPANT ENGAGEMENT

Region 10's Plan is a blueprint for a transformed population health-oriented Regional health care delivery system in which committed performing providers collaborate more effectively to address pressing Regional health care needs. Our engagement process, facilitated and led by Regional Anchor facility JPS Health Network (JPS), has laid the groundwork for the open communication channels and spirit of collaboration necessary for a modern and coordinated health care delivery system capable of delivering better care at lower cost to all of the Region's residents, regardless of their ethnicity, income level or insurance status. The Anchor's RHP team has worked tirelessly to include all Regional providers and ensure that they understand the purpose of the Waiver, as well as the Delivery System Reform Incentive Program (DSRIP), and how they could engage with other county government, other IGT entities and providers to create a cohesive set of DSRIP projects that truly address the Region's community health needs and overall population health objectives.

Our Region 10 Anchor facility, JPS, is a public hospital authority subject to the Open Meetings Act as well as the Texas Public Information Act. Thus, all RHP activities and committee meetings are by definition open to the public and publicly posted. Additionally, JPS has adapted its own culture of inclusiveness and provider engagement to its role as Anchor entity for the Regional DSRIP program engagement process by ensuring ease of participation for remotely located Regional stakeholders through a standard phone attendance option and the frequent use of online/phone webinars. All RHP information is publicly posted and Web-accessible.[1]

RHP Governance

Region 10 RHP's governance structure ensures all stakeholders are part of the plan development process under the leadership of the Anchor entity's RHP committee chairs. This structure, combined with an unbiased, data-driven assessment of the Region's health care needs, capacity and capabilities, has allowed stakeholders to gain a clear understanding of the Regional health care system's strengths and weaknesses rather than focusing only on those of individual provider

[1] Texas Government Code Chapter 552

systems. Figure 12 below lists each of the five RHP 10 Committees and the Chairs for each. Figure 13 below is a summary table showing Regional stakeholder representation on each committee as well as the roles of each committee. *(See Appendix E-1 for additional relevant committees detail and meeting materials, as well as a calendar listing of all meetings.)*

Figure 12: Region 10 RHP Committee Structure

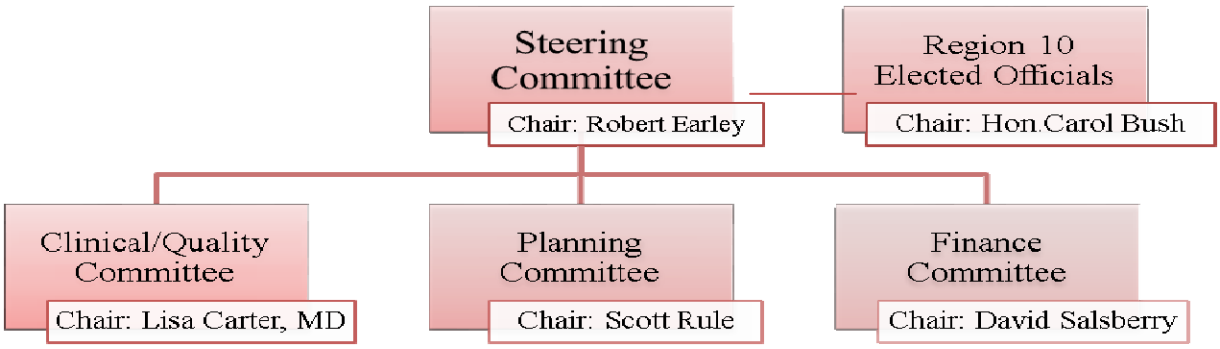


Figure 13: Region 10 RHP Committee Detail

Committee/ Work Group	Members	Role	Meeting Frequency
Region 10 RHP			
RHP Steering	CEOs of all performing providers	Final approval/review of key initiatives.	Monthly
RHP Elected Leaders	County Judges or their designee	Maintain ongoing communication/engagement with counties and county stakeholders in Region 10.	Monthly
RHP Finance	Finance officers of performing providers	Review of DSRIP projects, UC pool and IGT capacity. Development of valuation methodology.	Bi-Weekly
RHP Clinical Quality	Quality/Medical officers of performing providers	Development/review for quality metrics for DSRIP projects, as well as for learning collaboratives.	Bi-Weekly
RHP Planning	Planning officers of performing providers	Overall strategic planning and development of RHP plan, including stakeholder engagement	Bi-Weekly

All Region 10 stakeholders – performing providers, social and health care advocates, and elected officials – were warmly invited and encouraged to attend Region 10's inaugural RHP meeting in April 2012. The RHP Anchor also reached out individually to leadership at each of the Region's performing providers and county judges to secure their participation and make them aware of the purposes of DSRIP. During the initial meeting, and all subsequent meetings, Region 10's RHP team presented stakeholders with detailed presentations of information pertaining to the development of the RHP and DSRIP projects. For stakeholders unable to attend meetings either in person or electronically, the Anchor made all information available through biweekly Finance, Planning and Clinical Quality committee meeting email updates, as well as weekly RHP newsletters.

In addition to these formalized outreach and engagement processes, RHP 10 also provided ongoing individual technical assistance (TA) to performing providers to ensure each performing provider was fully supported in their DSRIP project development efforts. This TA consisted of multiple rounds of electronic and face-to-face feedback on each provider's projects submitted to the RHP, as well as one-on-one sessions with each provider's project development team. This extra level of support has been crucial in ensuring that all providers' projects met specific and evolving Waiver requirements set forth by CMS and HHSC. It also allowed for the provision of extra support to smaller providers with fewer internal project development resources and minimal or no experience in interpreting and responding to federal and state guidance.

In spite of our outreach and engagement efforts, a small number of Region 10 providers have opted out of DSRIP participation. Nonetheless, our planning efforts have been enriched with their input. *(See Appendix E-2 for a list of Region 10 providers who have opted not to participate in DSRIP.).*

RHP Steering Committee:

Region 10 RHP's steering committee provides leadership and shapes the development of the RHP. Inclusion of leadership from participating performing provider was critical to ensure the commitment of the Region's major providers. This committee's responsibilities include educating and informing all stakeholders on the purpose, intent and consequences related to the development and implementation of the RHP plan.

The RHP Steering Committee met on May 30, 2012, June 20, 2012, July 18, 2012, August 15, 201, September 19, 2012 and October 31, 2012.

RHP Elected Officials Committee:

Region 10's Elected Officials Committee's roles and responsibilities are to educate and inform constituencies and stakeholders on the purpose, intent and consequences related to the development and implementation of the Waiver, and facilitate coordination and collaboration among Region 10 stakeholders.

The Elected Officials Committee met on May 30, 2012, June 20, 2012, July 18, 2012, August 15, 201, September 19, 2012 and October 31, 2012.

RHP Finance Committee:

The Finance Committee's roles and responsibilities were to build a detailed, structurally sound and internally consistent budget (for fiscal years 2013 through 2016 of the initial term of the Waiver) that supports the Region 10 RHP plan. Secondarily, the Committee works to educate members on financial aspects of Waiver development, communicate informational requirements, develop consensus on Regional financial principles, and solicit feedback for development of position papers on Waiver financing.

The Finance Committee met on May 24, 2012, June 14, 2012, June 28, 2012, July 12, 2012, July 26, 2012, August 9, 2012, August 23, 2012, September 27, 2012 and October 11, 2012.

RHP Planning Committee:

In particular, this committee is responsible for providing technical assistance and support to performing providers during project development. Members of this Committee take lead responsibility for coordination with all other Region 10 committees.

The Planning Committee met on May 24, 2012, June 14, 2012, June 28, 2012, July 12, 2012, July 26, 2012, August 9, 2012, August 23, 2012, September 27, 2012, October 11, 2012, November 15, 2012 and December 3, 2012.

RHP Clinical & Quality Committee:

The Clinical Quality Committee's primary role and responsibility is to ensure that all DSRIP projects meet quality objective standards, are linked to patient-focused outcomes, and fully comply with Waiver quality requirements.

The Clinical & Quality Committee met on May 24, 2012, June 14, 2012, June 28, 2012, July 12, 2012, July 26, 2012, August 9, 2012, August 23, 2012, September 27, 2012, October 11, 2012, November 15, 2012 and December 3, 2012.

Learning Collaboratives

Region 10 RHP's ongoing engagement of RHP participants throughout the Waiver extends to our efforts to promote sharing of information, best practices and lessons learned through the development and implementation of learning collaboratives. Many projects in our RHP plan test innovative models of care that move away from episodic treatment toward a more integrated and coordinated approach centered on the patient's whole-person needs and health outcomes. As the Region's providers implement improvements, it is important that they learn from each other's successes and challenges, as well as identify best practices that can be widely replicated. In this way, our collective learning can accelerate transformation. We include a brief mention here in Section IV because we see the learning collaboratives as another form of ongoing stakeholder engagement and inclusion to help bring about realization of the DSRIP program's objectives.

PUBLIC ENGAGEMENT

Region 10 RHP engaged the Region beyond its provider community at every step of the RHP development plan process, connecting with each county's elected officials through emails, phone calls and in-person meetings to ensure they had a firm grasp of the purpose of DSRIP and our process of Regional engagement. County Visioning Sessions open to the general public were conducted for six of the Region's counties (Ellis, Erath, Somervell, Hood, Navarro, Johnson) to encourage local discourse regarding local health needs and DSRIP project development.

The general public has had an excellent opportunity to be fully engaged in Region 10's RHP plan development process due to the RHP's inclusionary policies and processes. Further, the proposed Region 10 Plan and all RHP materials will be posted for public comment and reviewed via a well-advertised public webinar to encourage public discourse and approval.

Building Local Support

Region 10's County Visioning Sessions brought together local leadership, stakeholders and performing providers to discuss local health care needs, resources and gaps in the current delivery system, develop a local vision and goals for health care delivery, and identify potential opportunities for county and Regional collaboration. County elected officials and their staff were asked to support planning and logistics, including identifying a venue, local stakeholders, and providers. The sessions, all of which took place during July 2012, included presentations of data about the county's needs, delivery system resources and gaps, including findings from the Stakeholder Surveys, the County Community Health Needs Assessment, and the Performing Provider Readiness Assessments. These sessions also included facilitated discussions to identify county-specific health care delivery system visions.

Public Review of the RHP Plan

The Planning Committee released the Region 10 RHP Pass 1 plan for public comment on November 2, 2012. The final RHP plan was posted online on December 6, 2012. Both plans were made publicly available on the Anchor's website for a week and were shared via email with all of Region 10's county elected officials, other participating IGT entities and performing providers.

Region 10 also conducted two public webinars on November 7, 2012 and December 12, 2012 to provide the public with an opportunity to engage in a dialogue around the RHP plan. These webinars included an overview of the 1115 Waiver, a description of the RHP development process and a presentation of projects with their associated outcomes. Public comments were accepted until December 14, 2012 and incorporated into the final plan.

Ongoing Stakeholder and Public Engagement

The Region 10 RHP Committees will continue to convene formally on at least a quarterly basis throughout the Waiver period to discuss updates and issues in Waiver implementation, in addition to engaging providers through other activities such as Learning Collaboratives. The RHP team will also send out weekly or monthly newsletters and quarterly reports to all Regional stakeholders (including performing providers and their affiliates, county officials, IGT entities, consumer advocates, and all other interested community members).

Section V. DSRIP Projects

SECTION V. DSRIP PROJECTS

A. RHP PLAN DEVELOPMENT

Region 10 RHP'S approach to developing DSRIP projects incorporated all guidance from HHSC and CMS. Specifically, our approach consisted of:

1. Identifying community needs by engaging all Regional stakeholders and developing Regional goals that focused on Regional transformation through integration and provider collaboration;
2. Sharing this information with performing providers to ensure they proposed and developed projects based on Regional needs and goals, with a particular focus on Medicaid and indigent population needs;
3. Working with performing providers to ensure that all projects were selected from the options provided in the RHP Planning Protocol;
4. Confirming that performing providers integrated each of the project categories in their efforts and valued each project based on their linked Category 3 outcome(s) and the value those outcomes have for the community *(see Subsection B on Project Valuation)*;
5. Ensuring all projects chosen by performing providers and their respective IGT entities were properly compiled into the RHP plan; and,
6. Ensuring each project was evaluated for Pass 1 inclusion consistent with the guidance of Section IV of the Program Funding and Mechanics Protocol (including successfully completed electronic workbooks).

This process continues to be refined iteratively as the RHP receives further guidance from HHSC and CMS.

Identifying Community Needs and Developing Regional Goals

Region 10 RHP identified community health needs for the Region and specific counties in the Region through extensive primary and secondary data collection efforts (described in more detail in the Methodology subsection of Section III). We organized the findings into a Community Health Needs Assessment that enabled providers to select from among the identified community need priorities and develop projects designed to address those needs. *(Please see Section III for more information about the Region's health needs, including a Summary Table of Community Health Needs for Region 10.)*

Region 10 RHP's Pass 1, 2 and 3 projects address four different types of community needs: Capacity, Access, Delivery Transformation, and Population Health *(Figure 14)*.

1. **Capacity Needs**. Critical Regional needs in this category are to expand access to primary care, high demand specialty care, and behavioral health services.

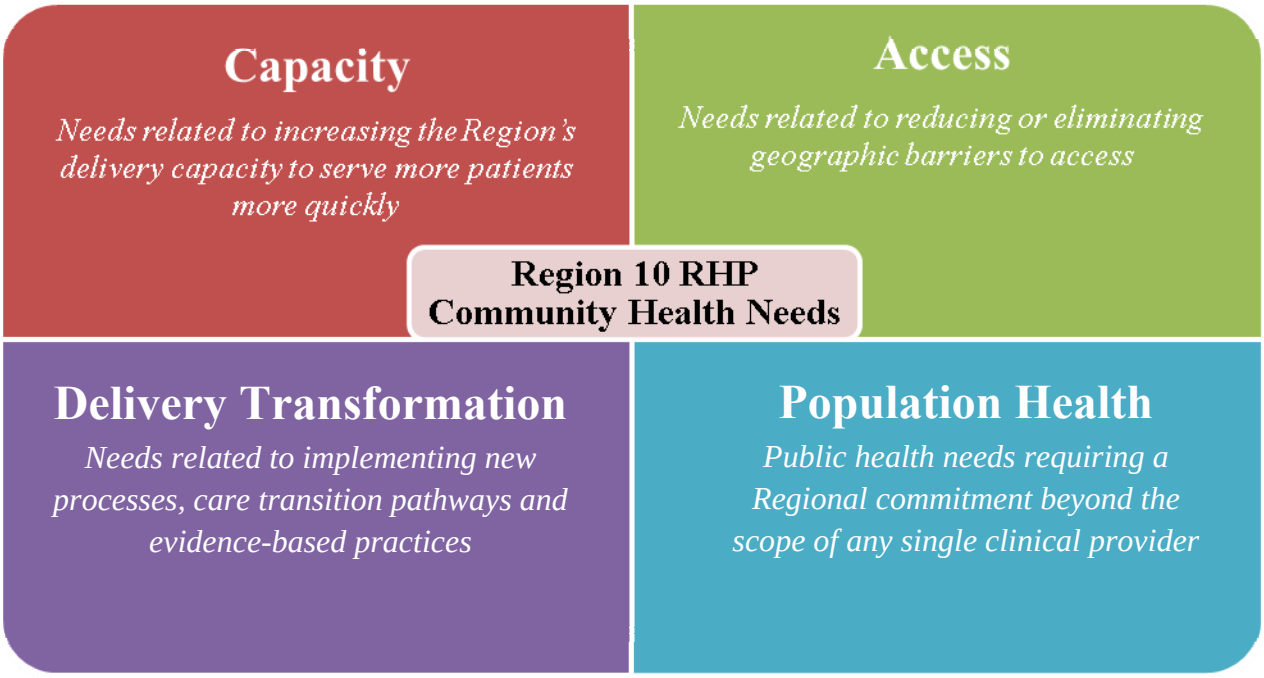
- This includes projects that allow entities to have more providers, reach out to more patients and ensure more available services.

2. **Access Needs.** Critical Regional access needs hinge on developing access to a comprehensive set of services that improves the physical, mental and social health of all the population in Region 10, regardless of insurance status, ethnicity, and income.
   - This includes developing strategies to address geographic barriers, including strategies focused on integrating mental health care into primary care settings.

3. **Delivery Transformation Needs.** System transformation will require ongoing engagement of providers across the Region to ensure improved coordination and communication to better serve patients and families.
   - This category includes projects that enable providers to work together creatively across the Region to achieve an integrated Regional care delivery system.

4. **Population Health Needs.** Addressing population health needs will require health education programs that target and appropriately engage Region 10's residents.
   - This includes creating policies and programs to engage and educate all persons living in Region 10 about how health behavior and lifestyle choices affect health status, and the role each individual plays in managing and improving their health and that of their children.

Figure 14: Categories of Identified Community Health Need



To engage all stakeholders in developing these Regional goals and the subsequent Regional plan, the RHP shared the Community Health Needs Assessment findings with performing providers, IGT entities, stakeholders and the public through RHP committee meetings, posting online, and County Visioning Sessions held in participating counties *(Please refer to Section IV for additional detail)*.

Developing and Valuing Region 10 projects

Region 10 RHP used an iterative, hands-on approach to support performing providers and IGT entities in developing and valuing Region 10 DSRIP projects. This effort included the dissemination of information, development of shared tools and templates, and ongoing one-on-one assistance to performing providers and their project teams. (*See Appendix F for a timeline of actions taken by Region 10 RHP to support DSRIP project development).*

Region 10 developed and shared a number of tools, including sample projects and project templates, to assist providers in developing appropriately targeted and valuable projects**.** The RHP team also provided numerous tools, such as crosswalks and summary tables of the DSRIP Planning protocol, to make it easy for providers to select project options and the appropriate related milestones and metrics. *(Section III provides a more detailed description of tools developed for providers to assist them in identifying community needs and understanding project options).*

The RHP team worked with providers one on one as requested through office hours, by phone and via email, serving as a central point to disseminate state protocols and information to all providers on a rolling basis. This ensured that all providers and stakeholders remains engaged in the process and received up-to-date guidance from HHSC and CMS. During the Pass 1, 2 and 3 project finalization phases, the RHP team provided another round of review and technical assistance for editing, formatting and collating projects and assisting with electronic workbook completion.

DSRIP Project Selection and Compilation

DSRIP projects were evaluated multiple times by the Region to ensure adherence to Section VI of the Program Funding and Mechanics Protocol. Given the large number of participants in Region 10, the number of projects exceeded the requirements of projects and allowed the Region 10 RHP to give providers flexibility in their valuation and how many projects they wanted to pursue.

Region 10 RHP recognized that each IGT entity had autonomy over the decision of whether or not to fund eligible projects. Therefore, the RHP worked to guide IGT entities and performing providers to select projects that met DSRIP guidance but did not interfere with IGT decision-making. Rather, the RHP encouraged each IGT entity to take the following factors into account:

- **High value for patients.** Does this project improve the patient experience, quality of care and outcomes for your patient population?

- **Meet the triple aim.** What is the project's relative impact on health care services in Region 10 and does it meet CMS's triple aim objectives?

- **Increase access to underserved populations.** What is the project's impact on various underserved populations, particularly the medically indigent and/or Medicaid populations?

- **Project design.** Is the project well-conceived and are the following components well-defined?
    - Population
    - Reasonableness of outcome
    - Specified core components
    - Is Continuous quality improvement
    - Project significance
    - Project effort level
    - Resource adequacy
    - Relevance to achieving Regional transformation goals
    - Previous funding through another federal initiative

- **Meets an identified Region 10 community health need.** Does the project address an identified priority community health need?

- **Return on investment.** In areas with more projects than available IGT, consider:
    - The relative impact of IGT commitment compared with other potential projects; and,
    - The per capita amount of IGT required (population impacted/IGT required).

- **Other considerations.** IGT entities and performing providers were also urged to consider other aspects of project eligibility:
    - Would this project be undertaken even without DSRIP dollars?
    - Size of facility/resources available to performing provider – are there stretch goals in the proposed outcomes?
    - Perceived public opinion/need for this project in your community?

Providers worked with their IGT entities to select Pass 1, 2 and 3 projects. Projects that were chosen were then compiled and incorporated into the RHP plan. Projects not chosen that were incomplete or not fully developed were sent back to performing providers. As part of the RHP's ongoing commitment to engagement and transparency, the RHP developed a draft plan which included Pass 1 projects that was publicly posted on the Anchor website from November 2 through 9, 2012, as well as widely disseminated to RHP participants. Written comments from both the public and from RHP participants were highly encouraged. In addition, the RHP held a webinar on November 7, 2012, open to the public, to share the draft plan and to collect further feedback. This webinar was recorded and the recording made publicly available online. All comments received were reviewed and incorporated into the RHP plan as appropriate.

Pass 2 and 3 allowed the providers to develop and have projects funded that were not ready or chosen during Pass 1. It also allowed the IGT entity to allocate funds to providers who were not

eligible during Pass 1. Pass 2 and 3 projects were developed, valued and final selection made using the same processes described above.

Pass 3b was offered to participating providers of Region 10 in response to the identification of three potential collaboration projects. In addition, providers were allowed to resubmit projects previously proposed but not selected due to a lack of interest, support, or IGT funding. No additional projects were proposed; the three collaborative projects were resubmitted as non-collaborative projects and funding in pass 3b.

Category 4 Exemptions in Region 10

Region 10 does not have any hospital providers that fall under the exemption for Category 4 reporting specified in Attachment J, paragraph 11.f of the Program Funding and Mechanics Protocol. However, Wise Regional Hospital and Glen Rose Medical Center may be exempt from certain measures under various domains due to small sample sizes.

Projects and Project Requirements for Region 10 (Tier 2)

Region 10 RHP is a Tier 2 Region, and thus is required to have at least 12 Category 1 and 2 projects, with a minimum of six of those 12 projects falling under Category 2. The providers in this Region, after the extensive development and review process outlined above, fully developed and submitted - 112 Category 1 and 2 projects that are linked to 207 - Category 3 outcomes -.

These -112 projects do not include the additional Category 1 and 2 projects that were considered by performing providers and their respective IGT entities, but not chosen. *(See Appendix B for a list of all projects, including those considered but not chosen.)*

PROJECT VALUATION (SECTION V.B)

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project.

As a start to developing the valuation process, the Region determined that outcome values should be based on an interpretation of the triple aim goals:

- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care

Therefore, Region 10 considered three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the health care system. For valuing the patient experience, a value was chosen and providers then rated how achieving the outcome would impact a patient's experience in life. Providers were advised to consider factors such as earning potential, transportation requirements, emotional and financial burden on caregivers, and quality and length of life. From this, a patient experience valuation for achieving the outcome was computed in a model.

In order to value improving the health of populations, a model was built that employed a similar methodology to the one above in that it asked providers to rate how achieving the outcome would impact the community. Factors considered were lost productivity, including work absence and work participation -, community safety, and reduction to societal burden (e.g., Medicaid, welfare). From this rating, a valuation of improvement to the community was computed for achieving the outcome.

The final component of the triple aim is reducing health care costs. A matrix was built that listed health care pricing factors for the outcomes chosen by performing providers and the matrix was populated with valuation numbers. For example, an inpatient admission was valued using data collected by the State of Texas. Providers multiplied the valuation amount by the number of lives impacted as a result of a successful outcome to compute the health care cost component of value.

In order to determine how to calculate the ultimate valuation, performing providers then considered the goals and structure of the Waiver. The Waiver's stated goal is to transform Texas' health care delivery system. To achieve a further goal of accelerating transformation, Region 10 concluded the Waiver was designed to create significant incentives over a relatively short time period. Accordingly, the Waiver was structured to reward providers for making investments in new/improved delivery systems through Categories 1 and 2 projects. Category 3 was ultimately structured to provide a bonus for achieving results through the investments made.

Performing providers determined an appropriate incentive for an accelerated reform process would involve a multiplier of the total annual value of the benefits provided to the patient, to the

community and to the health care system. Through discussions, performing providers also concluded the value provided by a project will usually extend beyond the population included in the direct activity of the project (the "halo effect").

The model developed by Region 10 uses a valuation for each factor of the triple aim and aggregates the annual benefit related to each Category 3 outcome for each project. Performing providers decided a five-year multiplier was needed to provide a significant incentive. The Region also chose a general 30% impact related to the halo effect.

Once the Region 10 model calculates the value of Category 3 outcomes, it then assigns prices to the Category 1 or 2 project and to the related Category 3 outcome. It assigns prices for each year's metrics, milestones, and performance outcomes based on the individual provider's choice from the range of percentages assigned to each category by the Project Funding and Mechanics Protocol.

Because the model computes value as a result of the outcomes on a per patient basis, it automatically adjusts for the size of the provider and the population impacted by a project. Accordingly, while similar projects may have different values, the variation in many cases will be directly related to population differences.

Similar projects may also have different values based on the provider's choice of the number of Category 3 outcomes, as well as the actual outcomes chosen. More Category 3 outcomes will result in additional value identified for the project, and different outcomes will have different associated values.

Finally, while similar projects may have similar values, they could still have different prices reported for DSRIP purposes. In some cases, valuations were larger than a provider's DSRIP allocation. Providers then made decisions to "discount" the valuations to a reduced price in order to include the project in the Region's plan.

While a model was developed by the Anchor for use by all providers, it was also possible for providers to compute a valuation with other models. Some larger providers employed health economists and created more complex computations. In order to simplify valuation, some providers may have decided not to use all possible value factors that could be applied to a given outcome. However, all Region 10 providers used the same general concept of economic value assigned to outcomes developed at the Regional level.

Category 1: Infrastructure Development

Project Summary

Project Option – 1.1.1 – Establish more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)

Unique Project ID: 021184901.1.1
Performing Provider Name/TPI: Cook Children's Medical Center / 021184901

Provider: Cook Children's Health Care System is the country's leading integrated pediatric health care delivery network. Based in Fort Worth, Texas, the not-for-profit organization includes a Medical Center (448 beds), Physician Network (297 pediatric specialists), Northeast Hospital, Pediatric Surgery Center, Home Health company, Health Plan (105,000 Medicaid and CHIP covered lives) and Health Foundation. The System has a six-county primary service area that represents 86% of its total volume covering 4,711 miles^2. It also provides tertiary and quaternary pediatric medical care to 122 counties in west and north central Texas, covering 257,086 miles^2 and to out-of-state patients. The system has more than 1 million patient encounters per year across the continuum of pediatric care. Cook Children's Health Plan covers 105,000 Medicaid and CHIP lives within the Tarrant Service Area. The System provided $3.1 million in true charity care in 2011. 57.4% of the System's patient care is provided to Medicaid, Medicaid Managed Care and CHIP beneficiaries.
Intervention: This project establishes another pediatric primary care clinic in an area where 42% of the families are below 200% of the Federal Poverty Level – specifically to establish a pediatric medical home and provide an alternative to the use of inappropriate sites for primary pediatric care [e.g., ERs]. If approved, this expands the network of Cook Children's pediatric neighborhood clinics by 1, from 5 sites to 6 sites.
Need for the project: Cook Children's already self-funds five neighborhood pediatric clinics and zip code 76119 [Forest Hill section of SE Fort Worth] is demonstrably the next most needy / underserved area for pediatric primary care, that demonstrates the highest use of the ER for pediatric primary care services and has a large enough patient population to support an additional clinic. CMS funding would allow a sixth clinic to be built.
Target population: Children ages 0 – 14 who live in zip code 76119 – a total of 12,445 children expected to grow to 13,699 by 2016. The estimated number of children served over the course of the waiver is 6,220 – 6,850 who previously had no pediatric primary care medical home. This project increases a Medicaid / uninsured population of children's access to pediatric primary care, reducing the use of the ER for primary care, lowering the cost of care and improving their overall health.
Expected patient benefits: Cook Children's expects to build a new clinic building, hire and train physicians and staff to provide pediatric primary care to the children in zip code 76119. By establishing a pediatric medical home, these children's families will reduce their use of the ER for pediatric primary care.

Project Option – 1.1.1 – Establish more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)

Unique Project ID: 021184901.1.1
Performing Provider Name/TPI: Cook Children's Medical Center / 021184901

Project Description:
A Cook Children's pediatric neighborhood clinic is a freestanding pediatric practice built in a neighborhood identified as having inadequate access to primary care for children. The practice is staffed with doctors and other clinical and support staff to help maintain health and promote healing for children from birth through the teen years, including well-child examinations, vaccines, sick visits, behavior problems and learning disorders. If a child has a chronic illness, the clinic provides a medical home to coordinate complex care among other Cook Children's providers. Ninety-two percent of Cook Children's Pediatric Neighborhood Clinic patients are Medicaid beneficiaries.[2]

The specific geographic area of need has been identified in a separate analysis. ZIP code 76119 located in the Forest Hill section of Southeast Fort Worth (inside the 820 Loop) was identified as having the greatest quantifiable community need for improved access to primary care that also has sufficient population to support a new practice. Thus, the project begins with locating a site within that designated area and continuing through construction. The building's design/development is based upon detailed construction documents and certificate of occupancy.

Goals and Relationship to Regional Goals:

Project Goals:
The purpose of this project is to expand primary care and medical home access to an identified population that is currently underserved and achieve the following goals:

1. Expand pediatric primary care capacity by constructing a new primary care clinic;
2. Expand primary care providers by hiring physician, nursing and support staff; and,
3. Reduce the burden of providing primary care in potentially inappropriate settings.

This project meets the following Regional goals:
This project meets a number of Regional goals which are aligned with the goals of the Waiver and CMS' triple aim. Specifically, by adding one additional neighborhood clinic, this project will improve the health of children in the designated area, which in turn improves their quality of life and ability to reach their full potential in the community. In addition, providing appropriate

[2] Cook Children's internal document: "Neighborhood Clinic Impact," May 18, 2012.

primary care in the appropriate setting will improve health outcomes while lowering health care cost for the Region due to decreased emergency department use for primary care.

Challenges:
Twelve percent of children in families whose household income falls below 200% of the federal poverty level and who live in five of the Region 10 counties do not have a primary care doctor. That makes them 3.0 times less likely to have a medical home. Nineteen percent of these parents report it is 2.1 times more difficult to access primary care services than the general population. This produces a population of children who are 2.4 times less likely to have seen a doctor or health care professional in the past year and 4.3 times less likely to have received all the medical care needed.[3] There is a clearly defined need for improved access to primary care for these children.

5-Year Expected Outcome for Provider and Patients:
Expand pediatric primary care capacity and providers for an estimated 26,480 pediatric primary care visits over three years through a new pediatric clinic facility constructed in an identified underserved area. There will be a demonstrable decrease in the use of Cook Children's Medical Center Emergency Department for primary care by patients who reside within this underserved area. This is based upon Cook Children's experience between 2005 and 2011 where the ratio of ED visits and pediatric neighborhood clinic [NHC] visits was 80% ED and 20% NHC in 2005. With five pediatric NHCs operational in 2011 that ratio is now 56% ED and 44% NHC.

Starting Point/Baseline:
Establishing a new pediatric primary care practice site begins with locating a site within that designated area, constructing the clinic building, staffing and opening the clinic and sustaining operations.

To operationalize the clinic, new providers and support staff will be hired and trained prior to opening in order to successfully sustain operations. The average Cook Children's pediatric neighborhood clinic is staffed by four providers, eight clinical support staff and six nonclinical support staff – 18 total staff members.

Based upon historical data of the first 12 months of operation and subsequent growth from five-previous pediatric neighborhood clinic operations in demographically similar neighborhoods identified based on need, internal quarterly operations reports: once open, the pediatric neighborhood clinic should see approximately 8,000 patient visits in its first 12 months of

"Comparative Health Access Issues for Children 0 – 14
Denton, Hood, Johnson, Parker, Tarrant and Wise Counties Texas"
Community-wide Children's Health Assessment and Planning Survey [CCHAPS]: "2008 Parent Survey Report."

operation, grow at a rate of 10% per year and peak at 9,680 patient visits in the last year of the Waiver period.

Rationale:
Cook Children's has more than seven years of experience starting and sustaining pediatric neighborhood clinics, presently operating five locations inside the 820 Loop in Fort Worth, Texas. A specific study of was conducted in February, 2012 to quantitatively identify the zip code with the greatest community need for improved primary care access. The criteria used were: the ZIP codes with the greatest population of families with children, whose median household income was at or below 100% of the federal poverty level, and whose use of the emergency department for primary care was the greatest. Sociocultural factors were also examined.[4] ZIP code 76119, located in the Forest Hill section of Southeast Fort Worth (inside the 820 Loop), was identified as having the greatest quantifiable community need for improved access to primary care that also has sufficient population to support a new practice. ZIP code 76119 has an ages 0-14 aged population of 12,445 and is expected to grow to 13,699 by 2016 (a 9.8% growth rate over five years). In 24.6% of the households, the an annual income is below $15,000. In 17.6% of households income is between $15,000 and $25,000 – compared to the U.S. averages of 12.9% and 10.8%, respectively. Depending upon family size, this suggests that 42.0% of these families are below 200% of the federal poverty level. Demographically, 46.1% of the population is Black – Non-Hispanic and 38.7% Hispanic.[5]

A significant portion of the population ages 0 -14 years will make the Cook Children's pediatric neighborhood clinic their medical home, improving their access to primary and preventive care, increasing the likelihood a child will see a pediatrician every 12 months, receiving the medical care needed, and reducing their dependence on the emergency department as a source of primary care.

Project Components:
While no core components are required, the core activities for the project include (1) construction, (2) hiring and training provider and support staff, (3) incrementally increasing the number of pediatric primary care visit in the selected area and (4) reducing the burden on hospital emergency departments to provide pediatric primary care.
By adding a new primary care practice within a neighborhood that has an identified need, the number of pediatric primary care clinic is expanded by one, the number of primary care providers are increased by 4 (3 pediatric, primary care physicians and 1 pediatric nurse practitioner, plus an additional 14 non-physician staff, providing jobs within the neighborhood served, increasing the number of pediatric primary care visits in an appropriate setting by an

[4] Cook Children's internal document: "Determining the community need for another Pediatric Neighborhood Clinic," March 1, 2012.
[5] Thomson Reuters – Claritas Demographic Expert 2.7.

estimated 10,000 visits annually and reducing the burden of providing primary care in otherwise potentially inappropriate sites of care.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.10 – Overuse of emergency department (ED) services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The concept of the medical home has evolved since introduction of the terminology by the American Academy of Pediatrics in 1967, which was envisioned at the time as a central source for all the medical information about a child.[6] That evolution has placed the medical home model as the universally acknowledged best practice for improving access to primary and preventive care for children, both of which will be expanded and enhanced by this project.

Related Category 3 Outcome Measures:

IT-9.2 ED appropriate utilization.

Outcome Measures and Reasons/Rationale For Selecting The Outcome Measures:
The new pediatric neighborhood primary care clinic will provide a primary care medical home for children ages 0-14 who live in ZIP 76119 reducing the number of inappropriate visits to the Cook Children's Medical Center emergency department.

Numerator: The number of visits to the Cook Children's pediatric neighborhood clinic whose residents have a 76119 ZIP code.
Denominator: The number of visits to the Cook Children's ED with a triage level of 4 or 5, i.e., primary care for children ages 0 -14 who live in ZIP code 76119.

Improvement target: The ratio of NHC visits to ED visit for primary care will show a ratio>1.0 which improves by 10% per year for each demonstration year

Relationship to Other Projects:
RHP Project ID: 021184901.1.2 Establish more primary care clinics (Develop one additional pediatric urgent care center to provide after-hours care)
RHP Project ID: 021184901.1.3 Establish more primary care clinics (Develop a new pediatric dental clinic)

[6] Palfrey, J. (2006-10-31). *Child health in America: Making a difference through advocacy*. ISBN 978-0-8018-8453-5

Beyond a pediatric primary care practice, there are other related primary care services that can complement that practice such as after-hours urgent care and dental care.

Related Category 4 Population-focused improvements:

1. Potentially preventable admissions,
    a. Bacterial pneumonia immunization – pediatric primary care is the best site to assure children receive immunization appropriate for their age.
    b. Influenza immunization – pediatric primary care is the best site to assure children receive immunization appropriate for their age.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Valuation assumes the NHC will enroll 6,000 pediatric patients in the 76119 ZIP code that are at high-risk for lack of primary care services. The project forecasts an inverse relationship between ED visits and primary care visits, with a forecasted 10% decrease in ED visits per year from 76119, once the clinic is established. Annual pediatric emergency department visits from 76119 are 1,700 visits per year. The result of the decrease in ED visits also assumes a corresponding decrease in Medicaid and/or other governmental funding sources for high-cost services in the ED. The cost per ED visit, established by the Region 10 Anchor hospital, is $1,200 per visit. The project also assumes that increased access to primary care results in decreased hospital admissions. Cook Children's currently experiences an 11.4% ED admit rate. On average, a Cook Children's pediatric admission costs $28,475.

021184901.1.1	1.1	1.1	Establish more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)	
Cook Children's Medical Center				021184901
Related Category 3 Outcome Measure(s):	*021184901.3.1*	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]: Establish additional primary care clinic (pediatric). Metric 1 [P-1.1]: One additional clinic Goal: 1 Data Source: Administrative documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $$1,225,921 **Milestone 2** [P-5]: Train/hire additional primary care providers and staff (pediatric). Metric 1 [P-5.1]: Documentation of increased number of providers and staff Goal: 3 pediatric physician providers, 1 pediatric nurse practitioner and 14 non-provider support staff Data Source: Administrative documentation Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,225,920	**Milestone 3** [I-12]: Increase primary care clinic visits Metric 1 [I-12.2]: Documentation of increased number of patients and patient visits Goal: 8,000 visits Data Source: Administrative documentation Milestone 3 Estimated Incentive Payment: $2,507,650		**Milestone 4** [I-12]: Increase primary care clinic visits Metric 1 [I-12.2]: Documentation of increased number of patients and patient visits Goal: 10% increase in visits from 8,000 visits to 8,800 visits Data Source: Administrative documentation Milestone 4 Estimated Incentive Payment: $2,682603	**Milestone 5** [I-12]: Increase primary care clinic visits Metric 1 [I-12.2]: Documentation of increased number of patients and patient visits Goal: 10% increase in visits from 8,800 visits to 9,680 visits Data Source: Administrative documentation Milestone 5 Estimated Incentive Payment: $2,216,061

021184901.1.1	1.1	1.1	Establish more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)	
Cook Children's Medical Center				021184901
Related Category 3 Outcome Measure(s):	*021184901.3.1*	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)**
Year 2 Estimated Milestone Bundle Amount: $2,451,841	Year 3 Estimated Milestone Bundle Amount: $2,507,650		Year 4 Estimated Milestone Bundle Amount: $2,682,603	Year 5 Estimated Milestone Bundle Amount: $2,216,061
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*):* $9,858,155				

Project Summary

Project Option 1.1.1 – Expand Primary Care Capacity [Develop one additional Cook Children's pediatric urgent care clinic]

Unique Project ID: 021184901.1.2
Performing Provider Name/TPI: Cook Children's Medical Center / 021184901

Provider: Cook Children's Health Care System is the country's leading integrated pediatric health care delivery network. Based in Fort Worth, Texas, the not-for-profit organization includes a Medical Center (448 beds), Physician Network (297 pediatric specialists), Northeast Hospital, Pediatric Surgery Center, Home Health company, Health Plan (105,000 Medicaid and CHIP covered lives) and Health Foundation. The System has a six-county primary service area that represents 86% of its total volume covering 4,711 miles^2. It also provides tertiary and quaternary pediatric medical care to 122 counties in west and north central Texas, covering 257,086 miles^2 and to out-of-state patients. The system has more than 1 million patient encounters per year across the continuum of pediatric care. Cook Children's Health Plan covers 105,000 Medicaid and CHIP lives within the Tarrant Service Area. The System provided $3.1 million in true charity care in 2011. 57.4% of the System's patient care is provided to Medicaid, Medicaid Managed Care and CHIP beneficiaries.
Intervention: This project establishes another pediatric urgent care clinic in an area where 14% of the families, regardless of household income rate access to urgent care as "difficult." At the same time 40% of visits to the Cook Children's Medical Center ER have an initial care assessment of non-emergent or urgent. This project seeks to reduce the use of inappropriate, and arguably more costly, sites of care for pediatric urgent care [e.g., ERs]. If approved, this expands the network of Cook Children's urgent care clinics by 1, from 2 sites to 3 sites.
Need for the project: Cook Children's already self-funds two pediatric urgent care clinics. A specific location will be determined from a demonstrated need in combination with the highest use of the ER for pediatric urgent care services to be conducted in demonstration year 2. CMS funding would allow a third urgent care clinic to be built.
Target population: Children ages 0 – 14 who live in some yet to be determined part of Tarrant County where the population is 424,416 children and is expected to grow to 4664,102 99 by 2016. The estimated number of children served over the course of the waiver is reflected by and estimated 16,800 patient visits in demonstration years 4 and 5. This project increases a Medicaid / uninsured population of children's access to pediatric urgent care, reducing the use of the ER for urgent care, lowering the cost of care and improving their overall health.
Expected patient benefit: Cook Children's expects to build a new clinic building, hire and train physicians and staff to provide pediatric urgent care to the children in a yet to be determined part of Tarrant County so children's families will reduce their use of the ER for pediatric urgent care.

Project Option 1.1.1 – Expand Primary Care Capacity [Develop one additional Cook Children's pediatric urgent care clinic]

Unique Project ID: 021184901.1.2
Performing Provider Name/TPI: Cook Children's Medical Center / 021184901

Project Description:
Cook Children's currently operates two pediatric urgent care clinics which are freestanding pediatric practices that see children with one-time urgent needs when their regular doctor isn't available. Urgent care services include: tummy ache, fever, bone fractures, sprains, burns, cuts, sports injury, minor accidents, rash, insect bites, minor animal bites or scratches, asthma, allergy, bronchitis, croup, colds, flu, sore throat, strep throat, foreign object removal (marbles, peas, beans and other interesting things), anything that makes mom or dad worry.

A third Cook Children's pediatric urgent care clinic will be built in an area yet to be determined based upon the need defined by that area's use of the Cook Children's ED as a source of primary and urgent care after regular physician offices are closed or otherwise inaccessible. In addition to the underserved, the designated target population will include children whose families are Medicaid and CHIP eligible.

Goals and Relationship to Regional Goals:

Project Goals:
Based upon the findings of the 2008 Community-wide Children's Health Assessment and Planning Survey, parents rate access to pediatric urgent care services the next highest priority behind pediatric primary and preventive care.[7]

The purpose of this project is to expand pediatric urgent care access to a population that is currently underserved and achieve the following goals:

- Expand pediatric urgent care capacity by constructing a new urgent care clinic;
- Expand urgent care providers by hiring physician, nursing and support staff; and,
- Reduce the burden of providing urgent care in potentially inappropriate settings.

This project meets the following Regional goals:
This project meets a number of Regional goals, which are aligned with the goals of the Waiver and CMS' triple aim. Specifically, by adding one additional urgent care clinic, this project will improve the health of children in the designated area, which in turn improves their quality of life and ability to reach their full potential in the community. In addition, providing appropriate

[7] Community-wide Children's Health Assessment and Planning Survey [CCHAPS] 2008: 2008 Parent Survey Report. www.cchaps.org.

urgent care in the appropriate setting will improve health outcomes while lowering health care cost for the Region due to decreased emergency department use for urgent care.

By adding a new pediatric urgent care clinic within an area that has an identified need, the number of primary care/urgent care medical providers is increased – including non-physician staff, providing jobs within the neighborhood served, and reducing the burden of providing urgent care in otherwise potentially inappropriate sites of care.

Challenges:
Regardless of household income, 14% of children in families who live in five of the Region 10 counties rank access to urgent care as difficult.[8] At the same time, 40% of the visits to the Cook Children's Medical Center emergency department have an initial care assessment of non-emergent or urgent.[9] These care levels suggest that a more appropriate site of care is a pediatric primary care office or a pediatric urgent care clinic.

5-Year Expected Outcome for Provider and Patients:
The pediatric urgent care clinic is in the early phase of design development. It still requires site selection, property acquisition and construction which will not be completed until the latter part of demonstration year 2. As totally new construction, the pediatric urgent care will not begin seeing its first patients until demonstration year 4.

Starting Point/Baseline:
Based upon historical data of the first 12 months of operation and subsequent growth from previous pediatric urgent care clinics, the new pediatric urgent care clinic is expected to follow the same growth in patient visits as other UCCs in the Cook System—approximately 8,000 patient visits in the first 12 months of operation and growth rate of 10% per year for a total of 16,800 urgent care visits in the last two years of the Waiver period.

Rationale:
Cook Children's has more than seven years of experience starting and sustaining pediatric urgent care centers, presently operating two within Tarrant County.

Tarrant County is identified as having the greatest quantifiable community need for improved access to pediatric urgent care that also has sufficient population to support additional and new Service. Tarrant County has an ages 0-14 population of 424,416 which is expected to grow to 464,102 by 2016 (a 9.4% growth rate over five years). Twenty-four percent of the households have an annual income below $25,000 and another 17.6% between $15,000 and $25,000 –

[8] "Comparative Health Access Issues for Children 0 -14
Denton, Hood, Johnson, Parker, Tarrant and Wise Counties Texas"
Community-wide Children's Health Assessment and Planning Survey [CCHAPS]: "2008 Parent Survey Report."
[9] Cook Children's internal document: "2012 Master Facility Plan Update." July 10, 2012.

compared to the U.S. averages of 12.9% and 10.8% respectively. Depending upon family size, this suggests that 42.0% of these families are below 200% of the federal poverty level. Demographically, 13.6% of the population is Black – Non-Hispanic and 29.6% Hispanic.[10]

Those seeking pediatric urgent care approximate the same payer mix as those seeking care in the Cook Children's Medical Center emergency department – 64.7% government payer, which is overwhelmingly Medicaid.[11]

Project Components:
While no core components are required, the core activities for the project include (1) construction, (2) hiring and training provider and support staff, (3) incrementally increasing the number of pediatric urgent care visit in Tarrant County and (4) reducing the burden on hospital emergency departments to provide pediatric urgent care.

By adding a new pediatric urgent care practice in an area that has an identified need, the number of pediatric urgent care clinics is expanded by one, the number of urgent care providers are increased by seven pediatric, urgent care physicians, plus an additional 21 non-physician staff, providing jobs within the area served, increasing the number of pediatric urgent care visits in an appropriate setting by an estimated 10,000 visits annually and reducing the burden of providing urgent care in otherwise potentially inappropriate sites of care.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.10 – Overuse of emergency department (ED) services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The proliferation of freestanding urgent care centers speaks to the concept's universal acceptance as a best-practice. By applying this standard to children's urgent care access for children will improve.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
IT-9.2 ED appropriate utilization.

[10] Thomson Reuters – Claritas Demographic Expert 2.7 and the North Texas Council of Government Tarrant 2010 Report.
[11] Cook Children's internal document: "CCMC Payer Mix by Patient Type, calendar year to date at June 30, 2012."

The new pediatric urgent care clinic will provide a service for children ages 0-14 when their regular physician is not available thereby reducing the number of inappropriate visits to the Cook Children's Medical Center emergency department.

Numerator: The number of visits to the Cook Children's pediatric urgent care clinic whose residence is in the identified service area – to be determined in DY2.
Denominator: The number of visits to the Cook Children's ED with a triage level of 4 or 5, i.e., primary care for children ages 0-14 who live in that identified service area.
Improvement target: The ratio of Urgent Care visits to ED visits for urgent care will show a ratio >1.0 which improves by 10% per year for each demonstration year.

Relationship to Other Projects:
RHP Project ID: 021184901.1.1 Establish more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)

Beyond a pediatric urgent care practice, another related pediatric primary care clinic can complement the urgent care practice by serving as a referral destination for pediatric urgent care patients who need a pediatric primary care medical home.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Valuation assumes the urgent care clinic will treat 8,000 pediatric patients per year in the 76119 ZIP code that are at high risk for lack of urgent care and/or primary care services. The plan projects a 10% decrease in ED visits per year, once the clinic is established. Annual pediatric emergency department visits from 76119 are 1,700 visits per year. The result of the decrease in ED visits also assumes a corresponding decrease in Medicaid and/or other governmental funding sources for high-cost services in the ED. The cost per ED visit, established by the Region 10 Anchor hospital, is $1,200 per visit. We estimate a decrease of 170 ED visits per year from the 76119 ZIP code. The project also assumes that increased access to Urgent Care services will result in decreased hospital admissions. Cook Children's currently experiences an 11.4% ED admit rate. We estimate a decrease of 19 inpatient admissions from the 76119 ZIP code. On average, a Cook Children's pediatric admission costs $28,475. Note: the 76119 ZIP code is used in this analysis for modeling purposes, since there is a demonstrated community need in that

area. The urgent care center will likely have a wider geographic base and Cook Children's plans to locate this center in an area that is most likely to meet the underserved needs of the broader Tarrant County area.

021184901.1.2	**1.1.1**		Expand Primary Care Capacity [Develop one additional Cook Children's pediatric urgent care clinic]	
Cook Children's Medical Center				021184901
Related Category 3 Outcome Measure(s):	*021184901.3.2*	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]: Establish additional urgent care clinic (pediatric). Metric 1 [P-1.1]: One additional pediatric urgent care clinic Goal: 1 Data Source: Administrative documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,133,286	**Milestone 2**[P-1]: Establish additional urgent care clinic (pediatric). Metric 1 [P-1.1]: One additional pediatric urgent care clinic Goal: 1 Data Source: Administrative documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,090,922 **Milestone 3** [P-5]: Train/hire additional primary care / urgent care providers and staff (pediatric). Metric 1 [P-5.1]: Documentation of increased number of providers and staff Goal: 7 pediatric physician providers and 21 non-provider support staff Data Source: Administrative documentation Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,090,922		**Milestone 3** [I-12]: Increase urgent care clinic visits Metric 1 [P-12.2]: Documentation of increased number of patients and patient visits Goal: 8,000 visits Data Source: Administrative documentation Milestone 3 Estimated Incentive Payment: $2,334,066	**Milestone 4** [I-12]: Increase urgent care clinic visits Metric 1 [P-12.2]: Documentation of increased number of patients and patient visits Goal: 10% increase in visits from 8,000 visits to 8,800 visits Data Source: Administrative documentation Milestone 4 Estimated Incentive Payment: $1,928,142

021184901.1.2	**1.1.1**		Expand Primary Care Capacity [Develop one additional Cook Children's pediatric urgent care clinic]	
Cook Children's Medical Center				021184901
Related Category 3 Outcome Measure(s):	*021184901.3.2*	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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,133,286	Year 3 Estimated Milestone Bundle Amount: $2,181,844		Year 4 Estimated Milestone Bundle Amount: $2,334,066	Year 5 Estimated Milestone Bundle Amount: $1,928,142
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $8,577,338				

Project Summary

Project Option – 1.8.6 –Increase, Expand and Enhance Oral Health Services (Establish one new Cook Children's Pediatric Dental Clinic.)

Unique Project ID: 021184901.1.3
Performing Provider Name/TPI: Cook Children's Medical Center / 021184901

Provider: Children's Health Care System is the country's leading integrated pediatric health care delivery network. Based in Fort Worth, Texas, the not-for-profit organization includes a Medical Center (448 beds), Physician Network (297 pediatric specialists), Northeast Hospital, Pediatric Surgery Center, Home Health company, Health Plan (105,000 Medicaid and CHIP covered lives) and Health Foundation. The System has a six-county primary service area that represents 86% of its total volume covering 4,711 miles^2. It also provides tertiary and quaternary pediatric medical care to 122 counties in west and north central Texas, covering 257,086 miles^2 and to out-of-state patients. The system has more than 1 million patient encounters per year across the continuum of pediatric care. Cook Children's Health Plan covers 105,000 Medicaid and CHIP lives within the Tarrant Service Area. The System provided $3.1 million in true charity care in 2011. 57.4% of the System's patient care is provided to Medicaid, Medicaid Managed Care and CHIP beneficiaries.
Intervention: This project establishes a pediatric dental clinic in an area where the families ranked access to pediatric dental care as one of the top five priorities. 42% of the Tarrant County population is below 200% of the Federal poverty level. Tarrant County is the only site in the region that has both the need and the population base to support a full-time (5 day per week) dental clinic. This project seeks to reduce the use of inappropriate, and arguably more costly, sites of care for pediatric dental care [e.g., operating rooms]. If approved, this the first dental clinic provided by Cook Children's.
Need for the project: A specific location will be determined from a demonstrated need in combination with the highest use of the OR for pediatric services to be conducted in demonstration year 2. CMS funding would allow a first ever pediatric dental clinic to be built.
Target population: Children ages 0 – 14 who live in some yet to be determined part of Tarrant County where the population is 424,416 children and is expected to grow to 4664,102 99 by 2016. The estimated number of children served over the course of the waiver is estimated to be 5,000 to 5,500 in demonstration years 4 and 5. project increases a Medicaid / Uninsured population of children's access to pediatric dental care, reducing the use of the OR for dental care, lowering the cost of care and improving their overall health.
Expected patient benefit: Cook Children's expects to build a new clinic building, hire and train a dentist and staff to provide pediatric dental care to the children in a yet to be determined part of Tarrant County and reduce the use of the OR for pediatric dental care.

Project Option – 1.8.6 –Increase, Expand and Enhance Oral Health Services (Establish one new Cook Children's Pediatric Dental Clinic.)

Unique Project ID: 021184901.1.3
Performing Provider Name/TPI: Cook Children's Medical Center / 021184901

Project Description:
Cook Children's has never had a pediatric dental clinic; however, the need is clearly defined. Based upon the findings of the 2008 Community-wide Children's Health Assessment and Planning Survey, parents rate access to pediatric dental care in the top five access priorities.[12] Dental care has a large impact upon children's general health. Instead of performing dental surgery on children, it would be preferable to address children's preventive dental care. Based on the success of Cook Children's led community collaborations – Children's Oral Health Coalition and Save a Smile – and coupled with the CHNA results and the Cook Children's Promise, it is time to begin to become more directly involved in dental care for children.

Early design elements for a pediatric dental clinic include four dental treatment rooms staffed by a pediatric dentist with dental and supportive staff to provide routine preventive examinations and restorative dental care. The pediatric dental clinic is expected to provide a different service to a population of children ages 0-14 in a yet to be defined geographic area. That definition will specifically include patients whose families are Medicaid- or CHIP eligible and demonstrable underserved.

Goals and Relationship to Regional Goals:

Project Goals:
The purpose of this project is to expand pediatric dental care access to a population that is currently underserved and achieve the following goals:

- Expand pediatric dental care capacity by constructing a new dental clinic.
- Expand dental care providers by hiring a dentist and support staff.
- Reduce the burden of providing dental care in potentially inappropriate settings, i.e., out-patient surgery.

This project meets the following Regional goals:
This project meets a number of Regional goals, which are aligned with the goals of the Waiver and CMS' triple aim. Specifically, by adding a new pediatric dental clinic, this project will improve the health of children in the designated area, which in turn improves their quality of life and ability to reach their full potential in the community. In addition, providing appropriate

[12] Community-wide Children's Health Assessment and Planning Survey [CCHAPS] 2008: 2008 Parent Survey Report www.cchaps.org.

dental care in the appropriate setting will improve health outcomes while lowering health care cost for the Region due to decreased operating room use for dental care.

By adding a new pediatric dental care clinic within an area that has an identified need, the number of pediatric dental providers is increased – including non-dentist staff– providing jobs within the neighborhood served, reducing the burden of providing dental care in otherwise potentially inappropriate sites of care, and specifically targeting children who otherwise would not see a dentist.

Challenges:
Seventeen percent of the parents of children in families whose household income is below 200% of the federal poverty level rank access to dental care as difficult – twice that of all other families.[13] When that is viewed in the context of an average of 34.8% of children ages 2-8 enrolled in Medicaid not receiving at least one dental checkup during fiscal year 2010,[14] there is a clearly defined need for improved access to both pediatric urgent care and pediatric dental care for these children.

5-Year Expected Outcome for Provider and Patients:
Cook Children's has never had a freestanding pediatric dental clinic; however, the need is clearly defined. Early design elements for a pediatric dental clinic include four dental treatment rooms staffed by a pediatric dentist with dental and supportive staff to provide routine preventive examinations and restorative dental care. The pediatric dental clinic is expected to provide a different service to the same population as pediatric primary care clinics.

The pediatric dental clinic is in design development. It requires site selection, acquisition and construction that will not be completed until the latter part of demonstration year 2. As a totally new construction, the pediatric dental clinic will not begin seeing its first patients until demonstration year 4. It is expected that these patients' dental needs are not being adequately met within the present scope of community dental services.

Starting Point/Baseline:
As a new service, Cook Children's current dental patient visit baseline is zero. Establishing a new pediatric dental care site begins with locating a site within a specifically identified area of need, constructing the clinic building, staffing and opening the clinic and sustaining operations. A preliminary pro forma estimates that the pediatric dental clinic would see approximately 5,500

[13] "Comparative Health Access Issues for Children 0 -14
Denton, Hood, Johnson, Parker, Tarrant and Wise Counties Texas"
Community-wide Children's Health Assessment and Planning Survey [CCHAPS]: "2008 Parent Survey Report."
[14] Texas Health and Human Services: "A report on service utilization of Texas Healthy Steps dental checkup – State fiscal year 2010."

dental visits in its first 12 months of operation – demonstration year 4. It will grow at a 10% rate the following year for a two year total of 11,550 pediatric dental visits in the last two years of the Waiver period.

Rationale:
Dental care has a large impact upon children's general health. Instead of performing dental surgery on children, it would be preferable to address children's preventive dental care. Based on the success of Cook Children's-led community collaborations – Children's Oral Health Coalition and Save a Smile – and coupled with the CHNA results and the Cook Children's Promise, it is time to begin to become more directly involved in dental care for children.

Based upon the findings of the 2008 Community-wide Children's Health Assessment and Planning Survey, parents rate access to pediatric dental care in the top five access priorities.[15]

Tarrant County is identified as having the greatest quantifiable community need for improved access to pediatric urgent care that also has sufficient population to support additional a new dental service. Tarrant County an ages 0-14 population of 424,416, which is expected to grow to 464,102 by 2016 (a 9.4% growth rate over five years). In 24% of the households, annual income is below $25,000 and in another 17.6%, between $15,000 and $25,000 – compared to the U.S. averages of 12.9% and 10.8% respectively. Depending upon family size, this suggests that 42.0% of these families are below 200% of the federal poverty level. Demographically, 13.6% of the population is Black – Non-Hispanic and 29.6% Hispanic.[16]

Project Components:
While no core components are required, the core activities for the project include (1) construction, (2) hiring and training provider and support staff, (3) incrementally increasing the number of pediatric dental care visit in Tarrant County and (4) reducing the burden on hospital operating rooms to provide pediatric dental care.

Dental care has always been provided by freestanding dentists, which must be considered a best-practice. By applying this standard to children's dental care access for children will improve.

By adding a new pediatric dental practice in an area that has an identified need, the number of pediatric dental clinics is expanded by one, the number of dental providers are increased by one pediatric dentist – plus an additional 10.5 non-physician staff, providing jobs within the area served, increasing the number of pediatric dental visits in an appropriate setting by an estimated 6,000 visits annually, and reducing the burden of providing dental care in otherwise potentially

[15] Community-wide Children's Health Assessment and Planning Survey [CCHAPS] 2012: "2012 Parent Survey Report" to be published October 9, 2012.
[16] Thomson Reuters – Claritas Demographic Expert 2.7 and the North Texas Council of Government Tarrant 2010 Report.

inappropriate sites of care.

Unique community need identification numbers the project addresses:

- CN.6 – Lack of access to dental care.

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

By creating a new pediatric dental clinic within an area that has an identified need, the number of dental providers is increased – including non-dentist staff – providing jobs within the neighborhood served, and reducing the burden of providing dental care in otherwise potentially inappropriate sites of care.

By creating a pediatric dental care clinic, access to dental care for children will measurably improve. Providing early preventive dental care will reduce the need for restorative and emergency dental care will be reduced, decreasing caries-related treatment costs.[17]

Related Category 3 Outcome Measures:

IT-7.2 Cavities: Percentage of children with untreated dental caries

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
The new pediatric dental care clinic will provide a service for children ages 0-14 thereby reducing the number of children with untreated dental caries.

Numerator: The number of visits to the Cook Children's pediatric dental clinic for treatment of dental caries whose residence is in the identified service area – to be determined in DY2.
Denominator: The population of children ages 0-14 in the dental clinic's service area.
Improvement target: The percentage of children treated for dental caries in the defined population will show a reduction of 10% per year from baseline for each subsequent demonstration year.

Relationship to Other Projects:
Potentially, admissions for dental surgery – while not specifically described in the Category 4 reporting measures, the number one outpatient surgery performed at Cook Children's Medical Center is for dental procedures. A pediatric dental clinic will dramatically decrease the cost of dental care, as the higher cost of surgical dental intervention is avoided by prophylaxis or early intervention in a freestanding, lower cost dental services model.

[17] Lee JY, Bouwens TJ, Savage MF, Vann WF. "Examining the cost-effectiveness of early dental visits. Pediatr Dent 2006; 28 (2):102-105.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Project valuation assumes 5,400 pediatric dental visits annually beginning DY 4. Population is comprised primarily of pediatrics with little or no access to dental care. As a result, we assume that a sizable portion of the population has untreated dental caries (30% or 1,620 pediatrics), with the project expecting to impact 10% or 162 of these patients with caries in year one and a 10% reduction per year thereafter in the ZIP code where the clinic is located. In addition, the increased access to dental treatments is projected to reduce ambulatory dental surgeries by 10% per year for the corresponding ZIP codes where the clinic is located. Both the reduction in treatment for dental caries and ambulatory surgeries is expected to reduce governmental program costs by at least $201 and $2,741 per case, respectively.

021184901.1.3	***1.8.6***	***1.8.6***	Increase, Expand and Enhance Oral Health Services (Establish one new Cook Children's Pediatric Dental Clinic.)	
Cook Children's				021184901
Related Category 3 Outcome Measure(s):	*201184901.3.3*	IT-7.2	Cavities: Percentage of children with untreated dental caries.	
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]: Establish additional dental care clinic (pediatric). Metric 1 [P-4.1]: One pediatric dental care clinic Goal: 1 Data Source: Administrative documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,515,337	**Milestone 2** [P-4]: Establish additional dental care clinic (pediatric). Metric 1 [P-4.1]: One additional pediatric dental care clinic Goal: 1 Data Source: Administrative documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $774,915 **Milestone 3** [P-X]: Train/hire dental care providers and staff (pediatric). Metric 1 [P-5.1]: Documentation of increased number of providers and staff Goal: 1 pediatric dentist and 10.5 non-dentist support staff Data Source: Administrative documentation Milestone 2 Estimated Incentive Payment *(maximum amount):* $774,914		**Milestone 3** [I-14]: Increase number of special population members who access dental services Metric 1 [I-14.1]: Documentation of increased number of children accessing dental services Goal: 5,400 visits Data Source: Administrative documentation Milestone 3 Estimated Incentive Payment: $1,657,957	**Milestone 4** [I-14]: Increase number of special population members who access dental services Metric 1 [I-14.1]: Documentation of increased number of children accessing dental services Goal: 10% increase in visits from 5,400 visits to 5,940 visits Data Source: Administrative documentation Milestone 4 Estimated Incentive Payment: $1,369,616
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,515,337	Year 3 Estimated Milestone Bundle Amount: $1,549,829		Year 4 Estimated Milestone Bundle Amount: $1,657,957	Year 5 Estimated Milestone Bundle Amount: $1, 369,616
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $6,092,739				

Project Summary
Project Option: 1.10.4 – Enhance Performance Improvement and Reporting Capacity - Public Health Surveillance using health information exchange (HIE)
Unique Project ID: 022817305.1.1
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/022817305

Tarrant County Public Health – 420 FTEs, 20 sites, serving 1.9 million people in Tarrant County

Tarrant County Public Health serves as the public health entity for a county of 1.9 million people The purpose of the Region 10 RHP Enhance Performance Improvement and Reporting Capacity - Public Health Surveillance using health information exchange (HIE) is to facilitate Tarrant County Public Health and other performing provider's use and analysis of the data housed therein in order to identify health conditions and disease state "hot spots" and/or disproportionately-affected groups within their populations or sub-segments of their populations and in turn, and to direct resources appropriately, meaning in ways that are specific to and will best address each provider's findings and needs.

The project is a new initiative for Tarrant County Public Health.

The project was designed to facilitate TCPH's ability to use electronic information in order to achieve public health goals while also addressing the problems of limited health information infrastructure and interoperability which leads to poor and ineffective care coordination and in turn, increased and unnecessary expenses.

Enhance Performance Improvement and Reporting Capacity - Public Health Surveillance using health information exchange (HIE) is designed to serve all those who seek health care services in Region 10.

The Region 10 RHP will benefit specific at-risk populations because there will be an emphasis on care coordination, chronic disease treatment, early detection, patient self-management and participation and health promotion and prevention. The project will also benefit the disproportionately medically disadvantaged/disenfranchised populations by allowing for the implementation of a system to stratify outcomes and quality measures by REAL (race, ethnicity and language) demographic information in order to identify potential health disparities and develop strategies to ensure equitable outcomes.

The expected project benefit is to assist all participating Region 10 RHP Performing Providers in demonstrating improved cost savings in care delivery and per episode cost of care through use of health information exchange and sharing of best practices. Use of health information exchange will help to decrease the above-referenced costs through enhancing efficient and effective use of resources in the hospital setting by eliminating duplicate radiology and laboratory testing performed as a result of the data not being accessible when needed due to limited interoperability of information sharing among providers.

Project Option -1.10.4 – Enhance Performance Improvement and Reporting Capacity - Public Health Surveillance using health information exchange (HIE)

Unique Project ID: -022817305.1.1

Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/022817305

Project Description:
- The Tarrant County Public Health (TCPH) project named "Enhance Performance Improvement and Reporting Capacity - Public Health Surveillance using Health Information Exchange (HIE)" details TCPH's innovative use of data in a regional HIE to identify problem areas and allocate resources where the most benefit may be achieved. The project involves a two-way flow of data between TCPH and the North Texas Accountable Healthcare Partnership's (NTAHP) regional HIE which will be used to analyze, assess and impact population health covering various health conditions and/or chronic diseases. Population health refers to the status of the entire population, not just those hospitalized or at risk of that. Health conditions/disease states include notifiable/reportable disease such as sexually transmitted infections or tuberculosis as well as pregnancy or chronic diseases such as obesity, diabetes, hypertension, congestive heart failure and asthma. This data will be analyzed to characterize the conditions in special populations (e.g., racial/ethnic groups or groups based on primary language or health literacy status).

An HIE with public health participation is innovative; it maximizes electronic health information sharing to accomplish public health tasks such as monitoring of population health trends and investigation of health threats. TCPH developed and maintains a syndromic surveillance reporting network featuring aggregate, de-identified data that soon will be more robust as additional providers send data to the regional HIE to obtain incentives for achieving Meaningful Use (MU) requirements. TCPH and providers will use this data (and individual, private health data on reportable conditions that TCPH maintains) to identify health conditions and disease state "hot spots" and/or disproportionately-affected groups and to direct resources appropriately, meaning in ways that are specific to and will best address each participant's populations, findings and needs. Resources include education related to health promotion and disease prevention, as well as interventions related to case management and evidence-based treatment in both the outpatient and inpatient settings. Ongoing analyses of the data and programs will suggest improvement opportunities. The project yields economies of scale in technology and staffing. Participating providers will be able to lower their per-episode cost of care by eliminating unnecessary or duplicate testing. The project also will reduce avoidable hospitalization and readmission rates, improve cost efficiencies, both internal and external to the hospital environment, and increase patient safety and patient satisfaction.

Goals and Relationship to Regional Goals:

Project Goals:
-This project will improve population health through more effective use of e-health information, including use of syndromic surveillance related to chronic and communicable diseases, use of Electronic Lab Reports (ELR) for notifiable/reportable disease monitoring, and the use of immunization data for preventive outreach. Because of the project, a standardized, interoperable model of care that is patient-centric, trusted, scalable, sustainable, and reliable will emerge. This model and the data store that supports it will facilitate the adoption of best practices that will improve the quality of care, increase patient safety, and reduce healthcare costs. Enhanced and expanded use of shared information will give TCPH and other Region 10 RHP performing providers necessary data to develop case management and treatment or prevention programs specific to the needs of their unique populations and sub-segmented populations. It will also improve point-of-care efficiency and cost effectiveness by eliminating duplication attributable to limited health IT infrastructure and interoperability. This project will further engage participants to identify needs for registry-driven data derived from the HIE and to develop use-case definitions for such data that, when leveraged fully, will assist with improved patient care (e.g., by connecting with state-supported prescription drug monitoring databases to identify persons with possible drug-seeking behaviors, etc.) and enhanced patient safety (e.g., access to medication lists from a wider set of providers, etc.).

This project meets the following Regional goals:
-This project is aligned with Region 10's triple aim of raising and maintaining the health of the community, improving health care delivery and lowering health care costs. Enhanced and expanded use of shared information will expand opportunities for targeted interventions and collaborations with the results being a healthier community, improved health care delivery and lower health care costs. Moreover, the participation of public health in this exchange is innovative; it sets a precedent for valuable collaboration between public health and the medical community. While such interaction has been focused primarily on notifiable/reportable diseases in the past, this project more fully accommodates public health's ability to share its unique insights on health promotion and disease prevention, which offers tremendous potential to improve the health of individuals in the community and beyond. For example, the impact of a reduction in obesity (based on educational and other programs led by public health) would have far-reaching positive effects on health.

Challenges:
Enhanced information sharing will work at mitigating/eliminating the silos that can exist across and among health care, mental/behavioral health and public health entities. With silos eliminated, opportunities for expanded collaborations and teamed solutions/approaches among all entities will be increased.

5-Year Expected Outcome for Provider and Patients:
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The five-year expected outcome is that TCPH and other Region 10 RHP participants will use the shared information to pinpoint issues and then efficiently and effectively allocate education, preventive and/or management resources to those concerns. Continual reassessment using the data will further highlight additional modes and areas for improvement and refinement. Region 10 performing providers' abilities to communicate with each other regarding individual private health information will also be positively impacted, thus resulting in improved patient safety and satisfaction and decreased health care delivery costs. The project will benefit specific at-risk populations because there will be an emphasis on using the data and subsequent analyses and assessments to facilitate intervention and program development (which may include interventions or programs designed to address care coordination, chronic disease treatment, patient self-management, and/or health promotion and prevention) that is specific to and will best address the needs of these special populations. The project also benefits the disproportionately medically disadvantaged/disenfranchised populations by setting the foundation for a system to stratify outcomes and quality measures by Race, Ethnicity And Language (REAL) demographic information to identify health disparities and develop strategies to ensure equitable outcomes.

Starting Point/Baseline:

TCPH is working with the NTAHP HIE in initial stages of developing data use agreements for public health reporting of syndromic surveillance and use of ELR data for notifiable/reportable diseases. TCPH is the public health entity that maintains syndromic surveillance systems for the North Texas region; as such, it will receive data that meets Meaningful Use criteria, whether for Stage 1, Stage 2, or eventually Stage 3 (see www.cdc.gov/ehrmeaningfuluse/). One Region 10 RHP performing provider (Cook Children's Healthcare System) is now participating in the NTAHP HIE as a data-sharing partner, with participation limited to the Phase One "Go-Live" Pilot. The NTAHP is queuing interested entities for connection, and in 2013, connection to the HIE should be generally available to the North Central Texas medical community. Once TCPH's Electronic Medical Record (EMR) system is fully implemented in all of its clinics, TCPH will also begin to participate in the HIE as a data-sharing partner and will benefit from individual-specific data regarding point-of-care efficiency and patient safety and satisfaction.

Rationale:

-Access to electronically shared information, whether patient-specific or in aggregate, will enable TCPH and other public health entities to maximize use of limited human and fiscal capital within their organizations. Resources currently devoted to chasing down information can better be used to analyze and act on the information automatically and electronically obtained and stored in an HIE. For example, use of ELR data and access to associated specific patient information would eliminate the need for public health staff to contact infection control professionals and/or treating physicians for basic information required in an epidemiological investigation, which subsequently, when indicated, initiates and directs a public health response.

As described, situations would be resolved in a more timely fashion, which translates into less disease burden in the community and, ultimately, a healthier population. Furthermore, more rapid analysis of data (due to decreased reporting lag time and more complete and consistent availability of required variables) would occur and be used to identify health conditions/disease state "hot spots" and/or disproportionately-affected groups who could be targeted for treatment, education, and preventive resources. It is well established that patients nationwide (and thus in Tarrant County and across Region 10) seek health care in many different settings and receive care from many different providers, including mental/behavioral health professionals. Results of the Regenstrief study in Indiana demonstrate that health care facilities are likely to benefit from an HIE and discount the notion that "all health care is local." The study also states that "improved care quality results from informed decisions made via immediate access to relevant health care information." Although the study looked at these issues in emergency department patients, TCPH believes these challenges apply to patients in all health care settings.

Project Components:

-A customizable project intervention was selected because the project is designed to enhance performance improvement and reporting capacity in an innovative manner not described in the other options (related to people, technology and systems.) The selected project intervention did not include any required core project components. The selected milestones and metrics will measure the progress of TCPH's use of electronic health information and increasing opportunities for collaborative efforts supporting interventions and programs aimed at improving patient safety and satisfaction and decreasing costs through enhancing efficient/effective use of resources.

Unique community need identification numbers the project addresses:

- CN.22 – Inadequate health IT infrastructure and limited interoperability to support information sharing among providers

-According to the June 2012 Regional Stakeholder Survey Summary Region 10 RHP Community Health Needs Assessment, one of the top four reasons cited as "barriers to effective overall care coordination in counties" was "limited health IT infrastructure and interoperability."

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

The project is a new initiative. TCPH staff responsible for project implementation did not receive any HITECH or other federal funding to perform the tasks described. TCPH will contract with the NTAHP HIE to develop capabilities (research tools and registries) to complete the project successfully and accomplish important public health goals. Any funds paid to NTAHP through this project would be funding additional capabilities not included in the basic infrastructure of the HIE.

The NTAHP was formed and funded in 2010 to develop a regional health information exchange to solve the problem of limited health information infrastructure and interoperability leading to poor and ineffective care coordination and, in turn, increased and unnecessary expenses. NTAHP is a recipient of HITECH funds awarded to the state of Texas and then to NTAHP as one of 12 regional HIEs. NTAHP was awarded a grant in the amount of $4.9 million and approximately half of the grant funds have been received. These grant funds and additional private funds collected have been spent in the effort to stand up the HIE (which means pulling together the community to establish consensus on policies, procedures, technology, standards, functionality and limitations) in accordance with the business and operational plan submitted to the State of Texas. All federal funds will be expended in NTAHP's Phase One efforts to stand up the HIE and connect as many health care entities as possible because the community determined initial capabilities would focus on individual patient care.

This project facilitates a two-way flow of data among public health, NTAHP, and participating providers. Syndromic surveillance systems housed at TCPH have already proven useful to hospitals in identifying and monitoring emerging community health trends and isolating specific health threats. The project can be expected to make these capabilities more readily apparent and useful to hospitals, as well as to introduce use of the data for monitoring population health trends and even for discovery and response to potentially preventable concerns such nosocomial complications. Greater medical community use of the analytical capabilities these systems offer, along with continued public health use, can be expected to yield improved health outcomes and alleviate community health problems.

Related Category 3 Outcome Measures:

Outcome Measures

- IT-5.1 Improved Cost savings: Demonstrate cost savings in care delivery – ED visits
- IT-5.2 Improved Cost savings: Demonstrate cost savings per episode cost of care – reduced radiology testing cost
- IT-5.3 Improved Cost savings: Demonstrate cost savings per episode cost of care – reduced laboratory testing cost

Reasons/rationale for selecting the outcome measures:

By the end of the Waiver Period, because of their use of the data within the HIE, Region 10 RHP performing providers will be able to demonstrate cost savings related to care delivery and per-episode cost of care by eliminating unnecessary or duplicate testing. The collective end results of the project will be decreased potentially avoidable hospitalization and readmission rates and improved cost efficiency, both internal and external to the hospital environment. Participating Region 10 RHP performing providers will establish their own baselines for cost of care delivery and per-episode cost of care, and, at the end of the Waiver Period, they will be able to demonstrate a decrease from their individual baselines.

Relationship to Other Projects:

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The "Enhance Performance Improvement and Reporting Capacity - Public Health Surveillance using health information exchange (HIE)" project is vital to other TCPH DSRIP projects. TCPH will use the data to pinpoint areas and populations for health promotion and chronic disease prevention via Community Health Educators. TCPH will also be able to target areas for acute disease management or mitigation related to sexually transmitted infections, communicable disease and outbreak intervention. The "Enhance Performance Improvement and Reporting Capacity - Public Health Surveillance using health information exchange (HIE)" project will dovetail with nearly every other initiative in the Region 10 RHP DSRIP program, as it assists to transform processes to be successful in an electronic health information environment.

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

Please refer to Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of all participating provider projects for each collaborative. Though this project does not fit into the two learning collaboratives, over time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- TCPH defined the population directly impacted by the project as Emergency Department (ED) patients who visit facilities participating in the HIE. ED visits totaled 791,926 with a daily average of 2,170 in 2011. According to the National Hospital Ambulatory Medical Care Survey 2006 Emergency Department Summary," 38.2% of ED visits resulted in orders for laboratory testing and 44.2% for radiological studies. The percentage of the Tarrant County population expected to be positively impacted by the project is 0.-5% of DY5 ED visits as compared to baseline ED visits. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.27% of the total project valuation was allocated to Category 1 and 2. A cost savings of $29 per visit times 3,960 ED visits (3,960 is the number of 0.5% ED visits with a cost decreases in DY5) equals $114,829. ["The Business Case for Payer Support of a Community-Based

Health Information Exchange" by Tzeel, Lawnicki and Pemble] This value is multiplied by individual impact of 3 and community impact of 4 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total project value. An average cost savings per episode of care of $214 per radiology test X 1,000 (based on an overall 2% reduction in radiology tests performed equaling a decrease of 1,000 tests) is $$214,000. [Hospital Costs Index by Cleverly & Associates 2007] This value is multiplied by individual impact of 3 and community impact of 4 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total project value. An average cost savings per episode of care of $363 per laboratory test times 2,000 (based on an overall 2% reduction in laboratory tests performed equaling a decrease of 2,000 tests) is $726,000. [Hospital Costs Index by Cleverly & Associates 2007]. This value is multiplied by individual impact of 3 and community impact of 4 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total project value. The actual HIE total project valuation for 5 years equals $16,455,337. However, due to DSRIP Public Health funding available the project value was discounted by 57.8% to $6,947,507.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because the reduction in tests will save patient time, pain, diagnostic time and money.

To determine the value to the community - impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4**.** We believe this to be the correct number because it will save the community resources and money by reducing duplicative radiology and lab tests.

-022817305.1.1	*-1.10.4*	*N/A*	*-ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY – PUBLIC HEALTH SURVEILLENCE USING HEALTH INFORMATION EXCHANGE (HIE)*	
Tarrant County/dba Tarrant County Public Health				*022817305*
Related Category 3 Outcome Measure(s):	*-022817305.3.1* *-022817305.3.2* *-022817305.3.3*	*3.IT-5.1* *3.IT-5.2* *3.IT-5.3*	*Improved Cost savings: Demonstrate cost savings in care delivery – ED visits* *Improved Cost savings: Demonstrate cost savings per episode cost of care – reduced radiology testing cost* *Improved Cost savings: Demonstrate cost savings per episode cost of care – reduced laboratory testing cost*	
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]: 10% increase over baseline using HIE through sharing/exchanging - and ELRs (electronic lab reports) Metric 1 [P-X.1]: Number of ELRs transmitted to TCPH by NTAHP HIE participants in Region 10 Baseline/Goal: -10%increase over baseline Data Source: - TCPH documents Milestone 1 Estimated Incentive Payment: $1,463,571	**Milestone 2** [P-X]: 25% increase over baseline using HIE through sharing/exchanging - ELRs Metric 1 [P-X.1]: Number of - ELRs transmitted to TCPH by NTAHP HIE participants in Region 10 Baseline/Goal: 25%increase over baseline Data Source: - TCPH documents Milestone 2 Estimated Incentive Payment: $763,412 **Milestone 3** [P--9]: 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		**Milestone 4** [I-X]: Monitor/measure community health related to specific health conditions or disease states Metric 1 [I-X.1]: Identify a HEDIS-like audit process to measure community health related to specific health conditions or disease states and/or disparities or social determinants Goal: Identify appropriate audit processes Data Source: Various Milestone 4 Estimated Incentive Payment: $544,448 **Milestone 5** [I-X]: 50% increase over baseline using HIE through sharing/exchanging "- ELRs Metric 1 [I-X.1]: Number - ELRs transmitted to TCPH by NTAHP HIE participants in Region 10 Goal: 50% increase over baseline Data Source: - TCPH documents	**Milestone 7** [I-X]: Develop a best practice sharing plan to implement evidence-based strategies to address issues in specific health conditions or diseases states (with/without target populations based on disparities and /or social determinants) via treatment, case management or preventive programs Metric 1[I-X.1]: Development of plan Goal: Develop best practice sharing plan Data Source: TCPH Milestone 7 Estimated Incentive Payment: $526,037 **Milestone 8** [I-X]: 90% increase over baseline using HIE through sharing/exchanging - and ELRs transmitted to TCPH by NTAHP HIE participants in Region 10 Metric 1 [I-X.1]: Number of - ELRs transmitted to TCPH by NTAHP HIE

-022817305.1.1	*-1.10.4*	*N/A*	*-ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY – PUBLIC HEALTH SURVEILLENCE USING HEALTH INFORMATION EXCHANGE (HIE)*	
Tarrant County/dba Tarrant County Public Health				*022817305*
Related Category 3 Outcome Measure(s):	*-022817305.3.1* *-022817305.3.2* *-022817305.3.3*	*3.IT-5.1* *3.IT-5.2* *3.IT-5.3*	*Improved Cost savings: Demonstrate cost savings in care delivery – ED visits* *Improved Cost savings: Demonstrate cost savings per episode cost of care – reduced radiology testing cost* *Improved Cost savings: Demonstrate cost savings per episode cost of care – reduced laboratory testing cost*	
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)**
	publicly commit to implementing these improvements. Metric 1 [P--9.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP Goal/Baseline: 100% attendance Data Source: Documentation of participation Metric 2 [P-7.2]: Implement the "raise-the-floor" improvement initiatives established at the semiannual meeting Goal/Baseline: 1 initiative implemented Data Source: TCPH documents Milestone 3 Estimated Incentive Payment: $763,412		Milestone 5 Estimated Incentive Payment: $544,448 **Milestone 6** [P--9]: 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. Metric 1 [P--9.1]: Participate in semiannual face-to-face meetings or seminars organized by the RHP Goal/Baseline:100% attendance Data Source: Documentation of participation	participants in Region 10 Goal: 90% increase over baseline Data Source: - TCPH documents Milestone 8 Estimated Incentive Payment: $526,037 **Milestone 9** [P--9]: 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. Metric 1 [P--9.1]: Participate in semiannual face-to-face meetings or

-022817305.1.1	***-1.10.4***	***N/A***	***-ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY – PUBLIC HEALTH SURVEILLENCE USING HEALTH INFORMATION EXCHANGE (HIE)***	
Tarrant County/dba Tarrant County Public Health				*022817305*
Related Category 3 Outcome Measure(s):	*-022817305.3.1* *-022817305.3.2* *-022817305.3.3*	*3.IT-5.1* *3.IT-5.2* *3.IT-5.3*	*Improved Cost savings: Demonstrate cost savings in care delivery – ED visits* *Improved Cost savings: Demonstrate cost savings per episode cost of care – reduced radiology testing cost* *Improved Cost savings: Demonstrate cost savings per episode cost of care – reduced laboratory testing cost*	
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)**
			Metric 2 [P--9.2]: Implement the "raise-the-floor" improvement initiatives established at the semiannual meeting Goal/Baseline:1 additional initiative implemented Data Source: TCPH documents Milestone 6 Estimated Incentive Payment: $544,448	seminars organized by the RHP Goal/Baseline:100% attendance Data Source: Documentation of participation Metric 2 [P--9.2]: Implement the "raise-the-floor" improvement initiatives established at the semiannual meeting Goal/Baseline: An additional initiative implemented Data Source: TCPH Documents Milestone 9 Estimated Incentive Payment: $526,037
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,463,571	Year 3 Estimated Milestone Bundle Amount: $1,526,823		Year 4 Estimated Milestone Bundle Amount: $1,633,345	Year 5 Estimated Milestone Bundle Amount: $1,578,111
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $6,201,850				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

- Project Option: 1.1.2 Expansion of Primary Care Capacity-TB Clinic Expansion
Unique Project ID: 022817305.1.2 (Pass 2)
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/022817305

Provider: Tarrant County Public Health has 420 FTEs, 20 sites, and provides public health services to 1.9 million in Tarrant County. The provider's role is to provide access to Tuberculosis Treatment to all citizens of Tarrant Co with or without the ability to pay.

Intervention: The primary purpose for this project is to provide non-traditional service hours to improve compliance of treatment of latent TB infection, reducing active TB in the pop. The project is an expansion to current TB Clinic.

Need for the project: The primary regional need addressed by this project is CN21-The high tuberculosis prevalence and low treatment completion rates of latent TB infection targeting the underserved clients generally at risk for TB disease development.

Target population: The targeted population is the estimated 900 patients diagnosed with latent TB infection who need access to service times that do not interfere with work/school.

Expected patient benefits: The project's benefit for these groups is twofold: By providing convenient access to the medication/ treatment after work hours, patients are successful at completing treatment& less likely to go on to develop active disease which is expensive to treat. Secondly the improved completion rates make the community safer from TB and decrease economic and health hardships of the underserved. In review, the indigent and Medicaid population is served with extended evening hours to prevent financial impact to families and individuals who lose paid work time to attend clinical hours that conflict with their financial sources.

Category 1 or 2 expected patient benefit: The Category 1 milestones selected are to hire and train staff in DY2, Provide 9 expanded clinic evening hours in DY3 and to increase access to primary care capacity by 10% in DY4 and by 20% in DY5. These milestones support the project's primary purpose of expanded service times by providing for the support staff and hours to provide preventive TB treatment. Supporting the citizenry with non- traditional clinic hours facilitates their access and time investment to be a healthy population.

Category 3 outcomes: The category 3 outcomes are: Improved treatment access and healthcare cost savings. These outcomes will demonstrate that the utilization of non- traditional clinic support hours and staff can improve patient treatment compliance and reduce healthcare costs by spending those dollars on the treatment of latent TB infection instead of the long term costs of treating active TB disease.

- Project Option: 1.1.2 Expansion of Primary Care Capacity-TB Clinic Expansion

Unique Project ID: 022817305.1.2 (Pass 2)
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/022817305

Project Description:
Expand Primary Care Hours and Expand Primary Care Staff–TB Clinic Expansion
This project involves the expansion of tuberculosis clinical hours for Tarrant County into the evening for specific service lines (i.e., medication distribution, screening services, LTBI case management and TB case reporting) on Monday, Wednesday, and Friday from 5 p.m. to 8 p.m. for improvement in patient access during nontraditional hours to provide less interference with work and school schedules. It takes 8100 visits per year to service 900 patients through 9 months of Latent Tuberculosis treatment. Currently the clinic provides 4 evening hours out of the total of 31 hours used to service these clients. This reflects 13% of the overall clinic time to be in the evening. By adding an additional 9 evening hours, the overall clinic time that is available in the evening is increased to 33%. This allows for the nursing staff to provide case management, reminder notifications of pending need of medication refills to facilitate the treatment completion, and continued education to occur so that we can increase the LTBI completion rates by 10% and 20 % in DY4 and DY5 respectively. The total number of patients diagnosed is not expected to significantly change but the completion rates are expected to increase due to case management, increased staff, and non traditional clinical hours.

Goals and Relationship to Regional Goals:
Project Goals:
The project purpose is to provide nontraditional service hours to improve latent tuberculosis treatment access and patient compliance and follow-up throughout the course of therapy, thereby improving patients' completion of therapy.
This project is related to Regional goals.
The Vision. Better Care: CMS aims to improve the overall quality of the U.S. health system by making health care more patient-centered, reliable, accessible, and safe. Better Health: CMS aims to improve the health of the U.S. population by supporting proven interventions to address behavioral and social determinants of health, and enhancing the quality of care delivered. Lower Costs: CMS aims to reduce the cost of the improved care delivery for individuals, families, employers, and the government.

Challenges:
A significant challenge for the provider is having enough hours outside work and school hours for patient convenience and staff to provide follow-up for the diagnosed cases of latent tuberculosis infection (LTBI). This group of patients often needs encouragement to maintain the therapy coarse that is nine months long, and convenience is often a factor in their completion rates, which run about 24% (subgroups of this general population run completion rates up to 55% when supervised delivery of medication is ordered).

5-Year Expected Outcome for Provider and Patients:
The five-year outcome expected is a 20% improvement in LTBI completion rates. The expected outcomes for individual patients is assistance in taking advantage of the LTBI treatment program offered in Tarrant County and decreased potential transmission of TB within families from incomplete treatment.

Starting Point/Baseline:
The tuberculosis division currently services between 990-1,100 clients per year diagnosed with latent tuberculosis infection in Tarrant County and five other counties contracted for medical service in Tarrant County through DSHS. One provider currently provides services for 11 hours weekly to the tuberculosis clinic. The evening hours currently available are Tuesdays from 4:30 to 7:30 p.m., with three nursing staff to see the scheduled medical clinic patients (12 scheduled patients and as many as 15 to 20 walk-in patients). With limited physician time during the week and a full-time nursing staff that already staffs 43 clinical hours, the additional clinic hours staffed with part-time staff will give patients access on days that may be more conducive to compliance and hours that are nontraditional for a specialty clinic.

Rationale:
The number of patients identified by smear positive tuberculosis cases fluctuates from year to year. Some cases have larger families and significant community contact points that must be evaluated. Others do not live with anyone and may be employed in areas with limited contact with others. In a five-year retrospective look at completion rates, the trend in Tarrant County is below the targeted number set by the CDC as described in Healthy People 2020. The milestones were chosen to identify a starting point and provide staff training to work toward improving Tarrant County completion of therapy rates in this group. The improvement targets were designed to set an attainable goal toward the overall national objectives set forth in 2010 of 79-85% completion of therapy rates. (CDC MMWR-Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis, Dec 16, 2005/Vol. 54/No. RR-15, pp. 1-37.)

TCPCH is required to provide statistics on patients seen for tuberculosis treatment to state DSHS. Those numbers have not met the baseline that the state and CDC have set for goal improvement. The CDC has put a focus on getting patients who are identified and start treatment to complete that treatment plan. This project plan was selected to provide manpower and access points to make that easier for patients to complete.

Project Components:
The increase in staffing and the increase in evening clinic hours are selected to attain the goals of increased patient access and improved patient completion rates. The component of additional clinical sites was not feasible for improving completion without duplication of services. The

overall number of patients diagnosed with LTBI cannot be increased by additional sites; however, the improvement of access of hours and personnel can provide case management that will assist in improving overall compliance and completion. Shook, Morgan, Transportation Barriers and Health Access for Patient Attending a Community Health Center- A field study (Portland State University, School of Urban Studies and Planning. June 10, 2005.

The risk factors that make a person more likely to develop active tuberculosis after being offered treatment for latent TB infection (LTBI) include inner city dwellers, the poor/indigent, those with comorbidities, and those who live in congregate settings. Races with higher rates of low income also show a proportionately higher rate of TB when compared to other races. These groups of patients often have difficulty accessing services for basic health care needs, and especially those services that require access during normal business hours, which affects their livelihood or care of family members. For these reasons the milestones and metrics were chosen to provide additional service times and improve the patient's ability to have control over their own disease progression.

Unique community need identification number the project addresses:
CN.3 and CN.7 Tarrant County Public Health supplies medical management for five surrounding counties for their active TB cases. As TB is an infectious disease with specific protocols, Tarrant County Public Health provides specialty care within this clinic setting. (Shook M. Transportation barriers and health access for patient attending a community health center: a field study (Portland State University, School of Urban Studies and Planning 2005).

CN. 21 – (High Tuberculosis prevalence and low treatment completion rates of LTBI) Tarrant County Public Health provides the Tuberculosis Elimination Clinic and follows the trends and statistics for the county about incidence of TB, treatment within the county, and completion rates of patients who are started on preventive medication. Those rates are currently below the targeted rates.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project is an expansion of clinical hours and staffing for those additional hours. The current TB clinic hours are not directly supported by any federal funding.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

Outcome Measure 1: 3.IT-12.6
Other Treatment Completion for Patients with Latent TB Infection:

Clinical follow-up visits play a critical role in the completion of LTBI medication treatment. The target improvements for this outcome measure are in DY4 to improve the number of patients seen for follow up visits by 10% over DY2. In DY5, the target is to improve the number of patients seen for follow-up by 20% over DY2. These improvements are evidenced in the Healthy People 2020 document that targets an overall national improvement in LTBI completions rates, as a goal to continue to decrease overall tuberculosis disease in the U.S. This goal set by the federal government suggests that the RHP set the same goal for the local population to attain regional tuberculosis disease and prevention measures. Studies have shown an economic benefit of $4,000 for each client who completes LTBI treatment.
http://www.businessgrouphealth.org/preventive/topocs/tuberculosis.cfm.

Outcome Measure 2: 3.IT-5.1
Cost of Care
The Healthy People 2020 goals suggest evidence for the strategies set forth locally to combat tuberculosis on the community level. The targeted improvements for this outcome measure include in DY4 the 10% increase in LTBI completion rates seen over DY2 baseline. In DY5 the goal is a 20% increase in LTBI completion rates over DY2 baseline. Of the estimated 198 additional LTBI clients seen, 66% are expected to complete treatment or approximately 91 clients. By the end of DY5, 10% of those 91 additional LTBI clients completing treatment would have been expected to convert to active TB had they not completed LTBI treatment. Holland et al. indicate in their study, "Costs and cost-effectiveness of four treatment regimens for latent tuberculosis infection," that the LTBI cost is $205, compared to the treatment cost of active TB at $12,512. Therefore LTBI treatment saves $12,307 in treatment costs.
For the outcomes targeted, both increases in patients utilizing the clinic times and the increase in completion rates, the health of low-income patient populations will be impacted. Providing improved access through additional evening hours and supportive clinic staff improves patient completion of preventive treatment before disease treatment is required.

The Category 1 increase in staff and clinic hours outside of standard physician hours support the above goals and improvement goals set by the Category 3 outcome measures.

Outcome Measure 3: 3.IT 2.14
Other Admission Rate-Decrease in Tuberculosis hospital admissions with improved LTBI treatment access and case management.
As stated in the previous 2 outcome measures, the therapy completion of identified LTBI clients that accept treatment decreases the burden of active TB cases in the community and also decreases the admissions over time for patients with TB like symptoms in the hospitals of Tarrant County. This measure will show that by providing the improved access times and case management that assist patients with successful completion of therapy, the overall case rate will

decrease by 1% yearly over the DY2 baseline as reported by the hospitals to the Health Department. In DY5 the overall case rate will decrease by 3% over the DY2 baseline.

Relationship to Other Projects:

Related Project:
022817305.2.5 – Implementation Evidence-based Disease Prevention Program–TB medication management. This related project focuses on a targeted subset of LTBI diagnosed patients who qualify for specific treatment plans that include directly observed therapy (DOT) with rifapentine. The targeted subsets are contacts to active TB cases, homeless shelter residents, and refugees. The TB clinic expansion project provides additional hours for DOT and self-supervised drug dispensing to **all** LTBI diagnosed clients who elect to take treatment.

Related Category 4 population-focused improvements: N/A

Relationship to Other Performing Providers' Projects in the RHP.
No other performing providers have TB clinic expansion projects. However, Tarrant County Public Health will participate in regional information sharing of innovative project implementations.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Tarrant County Public Health defined the population that will be directly impacted by the project as LTBI clients seen in DY5 compared to the number seen in 2011. A 20% increase in the LTBI clients completing treatment is a positive impact of the project. A second positive impact is 10% of those 91 LTBI clients completing treatment would have been expected to convert to active

TB; therefore those 91 will be positively impacted. The third positive impact is a 3% decrease in the annual hospital reported TB cases. Based on HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.26% of the total project valuation was allocated to Category 1 and 2. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.
Outcome Measure 1: 3.IT-12.6 $4,000 economic benefit for the 20% increase in LTBI client seen by the TB Clinic expansion with 66% of those clients expected to complete LTBI or 91 additional LTBI clients completing treatment ($4,000 X 91=$364,000). $364,000 is multiplied by the individual impact of 3 and the community impact of 3 to determine the value per year. The total value is multiplied by 5 years and a halo effect of 1.3 to determine the IT-12.6 actual total outcome valuation of $5,205,200.
Outcome Measure 2: 3.IT-5.1 91 additional clients are expected to complete LTBI treatment of those 91 clients 10% would have been expected to convert to active time without LTBI treatment completion or 9. At least $12,307 is saved for each of the 9 LTBI treatment completion clients ($12,307 X 9 = $110,763. $110,763 is multiplied by the individual impact of 3 and the community impact of 3 to determine the value per year. The total value is multiplied by 5 years and a halo effect of 1.3 to determine the IT-1.20 actual total outcome valuation of $1,583,911.
Outcome Measure 3: 2.14 Based on a 10 year average 59 TB cases per year are hospital reported cases. There is a savings of $20,100 per potentially preventable TB hospital admissions for the 3% decrease in hospital reported TB cases ($20,100 X 2 = $40,200). $40,200 is then multiplied by the individual impact of 3 and the community impact of 3 to determine the value per year. The total value is multiplied by 5 years and a halo effect of 1.3 to determine the IT-2.14 actual total outcome valuation of $574,860. The TB Clinic Expansion actual total project valuation is $7,363,972 but due to Public Health DSRIP funding availability the project was discounted 7.8% for a total project valuation of $6,789,112. The completion of LTBI medication treatment provides the client with a lifelong health benefit with the prevention of the conversion to an active case of TB. Without the LTBI medication completion a conversion to active TB could occur anytime within the individuals lifetime. In addition to the clients health benefits LTBI medication treatment completion also protects and provides benefits to the clients family members and other close connect individuals.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person does not successfully complete the medication treatment it is possible for latent TB to convert to active TB. Once converted to active TB, the individual's health is affected. Active TB can result in long-term negative health effects and, in some cases, death. If the medication treatment is partially completed there is greater likelihood of developing a drug-resistant strain of TB. Usually treated with IV therapy, drug-resistant TB is more serious and costly.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person does not successfully complete the medication treatment it is possible for latent TB to convert to active TB. Once converted to active TB, it is possible to infect other individuals.

Valuation References

Outcome Measure 1: 3.IT-12.6 –

$4,000 economic benefit of each LTBI client completing treatment
http://www.businessgrouphealth.org/preventive/topocs/tuberculosis.cfm.

Outcome Measure 2: 3.IT-5.1

$12,307 saved on each nonconversion to active TB
Holland et al., "Costs and cost-effectiveness of four treatment regimens for latent tuberculosis infection."

Outcome Measure 3: 3.IT-2.14

$20,100 TB case hospital cost
"Tuberculosis Stays in US Hospitals, 2006", Laurel Homquist, M.S., C. Allison Russo M.P.H., and Anne Elixhaurser PhD

022817305.1.2	*1.1.2*	*1.1.2B, 1.1.2C*	*EXPAND PRIMARY CARE CAPACITY (EXPAND PRIMARY CARE HOURS AND EXPAND PRIMARY CARE STAFF-TB CLINIC EXPANSION-*	
Tarrant County/dba Tarrant County Public Health				*022817305*
Related Category 3 Outcome Measure(s):	*022817305.3.14* *022817305.3.15* *022817305.3.18*	*IT-2.6* *IT-5.1* *IT-2.14*	*Other Outcome Improvement Target: Other Treatment Completion for Patients with Latent TB Infection:* *Cost of Care : Improved cost savings* *Other Admission Rate:Decrease in Tuberculosis hospital admissions with improved LTBI treatment access and case management.*	
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-5]: Hire and Train additional primary care staff Metric 1 [P-5.1]: Documentation of increased number of staff Baseline/Goal: Zero available evening and weekend staff/increase of part time staff by 1 R.N., 1 LVN, 1 Clerks or combination TBD. Data Source: Documentation of Hiring and Training of required staff through HR records Rational: Must have competently trained personnel to staff additional hours Milestone 1 Estimated Incentive Payment *(maximum amount):* $**1,428,784**	Milestone 2 [P-4]: Expand the hours of a primary care clinic by providing 9 additional evening hours. (13% of the current clinic hours devoted to patient medication refills are in the evening and the increase by 9 hours will increase that percentage to 33% of the hours are evening.) Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline/Goal Current baseline evening hours are three per week on Tuesday evenings/ Goal is to add additional 9 hours per week Data Source: TCPH-TB Division Database Milestone 2 Estimated Incentive Payment: $**1,490,713**		Milestone 3 [I-15]: Increase access to primary care capacity Metric 1 [I-15.1]: Increase percentage of target population reached (10% increase of LTBI patients reached over baseline.) Goal: 10% increase of LTBI return visits over the baseline of DY2 (volume of a specific care provided/LTBI return care service) Data Source: Documentation from the TCPHD TB database and the EMR Milestone 3 Estimated Incentive Payment: $**1,597,341**	Milestone 4 [I-15]: Increase access to primary care capacity Metric 1 [I-15.1]: Increase percentage of target population reached (20% increase of LTBI patients reached over baseline.) Goal: increase of 20% of LTBI return visits over the baseline of DY2 (volume of a specific care provided/LTBI return care service) Data Source: Documentation from the TCPHD TB database and the EMR Rationale: Increase in patient access to service by the target population will facilitate patient completion of therapy rates Milestone 4 Estimated Incentive Payment: $**1,543,326**

022817305.1.2	*1.1.2*	*1.1.2B, 1.1.2C*	*EXPAND PRIMARY CARE CAPACITY (EXPAND PRIMARY CARE HOURS AND EXPAND PRIMARY CARE STAFF-TB CLINIC EXPANSION-*
Tarrant County/dba Tarrant County Public Health			*022817305*
Related Category 3 Outcome Measure(s):	*022817305.3.14* *022817305.3.15* *022817305.3.18*	*IT-2.6* *IT-5.1* *IT-2.14*	*Other Outcome Improvement Target: Other Treatment Completion for Patients with Latent TB Infection:* *Cost of Care : Improved cost savings* *Other Admission Rate:Decrease in Tuberculosis hospital admissions with improved LTBI treatment access and case management.*

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)
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,428,784	**Year 3 Estimated Milestone Bundle Amount: $1,490,713**	**Year 4 Estimated Milestone Bundle Amount: $1,597,341**	**Year 5 Estimated Milestone Bundle Amount: $1,543,326**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $6,060,164			

Project Option 1.12 .2 – Enhance Service Availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care-- Expand the number of community based settings where behavioral health services may be delivered in underserved areas

Unique Project ID: 081599501.1.1
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501

Provider: MHMRTC is the Local Mental Health Authority (LMHA) providing mental health, early childhood, addiction and intellectual developmental disabilities services, serving an 897 square mile area and a population of approximately 1.8 million residents. -As the Texas DSHS designated Local Mental Health Authority, MHMRTC functions as a safety net and is mandated to plan, develop policy, coordinate, and allocate and develop resources for mental health services in Contractor's Local Service Area (LSA).

Intervention: This initiative will expand MHMRTC's number of community-based settings (clinics) by one and extend hours in existing clinics. The initiative also requires hiring 21 staff.

Need for Project: Access to Behavioral Health services is rated as one of the highest community needs in the region. Tarrant County is recognized as a health professions shortage area for mental health providers as indicated in the RHP-10 Community Health Needs Assessment. CN.4. It usually takes 6 months for people in need to obtain mental health services. People with mental illness who are unable to access appropriate services incur huge costs to themselves, the health care system and the community. One study by the Integrated Care Collaboration, co-authored by Ziebell identified 9 patients using the ER over a 6 year period whose treatment cost $3 million-.

Target Population: Individuals with behavioral health conditions needing psychiatric care who are on MHMRTC's wait list for services. The current wait list consists of 844 uninsured people in need of services. Other entry points also exist to fill any capacity generated by this project, e.g. emergency departments. Further, because our current case load exceeds our capacity, this expansion will also result in the provision of more and more effective services to those already in treatment, i.e. the 5,900 already being served at a reduced level.

Category 1 or 2 milestones expected benefit: The project seeks to provide increased access to psychiatric care to 200 consumers in DY3, 450 additional consumers in DY4 and -500- more in DY5, for a total of 1,150 new patients over the course of the waiver.

Category 3 outcomes: IT-9.2 Emergency Department appropriate utilization (standalone measure); we will demonstrate increased access to care for underserved individuals with an expanding provider base and clinic settings, which will result in a reduction of Emergency Department visits for behavioral health conditions.

Project Option 1.12.- 2 – Enhance Service Availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care-- Expand the number of community based settings where behavioral health services may be delivered in underserved areas

Unique Project ID: 081599501.1.1
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501

Project Description:
We propose to establish behavioral health services in a new community-based setting in an underserved area; we will add one clinic and hire 21 new full-time behavioral health providers and staff -to ensure individuals have timely access to services. With the addition of a new location and new staff, MHMRTC plans to expand capacity and reorganize the provision of services within all of its clinics to be more efficient so that current clients are served better. Additional hours are also being added to existing clinics to accomplish these goals.

The location of the additional clinic will be identified in DY2. The 21 additional staff will consist of:

- Eight qualified mental health professionals (QMHP). These staff will provide curriculum-based psychosocial rehabilitation, medication training and support, skills training, routine case management, crisis services and group sessions in the community and in individuals' home or work site. QMHP's also complete assessments and treatment plans and provide supported employment and supported housing services.

- Two consumer benefits staff. These staff assist individuals with benefit acquisition (SSI, SSDI, Medicaid, Medicare, food stamps, TANF, FAFSA, medication vouchers and medications through Prescription Assistance Program).

- One assistant director. This position will provide leadership and oversight to the project and coordinate and collaborate with key stakeholders.

- Two customer service a-ssociates. These positions provide clerical support, including filing medical records, billing, data entry, scheduling, registration, and front desk duties.

- One nurse. This position will provide injections, nursing services, complete medication calls and provide support to clinic psychiatrist.

- Five peer specialists. These positions will provide face-to-face peer services and function on clinic treatment teams. Peers will go into the community and provide follow-up services to individuals between their clinic appointments and report back to the treatment team.

- Two psychiatrist/psychiatric nurse practitioners. The physicians will provide psychiatric evaluation and medication management services.

Because patients served by MHMRTC tend to be severely and persistently mentally ill, the average intensity and volume of services required is significant. Data shows that we deliver a volume of 3 to 5 services per month to clients with the intensity ranging from very high case management and counseling to lower outpatients services such as medication refills. The duration of care provided to our patients by MHMRTC can normally last years if not for the lifetime of the patient.

Goals and Relationship to Regional Goals:

Project Goals:
This project's goal is to increase MHMRTC'S ability to provide "the right care at the right time in the right setting, resulting in more patients being treated in the behavioral care outpatient clinic setting rather than emergency departments and inpatient settings. - By adding a clinic and increasing the number of psychiatrists and behavioral health staff available to provide services, we expect this project to reduce or eliminate - our wait list for behavioral health services and provide immediate access to services and supports for a larger number of individuals with behavioral health conditions such as severe and persistent mental illness, individuals with co-occurring substance use disorders and mental illness and individuals dually diagnosed with intellectual developmental disorders and mental illness.

- Our current staffing capacity for adult mental health services is 5,553 individuals. We are serving 5,900 individuals, which is already 347 over our capacity. Reorganization of services and expansion of capacity will also result in more effective services being provided to the current case load. - Another goal is to - reduc-e wait times for regularly scheduled medical visits through smaller medical caseloads.

This project meets the following Regional goals:
Access to Behavioral Health services is rated as one of the highest community needs in the Region**.**

Challenges:
-Our most significant challenge in accomplishing the goals of this project will be identifying and hiring qualified professionals.

5-Year Expected Outcome for Provider and Patients:
-The expected outcome for MHMRTC as the provider is the ability to meet more of the needs present in Tarrant County. Patients will experience care in the right place and at the right time, increasing their quality of life.

Starting Point/Baseline:

Our current behavioral health clinics numbers 9 service settings and our current staffing capacity for adult mental Health services is 5,553 individuals. We are serving 5,900 individuals, which is already 347 over our capacity. The goal of this project is to serve the 844 people currently on the wait list and to increase capacity to add service for more of the population that never gets to our wait list, bring the served population to 7,050, -.

Rationale:
Access to Behavioral Health services is rated as one of the highest community needs in the region. The costs of untreated mental illness include lost productivity, reliance on more costly care, including emergency room services, and increased incarceration and homelessness. One study by the Integrated Care Collaboration, co-authored by Ziebell identified 9 patients using the ER over a 6 year period cost $3 million to treat.

Currently, individuals on the wait list can wait 6 months or more for an appointment with a mental health professional. Even those already being served often must wait for appointments because our resources are strained beyond capacity. If these people can be seen in a more timely fashion, outcomes for the patient, for the community and for the health care system will all be improved.

Project Components:
- There are no required project components. However the success of the project requires:

- Identification of a location for the new clinic
- Hiring of health care professionals and support staff

-Continuous quality improvement initiatives will be to participate in face-to-face learning (meetings) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:
- CN.4. Lack of access to mental health services.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
With respect to behavioral health services, a key element of reform is increased access to services. This initiative represents an extension of MHMRTC services to a broader population of needy individuals.

Related Category 3 Outcome Measures:
Outcome Measure 1: *IT-9.2 ED appropriate utilization (Stand-alone measure)*

Outcome Measures and Reasons/Rationale For Selecting The Outcome Measures:
One in 8 visits to the emergency room is related to mental illness. Without access to appropriate treatment, people with mental illnesses are more likely to experience crises that lead

them to utilize costly emergency room services.[1]

Relationship to Other Projects:
All of MHMRTC's projects address the expansion of behavioral health services and/or the integration of services to better serve a co-morbid population. It is expected that as the projects progress, we will refine each of the projects to better serve populations. It is also expected that efficiencies will be identified that will enhance our ability to serve a larger percentage of the population that currently is unable to find appropriate care. In particular, the projects that will have an impact on this project are:
(1) 081599501.2.4 SUD Outpatient Navigation
(2) 081599501.2.1 Expand Detox Capacity
(3) 081599501.2.3 RN Care Management.

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

- **127373205.1.1** Helen Farabee Centers (the MHMR Local Mental Health Authority in Wise County) proposes to establish a substance abuse services division in a different part of the Region (Wise County) than the area MHMR of Tarrant County is designated to serve (Tarrant County). Additionally, the population that Helen Farabee is proposing to serve primarily focuses on the substance use disorder population while, MHMR of Tarrant County targets individuals with severe and persistent mental illness. There may be some individuals with co-occurring substance use and psychiatric disorders in the Tarrant County targeted group, but there would not be overlap with the services provided in Wise County.
- **126675104.1.1** JPS Health Network proposes to "Increase 1,000 additional patient visits, increase days and hours of operation, and establish urgent outpatient consult service" for mental illness patients. MHMR of Tarrant County's project to expand behavioral health capacity proposes an alternative provider choice for specialized psychiatric and psychosocial Medicaid services. This project addresses the needs of uninsured clients who have chosen MHMR of Tarrant County as their provider and are waiting for services. Both JPS and MHMRTC have as missions the underserved populations in Tarrant County and both have wait lists for services. These 2 expansions will serve a larger number of the population, but neither entity has the resources, to see all individuals with a need. Further, professionals needed to provide services are in short supply. The 2 projects will serve different people, but will still not be able to hire the resources that would be necessary to expand to all of the needy population.

This project will participate in the Region's Learning Collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives, along with a list of participating provider projects for each.) MHMR of Tarrant County will also be working with

[1] http://www.thenationalcouncil.org/galleries/policy-file/Spill%20Over%20Effect_State%20Budgets_NCSL.pdf

other Community Centers in learning collaborative to select a small amount of outcome measures for category 3, based on the valuation studies conducted by health care economists at the UT Austin and UT Houston. The collaborative will develop a strategy for collection of that data through HEIs or other shared data sources in local communities. The Community Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

Project Valuation:

Approach:

Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system.

In order to set an appropriate incentive RHP 10 agreed that a multiplier of 5 should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the annual value of a single successful intervention at full implementation and multiplying that value by 5. The multiplier of 5 was decided with much discussion by performing providers. The rationale was that to overcome resistance to change, both in the delivery system and the payment system, 5 years of benefits were needed. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

The incentive element of the Region 10 valuation methodology is relevant to all Texas transformation efforts. However, it is particularly relevant to transformation of the mental health care system, where patient experience, population health and costs have previously not received any focus, and where services tend to be provided primarily in emergency situations. Texas ranks 50th in the country in per capita funding for mental health services. Only one-third of the more than 480,000 adults in Texas with serious and persistent mental illness received services through the community mental health system. Therefore, the most important transformation that can occur in mental health is increased access to services. Until the advent of the waiver, the

system has not had funds to experiment with the types of interventions that are being made possible through waiver funding. Incentives for effective implementation and outcomes are important to allow for the identification of successful interventions and the ultimate sustained transformation of the system.

Rationale:
The calculation of the value of successful interventions for this project included values for the patient experience and health care cost elements of the triple aim. For purposes of the patient experience, the performing provider used an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses cost-utility analysis (CUA) to measure the cost of the program in dollars and the health consequences in utility-weighted units satisfying our valuation factors regarding patient experience, community benefit, and savings to the health care system. This valuation uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The QALY value results in significant values related to mental health interventions. These patients are intensive users of the health care system and are most often not functional in society. Incremental improvements in their status have an enormous impact on all three elements of the triple aim.

081599501.1.1	*1.12.2*	*1.12.2*	**Enhance Service Availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care--** Expand the number of community based settings where behavioral health services may be delivered in underserved areas	
MHMR of Tarrant County				**081599501**
Related Category 3 Outcome Measure(s):	*081599501.3.1*	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-6]: Establish behavioral health services in new community-based settings in underserved areas Metric [P-6.1]: Number of new community-based settings where behavioral health services are delivered Goal: add one (1) additional community-based setting Milestone 1Estimated Incentive Payment: $4,391,180	**Milestone -2** [P-4]: Hire and train staff to operate and manage projects Metric 1 [P-5.1]: -Number of staff secured and trained. -Goal = hire 10 additional Behavioral Health staff Data Source: HR records Milestone -2 Estimated Incentive Payment: $-**$1,526,985** **Milestone 3** [I-X]: Milestone: Increased utilization of community behavioral health care (Increase behavioral health clinic volume of visits) Metric [I-X.1]: Target population reached Goal: see an additional 200 unique patients Data Source: Patient registry, and/or EHR, Milestone 3 Estimated Incentive Payment: **$1,526,985** -**Milestone 4 [P-10]:** Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative		**Milestone 5** [I-X] Increased utilization of community behavioral health care (Increase behavioral health clinic volume of visits) Metric [I-X.1]: Target population reached Goal: see an additional -450 unique patients Data Source: Registry and/or EHR. Milestone 5 Estimated Incentive Payment: $**2,450,278** **Milestone 6 [P-10]:** 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 [P-10.1]: Participate in semi-	**Milestone 7**[I-X]:- Increase behavioral health clinic volume of visits and evidence of improved access for patients seeking services. Metric [I-X.1]: Target population reached Goal: see an additional 500 unique patients Data Source: Registry and/or EHR. Milestone 7 Estimated Incentive Payment: $**2,367,418** **Milestone 8 [P-10]:** 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 [P-10.1]: Participate in semi-

081599501.1.1	*1.12.2*	*1.12.2*	**Enhance Service Availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care--** Expand the number of community based settings where behavioral health services may be delivered in underserved areas	
MHMR of Tarrant County				**081599501**
Related Category 3 Outcome Measure(s):	*081599501.3.1*	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)**
	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 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 [P-10.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semi-annual meeting and documentation that the		annual face-to-face meetings or seminars organized by the RHP. Data source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 [P-10.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semi-annual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semi-annual meeting. Milestone 6 Estimated Incentive Payment**: $2,450,279**	annual face-to-face meetings or seminars organized by the RHP. Data source: Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 [P-10.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semi-annual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semi-annual meeting. Milestone 8 Estimated Incentive Payment: $**2,367,418**

081599501.1.1	***1.12.2***	***1.12.2***	**Enhance Service Availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care--** Expand the number of community based settings where behavioral health services may be delivered in underserved areas	
MHMR of Tarrant County				**081599501**
Related Category 3 Outcome Measure(s):	*081599501.3.1*	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)**
	participating provider implemented the "raise the floor" improvement initiative after the semi-annual meeting. Milestone 4 Estimated Incentive Payment: $1,526,984			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,391,180	Year 3 Estimated Milestone Bundle Amount: $4,580,954		Year 4 Estimated Milestone Bundle Amount: $4,900,557	Year 5 Estimated Milestone Bundle Amount: $4,734,836
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $18,607,526				

Project Option - 1.13.1 - Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

Unique Project ID: 081599501.1.2 (Pass 3)
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501

Provider: MHMRTC is the Local Mental Health Authority (LMHA) providing mental health, early childhood, addiction and intellectual developmental disabilities services, serving an 897 square mile area and a population of approximately 1.8 million residents. As the Department of Aging and Disability Services (DADS) designated local Intellectual and Developmental Disability (IDD) authority for the local service area (LSA) consisting of Tarrant county, MHMR of Tarrant County is delegated by DADS to function as a safety net and be responsible for planning, policy development, coordination, including coordination with criminal justice entities, resource allocation, and resource development for and oversight of intellectual and developmental disability (IDD) services in the most appropriate and available setting to meet individual needs in the LSA.
Intervention: This project will implement the Systemic Therapeutic Assessment, Respite, and Treatment (START) model in order to provide behavioral health crisis prevention and intervention services for individuals with intellectual/developmental disability (IDD) and/or autism spectrum disorder (ASD) with co-occurring behavioral and/or medical problems. Services will include a 24 hour/7 days a week crisis response capability; a therapeutic emergency respite facility to provide short term planned and emergency respite services; psychological/behavioral support services, and; intensive service coordination.
Need for project: Patients with IDD/ASD with co-occurring behavioral health issues have trouble accessing services in the appropriate setting. Providers in the current service environment are ill-equipped to deal with the unique needs of this population. Moreover, the mental health system is much more likely to use emergency services in any case, and with the lack of training in IDD/ASD issues almost always resorts to emergency services.[18]

[18] http://www.centerforstartservices.com/Files/News%20&%20Events/STARTmodel_OverviewNASDDS%20presentaion%2011-11.pdf

Finally, IDD/ASD patients with co-occurring medical conditions may also devolve into crisis as a result of communication or other problems related to their disorder. Currently, there are no specialized crisis stabilization programs for people with IDD/ASD in Tarrant County, leading to costly institutional placements.

Target population: 3% of the general population has an IDD or ASD. Of that population, approximately 30% has a co-occurring mental illness. In Tarrant County, that equates to approximately 15,000 people with co-occurring diagnosis and many others also at risk for crisis. MHMRTC currently services 2,900 IDD/ASD patients. Presumably, 900 of those have a co-occurring mental illness. 80% of the MHMRTC population has Medicaid coverage and the remainder is typically uninsured.

Category 1 or 2 milestones expected benefit: The project seeks to provide START services to 350 unique individuals in DY4 and additional 350 unique individual in DY5.

Category 3 outcomes:

IT-6.1 Patient satisfaction. By the end of the waiver, our goal is to achieve 20% improvement over baseline of patient satisfaction scores regarding satisfaction with patient's overall health status/functional status.

IT-9.2 ED appropriate utilization. By the end of the waiver, our goal is to reduce ED visits by 40%.

IT-2.13 Other admissions rate (psychiatric inpatient admissions for IDD clients in crisis stabilization project) Our goal is to reduce psychiatric inpatient admissions by 40%.

Project Option - 1.13.1 - Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

Unique Project ID: 081599501.1.2 (Pass 3)
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501
Project Description:
This project will implement the systemic, therapeutic, assessment, respite, and treatment (START) model in order to provide behavioral health crisis prevention and intervention services for individuals with IDD and/or ASD with co-occurring behavioral and medical problems. -The components of the proposed project include:

- -24/7- crisis response capability
- -A therapeutic emergency (and planned) respite facility
- Psychological/behavioral support services
- Intensive service coordination
- -Other community services needed to provide crisis stabilization

In addition, linking and technical support will be provided to existing service providers and family members to strengthen the service system and natural supports. Psychiatric and medical services will be coordinated. Staff will provide comprehensive assessments to determine appropriate services and provide those services when they are needed.

We anticipate a number of entry points into the program:

1. MHMRTC current clients which will be identified as at-risk of crisis based on their history
2. Work with JPS, other hospitals, and providers in our region to obtain referrals of patients in crisis
3. Advocacy groups

Goals and Relationship to Regional -Goals:
Project Goals:

1. -To provide crisis stabilization services to -the target population, resulting in -reduced inpatient hospitalization, placement in institutional settings (e.g., nursing homes, hospitals, and intermediate care facilities), and -use of emergency department (ED).

2. Enhance the existing service system and natural supports through technical assistance, education, and support in order to prevent crises. To reduce or eliminate the constant stress experienced by the patient and caregivers allowing patients to continue living in preferred living environments.

3. To improve access and coordination of crisis stabilization and support services through intensive service coordination. Service coordinators will provide linking, service planning, monitoring, and coordination activities to assist the consumer in navigating the system.

This project meets the following regional goals:

This project relates to the Region 10 goals to improve access to behavioral health services and to reduce the unnecessary use of Emergency Department (ED) services. The project relates to improving access to care and improving overall quality of care for the targeted safety net population and lowering cost of care by decreasing ED services.

Challenges:

The most significant challenge for this project is bringing together all of the service providers and stakeholders to develop a plan for coordinating services for the success of the project over the period of the waiver. For DY2 we have scheduled activities to develop the strategic plan for implementation of the projects. Specifically, we have planned:

- 3 strategic planning forums with engaged stakeholders in Tarrant County
- Establishment of task based subcommittees
- Development of a gap analysis of local/county/state resources
- Development of a set of action plans that detail steps to be taken, identification or roles and responsibilities and timelines to address identified gaps

5-Year Expected outcome for Provider and Patients:
The 5 year expected outcomes of this project for the provider is that the services provided to IDD/ASD patients are more efficient and effective, allowing for additional patients to be served. Patients' lives should be improved as the result of better management of conditions so they do not have to experience crises and resulting life limiting environments. Caregivers' lives will also be positively impacted by not needing to continually manage the crises of their charges.-**Starting Point/Baseline:**
Currently, there are no crisis stabilization services in Tarrant County for people with IDD/ASD, so typically crises are handled through emergency based services-. There are currently approximately 2,900 people being served by MHMRTC's IDD service coordination units, approximately 900 of which can be assumed to have co-occurring mental health or other medical conditions-. The baseline to be established is the number of those patients that will benefit from the START model. -We will also work with other service providers to determine the population that will benefit.

Rationale:
According to the RHP Protocol, "when a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation, sometimes the choice comes down to the ER, jail, or an inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings" Numerous national reports have been published to examine the problems associated with poor mental health service delivery for people with IDD /ASD over the last 25 years. There have been articles and books written that describe model programs. Recommendations include examination of local levels to evaluate the current services and promote positive outcomes, with a strong emphasis on cross-system collaboration on all levels of service provision. In 1999, the U.S. Department of Health and Human Services Report to the Surgeon General of the United States on Mental Health, described the system as "multifaceted and complex, made up of public and

private providers, multiple agencies and disciplines" (p.8).[2] The report acknowledged that the system does not function in a coordinated manner, creating problems especially for people with complex needs.

In February 2002, in A Report of the Surgeon General's Conference on Health Disparities and Mental Retardation, mental health services for people with IDD were described as a "pressing unmet health need and disparity" in the current system. The START model was cited in the Surgeon General's Report as a model program for this population.

Model programs were designed in some locations, and a study in Massachusetts found a significant decrease in the use of emergency services over a four-year period when services were provided based upon a comprehensive, coordinated approach. Research has identified the following trends related to the current service system.[3]

- *Staff training and development*: In spite of advances in procedures, there remains a tendency to overlook MH issues in people with IDD.
- *Cross-systems crisis prevention and intervention services*: Although there were a number of providers that had internal crisis intervention systems, access for people with IDD was difficult. Many reported they used the police department as an alternative to address crises. Behavior plans did not utilize cross-systems crisis planning. Crisis stabilization beds were not used effectively.
- *Community mental health services*: Few people with IDD benefit from generic community mental health services.
- *Day and vocational services*: Better services needed to provide wraparound day services.
- *Case management:* Case managers were relied upon to provide service linkage and advocacy system, but claimed that the caseload size prohibited sufficient time to respond to crises, provide service linkages, and follow-up on referrals.

Project Components:

-The project involves these core components:

a. Convening 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. *MHMRTC will work with several existing stakeholder groups including the IDD Needs Council of Tarrant County, the Mental Health Connection, and the Aging and Disabilities Resource Center Advisory Committee to review current services and identify gaps. The MHMRTC IDD Advisory Committee (comprised of at least 50% consumers) will also provide input. Stakeholder groups will also determine barriers/obstacles to effective service delivery.*

[2] Beasley, J. B., & duPree, K. (2003). A systematic evaluation and implementation strategy to promote effective community service systems for individuals with coexisting developmental disabilities and mental illness: National service trends and the "Connecticut Blueprint.". *Mental Health Aspects of Developmental Disabilities* , 50-58.

b. Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.

c. Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients. *The community stakeholders, along with MHMRTC will be involved in -assessing the behavioral health needs of the target population with IDD and autism currently receiving crisis services in a variety of settings to: (a) determine the types and volume of services needed to resolve crisis in community-based settings; and (b) conduct a gap analysis that will result in a data-driven plan to tailor community-based crisis stabilization alternative services to the behavioral health needs of the target population.*

d. Explore potential crisis alternative service models and determine acceptable and feasible models for implementation. *MHMRTC has identified the START services model and will pursue using this model. The START model offers provision of clinical assessment and support by using the following methods: training and empowerment for families and caregivers; effective positive behavior support approaches; therapeutic tools developed in collaboration with medical, allied health and mental health professionals; a residential therapeutic respite facility; and optimal utilization of existing resources through system linkages.*

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. *The project will also involve sharing and disseminating findings to other agency providers and stakeholders. A milestone has been included for purposes of ensuring CQI efforts.*

Unique community need identification numbers the project addresses:

- CN.4-Lack of access to mental health services
- CN.10-Overuse of emergency department (ED) services
- CN11-Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding.

<u>Related Category 3 Outcome Measures Related Category 3 Outcome Measure(s):</u>

Outcome Measures and Reasons/Rationale For Selecting The Outcome Measures:

IT-6.1 Percent improvement over baseline of patient satisfaction scores-. (stand-alone)
Assuming this project is successful, people who currently have needs that cannot be met in the community and therefore must rely on emergency services will be able to manage their

conditions more successfully. The goal is to avoid crises and the resulting stress on patients and their caregivers. Thus, success at meeting our goals will mean that patients are more satisfied with the services they are receiving.

IT-9.2 ED appropriate utilization. 1 in 8 emergency department visits is for mentally ill patients. IDD/ASD patients with mental illness present unique problems and are even more likely to use emergency mental health services that other forms of community mental health care. This intervention is designed to fill the gaps in the community system that cause the overuse of the emergency system.

IT-2.13 Other admissions rate. A similar START intervention developed in North Carolina noted 43% of the patients referred had a psychiatric inpatient stay in the year prior to involvement in START. Most of these hospitalizations could have been avoided had appropriate alternatives been present. Meeting the goals of this intervention would show decreases in the need for inpatient care in the IDD/ASD population.

Relationship to Other Projects:

081599501.2.3 RN Care coordination

081599501.2.2 Integrate primary and behavioral health

081599201.1.1 Expand behavioral health

The project will coordinate with the RN care management for assessing people who are involved in crisis stabilization services. Expanded behavioral health within MHMRTC will be accessed by people utilizing crisis stabilization services-When needed, integrated primary care services will also be available for this population

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

Lakes Regional MHMR is proposing a similar project to target the IDD population using the wraparound model and Pecan Valley MHMR is also providing crisis respite as an aspect of a project in collaboration with their internal behavioral health provider. MHMRTC is exploring using the START model and will collaborate with other MHMR providers in the RHP 10 to share resources and best practices surrounding this expansion and will propose to continue this collaboration in some capacity pending project funding and implementation. MHMRTC target population does not overlap with any of the other projects. The target population will be those living in MHMRTC's service area (Tarrant County). Pecan Valley and Lakes Regional MHMR Centers provide services to different populations in their unique service areas. This project will participate in the Region's learning collaborative activities. *(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)*

MHMR of Tarrant County will also be working with other Community Centers in learning collaborative to select a small amount of outcome measures for category 3, based on the valuation studies conducted by health care economists at the UT Austin and UT 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.

Project Valuation:

Approach:

Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system.

In order to set an appropriate incentive RHP 10 agreed that a multiplier of 5 should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the annual value of a single successful intervention at full implementation and multiplying that value by 5. The multiplier of 5 was decided with much discussion by performing providers. The rationale was that to overcome resistance to change, both in the delivery system and the payment system, 5 years of benefits were needed. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

The incentive element of the Region 10 valuation methodology is relevant to all Texas transformation efforts. However, it is particularly relevant to transformation of the mental health care system, where patient experience, population health and costs have previously not received any focus, and where services tend to be provided primarily in emergency situations. Texas ranks 50th in the country in per capita funding for mental health services.[3] Only one-third of the more than 480,000 adults in Texas with serious and persistent mental illness received services through the community mental health system. Therefore, the most important transformation that can occur in mental health is increased access to services. Until the advent of the waiver, the system has not had funds to experiment with the types of interventions that are being made possible through waiver funding. Incentives for effective implementation and outcomes are

[3] Hogg Foundation for Mental Health, presentation at Waiver summit on August 8, 2012

important to allow for the identification of successful interventions and the ultimate sustained transformation of the system.

Rationale:
The calculation of the value of successful interventions was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses cost-utility analysis (CUA) to measure the cost of the program in dollars and the health consequences in utility-weighted units satisfying all of our valuation factors regarding patient experience, community benefit, and savings to the health care system. This valuation uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The QALY value results in significant values related to mental health interventions. These patients are intensive users of the health care system and are most often not functional in society. Incremental improvements in their status have an enormous impact on all three elements of the triple aim.

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081599501.1.2	1.13	1.13.1 a-e	Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.
Mental Health Mental Retardation of Tarrant County (MHMRTC)			**081599501**
Related Category 3 Outcome Measure(s):	081599501.3.6 081599501.3.13 081599501.3.14	***IT-6.1*** ***IT-9.2*** ***IT-2.13***	*Percent improvement over baseline of patient satisfaction scores* *ED Appropriate Utilization* *Other Admission 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 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 - [P-1.1]: Number of meetings and participants Baseline/Goal: No current stakeholder meetings held/ Minimum of 3 stakeholder meetings Data Source: Attendance lists. Milestone 1 Estimated Incentive Payment: **$-1,793,056** **Milestone 2** [P-2]:Conduct mapping and gap analysis of current crisis system Metric [P-2.1]: Produce a written analysis of community needs for crisis services. Baseline/Goal: Lack of documentation of types and volume of services needed to resolve crisis	-**Milestone 3** [P-4]: Hire and train staff to implement identified crisis stabilization services. Metric- [P-4.1]: Number of staff hired and trained Baseline/Goal: Do not currently have staff in IDD crisis stabilization unit/Hire 10 staff Data Source: Staff rosters and training records. Milestone 3 Estimated Incentive Payment: **$1,870,712** **Milestone 4** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services. Metric [P-5.1]: Completion of policies and procedures. Data Source: Internal policy and procedures documents and operations manual. Milestone 4 Estimated Incentive Payment: **$1,870,712**	**Milestone 5** [I--Number of people enrolled in the program Metric- [I-X.1]: -Target population reached Baseline: MHMRTC IDD does not currently provide services in an IDD Crisis Stabilization program. Goal: Provide crisis stabilization services to 350 unique individuals -Data Source: Client records and encounter data Milestone 5 Estimated Incentive Payment: $**2,003,611** **Milestone 6** [P-6]: Evaluate and continuously improve crisis services. Metric [P-6.1]: Project planning and implementation documentation demonstrates plan,do,study, act quality improvement cycles. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality	**Milestone 7** [I-X]: Number of people enrolled in the program Metric [I-X.2]: Target population reached Baseline: MHMRTC IDD does not currently provide services in an IDD Crisis Stabilization program. Goal: Provide crisis stabilization services to 350 unique individuals Data Source: Client records and encounter data Milestone 7 Estimated Incentive Payment: $**1,935,856** **Milestone 8** [P-6]: Evaluate and continuously improve crisis services. Metric 1 [P-6.1]: Project planning and implementation documentation demonstrates plan,do,study, act quality improvement cycles. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality

081599501.1.2	1.13	1.13.1 a-e	Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.
Mental Health Mental Retardation of Tarrant County (MHMRTC)			**081599501**
Related Category 3 Outcome Measure(s):	081599501.3.6 081599501.3.13 081599501.3.14	***IT-6.1*** ***IT-9.2*** ***IT-2.13***	*Percent improvement over baseline of patient satisfaction scores* *ED Appropriate Utilization* *Other Admission 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)
in existing crisis system of IDD population/Gaps in the current crisis system and community need for crisis services identified. Data Source: Written Plan Milestone 2 Estimated Incentive Payment: **$1,793,057**		improvement. Milestone 6 Estimated Incentive Payment: $**2,003,612**	improvement. Milestone 8 Estimated Incentive Payment: $**1,935,857**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $3,586,113	Year 3 Estimated Milestone Bundle Amount: $3,741,424	Year 4 Estimated Milestone Bundle Amount: $4,007,223	Year 5 Estimated Milestone Bundle Amount: $3,871,713
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $15,206,473			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 1.1.1 – Expand Primary Care Capacity –

Unique Project ID: 121822403.1.1
Performing Provider Name/TPI: Ennis Regional Medical Center/121822403

Provider: ERMC is a 60-bed Acute Care General Hospital with a Primary Service Area serving approximately 44,750 residents of portions of Ellis County, Texas and including areas of Dallas County and Navarro Counties. ERMC provides general hospital and outpatient services for all ages and all income levels.
Intervention: The project's intention is to improve right care at the right setting. The project is a new initiative.
Need for the project: There is an identified need to improve right care at the right setting based on ERMC's research of the current use of the Emergency Department services compared with published national averages. ERMC research also indicates a relevant deficit in Primary Care capacity which forces patients to use costly and inappropriate services. Ellis County's population in 2009 was 151,352 residents. Of these residents 22,569 residents had Medicaid and 16,347 residents were living below poverty level. (Texas Department of State Health Services Health Currents Report, 2009)
Target population: All persons (all ages, all incomes) utilizing the Emergency Department for non-emergent services due to lack of Primary Care availability. Estimated number of patients to be served over course of waiver period: The essential benefit is realized when the patients who present to an Emergency Department without an emergent healthcare need have been redirected to and accepted by a Primary Care Clinic or Physician to be seen for their healthcare needs. ERMC has evaluated that 1,343 residents or 3% of the ERMC Primary Care Service Area could experience this benefit during combined DY4 and DY5 by increasing the number of clinic hours and off hour's availability thereby creating the capacity for increasing clinic visits 10% by DY5. The project benefit will be increased access to Primary Care and reducing the cost of care by providing the right care at the right setting.
Category 1 or 2 expected patient benefits: DY 4 and 5 combined will experience a 10% increase in clinic visits over baseline. How do they tie into project's purpose? The Milestones selected include expanding Primary Care Capacity by having more healthcare providers and clinics, increasing the capacity of clinic hours specifically for Medicaid, Medicare and medically indigent patients as well as expanding the hours that services are available on weekends and after hours. The Milestones will evaluate the impact and progress of the project elements by studying both the use of Emergency Department for non-emergent services and the increased number of available hours of clinic to direct identified patients for care. Increasing the availability of the clinic hours will increase the capacity available for patients needing primary care who currently utilize emergency services for clinic type illnesses and complaints.
Category 3 outcomes: ED appropriate utilization improvement by 15% overall in DY4 and DY5. How does this tie back to the project's purpose? The Category 3 outcome selected is a decrease in the utilization of the Emergency Department for non-emergent healthcare needs. The Regional Community Health Needs Assessment as well as Primary Service area research

indicated a serious lack of availability of Primary Care access which drives patients to the Emergency Department of the hospital seeking costly treatment for non-emergent healthcare needs. Without increasing the capacity of Primary Care, so that persons of all income levels can receive right care in the right setting, the identification and redirection of these patients presenting to the Emergency Department setting cannot occur.

Project Option 1.1.1 – Expand Primary Care Capacity –

Unique Project ID: 121822403.1.1
Performing Provider Name/TPI: Ennis Regional Medical Center/121822403

Project Description:
We propose a community-based expansion of primary care capacity in the Ennis Regional Medical Center Primary Service Area (PCSA). Ennis Regional Medical Center (ERMC) Primary Service Area currently encompasses the inhabitants of the following communities: Ennis, Palmer, and Italy in Ellis County; Ferris part Ellis and part southern Dallas County; and Italy in Navarro County, and many other citizens secondarily. Currently over 7,400 patients per year fail to meet criteria for an emergent visit to the emergency department at ERMC.

The goal of this project is to increase the general population's access to primary care across all payor sources. Increasing the ability for patients to seek and find primary care will improve utilization of primary care services rather than the hospital emergency department for non-emergent services. The expansion approach will include three facets: (1) expanding existing primary care base and expanding clinic hours and off-hours through assisting growing practices in recruitment efforts; (2) further expanding relationships (and clinic sites) with existing Federally Qualified Health Clinics, and (3) partner with established clinics and physician offices to educate and encourage the public on right care, right service. This project will positively impact quality of life, health outcomes, preventable admissions, and emergency department utilization.

Goals and Relationship to Regional Goals:

Project Goals:
The goals of this project are: (1) to increase access to ongoing, community-based primary care services for the target population, (2) increase awareness of the availability of primary care and importance of seeking timely and appropriate level of services, and (3) improve right care at the right setting.

This project meets the following Regional goals:

A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to achieving that goal by focusing on a key population. Lack of access to primary care leads to frustrations for the community when disparities and lack of resources for health care prevent their attempts to proactively manage their health care. Our advancements in health care for the community must increasingly be a partnership aimed at improving the patient experience, improving the population health, and reducing the cost of health care.

Challenges:
Recruitment of providers to care for Medicare, Medicaid, and medically indigent patients can be challenging given the low reimbursement associated with this care. However, providing adequate care to these populations is imperative to improving the health of our community and assuring proper care in the proper setting.

The emergency department of the hospital is open 24/7/365. This availability and accessibility is a habit-formed one-stop shop for health care requiring a paradigm change in the community to develop the self-discipline of proactively forming relationships with a primary care physician and seeking early treatment and other preventive health activities. But those services have to be made available first. Our advancements in health care for the community must increasingly be a partnership aimed at improving the patient experience, improving the population health and reducing the cost of health care.

5-Year Expected Outcome for Provider and Patients:
Expanded capacity and access to primary care providers will lead to a reduced number of patients seeking primary care in the emergency department. The specific goal of the project is to establish more primary care clinic hours from 7,191clinic hours per year to a goal of 14,000 per year, including an increase in off hours and weekend hours in DY2 and DY3 from 1,173 per year to 1,760 per year in order to be able to increase clinic visits 10% during DYs 4 and 5, which should reduce inappropriate utilization of the emergency department by 15% per year.

Starting Point/Baseline:
The current clinic patient hours per year are 7,191 with an additional baseline of 1,173 hours per year for off-hour and weekend availability.

Rationale:
According to Cost of Emergency Care, (2012) the national average of patients presenting to a hospital emergency department for a non-emergent condition is 12.5%. Currently the ERMC's emergency department serves 43% more non-emergent patients than this national average for a total of 55.6% per year. A phone survey of the PCSA by E. Henry (personal communication, October 16, 2012) revealed physicians and mid-level practitioners supply only 23 hours per week

for off hours or weekends, and 564 hours per regular hour week to serve a total population of 25,735 persons as calculated from 2010 Census Data, (2012). The average wait time for a new patient appointment is currently nine days. These private physician offices and clinics provide clinic hours to serve approximately 7,191 patients per year with each patient seen only once in the year. Murray et al. state the average number of clinic visits is 3.19 per person. The project is designed to increase clinic hours and off-hours availability an additional total of 7,396 clinic hours by DY 4 to accommodate the targeted population of 3% of the total Medicaid and indigent in Ellis County, 1,343 persons, (Texas Department of State Health Services Health Currents Report, 2009) by the end of DY 5.The emergency department is a costly location for care for any type of patient. With reductions in reimbursement for Medicaid patients receiving non-emergent care in a hospital emergency department, proper utilization is even more important. Further, the Community Health Needs Assessment points to access to primary care as an issue within our county. It also establishes an aging population, and as primary care physicians become increasingly fewer and harder to find in rural areas, it is important for our facility to provide the right care at the right time in the right setting, as well as encourage education regarding the importance of proper utilization of emergency services and supporting local physician and primary care services.

Project Components:
There is one core component for the project in expanding primary care capacity: to establish more primary care clinics. The needs for expanding primary care capacity are threefold: (1) Attracting additional primary care physicians to the area, (2) establishing more primary care clinics as well as supporting clinics for Medicaid, Medicare, and medically indigent patients, and (3) assisting in the design of daily operations to include convenient hours for the working public.

Unique community need identification numbers the project addresses:

- CN-2 – Lack of provider capacity

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.
Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-9.2: ED Appropriate Utilization Improvement Target: DY2-DY5: 10% Improvement in Emergency Department appropriate utilization over baseline.

Relationship to Other Projects:
There are no related projects.

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

RD-2 30-day readmissions will be positively impacted by the 10% increase in clinic volume hours of availability. Patients must have a ready access to a physician in order to comply with expected ongoing and proactive health care, especially after a recent hospitalization. RD-5 emergency department domain will be affected by the 10% overall improvement of ED appropriate utilization over baseline. The effect will be in improved utilization of all services and diagnostics in the emergency department to focus on patient treatment at the emergent level rather than clinic level.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Ennis Regional Medical Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)* .

Ennis Regional Medical Center defined the population that will be directly impacted by the project as patients currently seeking care in the emergency department when a primary care setting would be more appropriate. The percentage of the population expected to be positively impacted by the project is 3% of the Primary Care Service area or 1,343 persons which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome resulting from our project.

To determine the value to each individual positively impacted, we concluded that the value of this project is a 2 on a scale of 1 to 5. We believe this to be the correct number because when a person is positively impacted, a primary care visit provides a better patient experience, less time is lost from work, and this results in preventive care.

To determine the value to the community of each individual positively impacted, we concluded that the value of this project is a 2 on a scale of 1 to 5; we believe this to be the correct number because when a person is positively impacted, the emergency department is better able to serve patients with true emergent conditions.

121822403.1.1	***1.1.1***	***1.1.1***	Expand Primary Care Capacity (Ennis)	
PHRC-Ennis LP (Ennis Regional Medical Center)				121822403
Related Category 3 Outcome Measure(s):	121822403.*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)**
Process Milestone 1 [*P-4*]: Establish additional/expand existing/relocate primary care clinics. Metric 1 [P-1.1]: Number of expanded business hours Baseline/Goal: 7,191 clinic hours available hours per year/14,000 clinic hours available. Data Source: Concurrent Survey of clinics in Primary Care Service Area for hours of operation. **Milestone 1** Estimated Incentive Payment *(maximum amount):* $221,095	**Process Milestone 2 [P-1]** Expand the hours of a primary care clinic, including evening and/or weekend hours **Metric 1** [P-4.1]: Increased number of off hour/weekend hours at primary care clinic 50% over baseline Baseline/Goal: 1,173 hours of primary care clinic off hour/weekend hours available per year/1,760 hours available per year Data Source: Concurrent Survey of clinics in Primary Care Service Area for hours of operation. **Milestone 2** Estimated Incentive Payment *(maximum amount):* $226,128		**Improvement Milestone 1** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 2 [I-12.2]: Documentation of increased number of unique patients, or size of patient panel. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: 5% Increase in clinic visits over baseline. Data Source: Survey of clinic visits in Ennis Primary Care Service Area **Milestone 4** Estimated Incentive Payment: $241,908	**Improvement Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 2 [I-12.2]: Documentation of increased number of unique patients, or size of patient panel. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Additional 5% Increase in clinic visits over baseline for total of 10% increase. Data Source: Survey of clinic visits in Ennis Primary Care Service Area **Milestone 4** Estimated Incentive Payment: $199,833
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $221,095	Year 3 Estimated Milestone Bundle Amount: $226,128		Year 4 Estimated Milestone Bundle Amount: $241,908	Year 5 Estimated Milestone Bundle Amount: $199,833
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $888,964				

Project Option 1.13.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system; (Crisis Respite Behavioral Support Wraparound Program)

Unique Project ID: 121988304.1.1
Performing Provider Name/TPI: Lakes Regional MHMR Center / 121988304

Provider: Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. Our service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve over 9,500 individuals each year. Over 95% of our consumers are either Medicaid eligible or indigent. This specific project will target individuals in Ellis and Navarro counties. Ellis County has a population of 149, 610 with a span of 952 square miles; Navarro county has a population of 47,735 with a span of 1,086 square miles. Lakes Regional provides community-based, out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays. Over 95% of our consumers served are Medicaid eligible or indigent.
Intervention: Lakes Regional will develop a behavioral health crisis stabilization service for dually diagnosed individuals as an alternative to hospitalization which will include a crisis respite facility, and wraparound services to serve Ellis and Navarro counties in RHP 10. This project intervention is new; there is no other alternative crisis stabilization service or wraparound services for the targeted population in the proposed service area.
Need for the project: The project relates to the Region 10 goals: to improve access to behavioral health services and to reduce the unnecessary use of Emergency Department services (CN.4, CN.10) The project relates to improving access to care and improving overall quality of care for the targeted safety net population, and lowering cost of care by decreasing Emergency Department services.
Target population: Medicaid eligible and indigent individuals with intellectual and developmental disabilities who are dually diagnosed with a mental health diagnosis. We estimate serving 250 clients over the waiver period. Medicaid and indigent individuals with IDD and/or a Mental Health diagnosis will benefit from the array of services and supports in this project during crisis situations. Ellis and Navarro counties are designated as Mental Health Professional Shortage areas.
Category 1 or 2 expected patient benefits: The benefits include improved patient outcomes such as reducing recidivism and unnecessary ED visits. Wrap Around Behavioral Support Services will involve multi-disciplinary treatment team model geared to increase the individual's ability to deescalate during crisis and in many cases more rapidly; particularly when crisis services are provided in the natural environment. The expected patient benefit will reduce the use of services that have limited or no abilities to provide Dual Diagnosis (IDD/MH) treatment. Process milestones listed for the project are designed to establish baseline need for a crisis services alternative in the region, to gather data on the current community crisis system and to

design a program that is tailored to the needs of the target population with IDD/ASD/MH, prior to implementing services in DY4 and DY5.
Category 3 outcome: IT-6.1 The project goal is to achieve a 40% improvement by DY5 in patient satisfaction with health status/functional status related to improving access to care, quality of care, and health outcomes, as well as improving overall health for the target population.
Project Option 1.13.1 – Development of behavioral health crisis stabilization services as alternatives to hospitalization; Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system; (Crisis Respite Behavioral Support Wraparound Program)

Unique Project ID: 121988304.1.1
Performing Provider Name/TPI: Lakes Regional MHMR Center / 121988304

Project Description:
Lakes Regional will develop a behavioral health crisis stabilization service as an alternative to hospitalization by establishing a community-based program to provide a continuum of services, including a crisis respite facility, and wraparound services to serve Ellis and Navarro counties in RHP 10. The program will include an intensive and interdisciplinary behavioral response team to provide comprehensive wraparound services and interventions to high-risk clients who are dually diagnosed with intellectual and developmental disabilities/autism spectrum disorder and mental health diagnosis (IDD/ASD/MH), or have other co-occurring disorders and/or medical needs. The intervention will involve developing and implementing crisis stabilization services to address the identified gaps in the current community crisis system. By expanding crisis residential treatment, individuals in crisis will receive appropriate, cost-effective care at the right time and the right place by specialty behavioral health providers. Based on assessed levels of need and risk, the team would provide in-home consultation, specialty psychiatric services/telemedicine, skills training, family education, treatment planning, monitoring and referrals to needed services to ensure that high-risk individuals remain in the least restrictive environment in the community. In addition, a crisis respite/short-term treatment site would be established to stabilize referred individuals in crisis or in danger of out-of-home placement and/or psychiatric hospitalization. A key component of this project is the extensive ongoing training in applied behavioral analysis to team members/caregivers and significant others to avoid acute crisis events and assist in stabilizing individuals in their home. The team will receive training in providing culturally competent care, and interpretation services would be available, as well as transportation, as needed.

Goals and Relationship to Regional Goals:
The five-year goals of this project are to improve access to appropriate crisis alternatives by providing a crisis stabilization program with wraparound services, including the availability of translation and transportation services; and to improve patient satisfaction through early interventions and intensive wraparound services.

This project meets the following Regional goals:

The project relates to the Region 10 goals to improve access to behavioral health services and to reduce the unnecessary use of emergency department services (CN.4, CN.10) The project relates to improving access to care and improving overall quality of care for the targeted safety net population, and lowering cost of care by decreasing emergency department services.

Challenges:

Based on a recent Stakeholder meeting, input for Region 10 notes a significant and costly delay in moving individuals from the State Psychiatric Hospital into the community. Additional feedback indicates that individuals who are dually diagnosed experience barriers to care in more structured settings due to the status of being dually diagnosed with IDD/MH. Reportedly there is a significant and costly delay in the time it takes for an individual in crisis to be assessed by behavioral health crisis teams, and in some circumstances, not being assessed at all due to their dually diagnosed status. In this geographic rural area crisis teams are not always available on a timely basis. The Stakeholders also identified a huge barrier to access of services is the lack of availability of care before 8am and after 5pm.

The 2010 Annual Survey of Hospital Tracking Data for Ellis and Navarro Counties listed 58,567 and 21,450 emergency department visits respectively. A number of these ED visits may have included the specialty population targeted by this project. Both Ellis and Navarro counties are designated as official Mental Health Professional Shortage Areas.[19] The Region lacks key community-based alternatives to costly and unnecessary emergency commitments and ED visits for the target population, while 24% of the population in the Region reports having had a mental health occurrence related to stress or depression lasting longer than five days, and 40% making less than $25,000 per year in the Region.[20] The project will direct IDD/ASD/MH individuals to a community-based crisis alternative service at half the cost of hospitalization or institutionalization.[21] Stakeholders also identified post-jail care is not available or delayed which increases the rate of recidivism.

5-Year Expected Outcome for Provider and Patients:

The five-year expected outcome of this project is to provide an increase in utilization of appropriate crisis alternatives in DY5 by 250. The expected result will be a significant decrease in preventable behavioral health events that typically result in hospitalization, incarceration and institutional care for individuals with IDD by deescalating crises in the natural environment with Wrap Around Behavior Support Services. The patient benefit is the promotion of self-management of challenging behaviors for the target population in the community, and significant reductions in the overall cost of care by utilizing a seamless system of care. The availability of nursing services within the crisis-respite team will facilitate integrated care to address fragmentation and discontinuity of health care, improvement of patient satisfaction and outcomes.[22] Research has shown that the use of intensive case management reduced the number,

[19] http://bhpr.hrsa.gov/shortage/

[20] http://www.dshs.state.tx.us/Layouts/ContentPage.aspx?pageid=35474

[21] http://www.ncbi.nlm.nih.gov/pubmed/8678177, Day Hospital/Crisis Respite Care vs. Inpatient Care, Am J Psychiatry. 1996 Aug; 153(8):1074-83.

[22] Jansen D., Krol B., Groothoof J. and Post D. (2006). Towards improving medical care for people with intellectual disability living in the community: possibilities of integrated care. *Journal of Applied Research in Intellectual Disabilities.* 19: 214-218.

confidence interval and duration of inpatient admissions, reducing the number of reported needs and increasing patient satisfaction, as well as the cost of care borne by the health sector.[23] The outcome will be improvement in overall life satisfaction and ability to live independently for the target population/service recipients.

Projected patient impact by DY is as follows:
DY2 – Stakeholders will benefit from availability of an analysis of community needs for crisis services with identified gaps in the current system.
DY3 – Stakeholders will benefit from a program designed to tailor to the crisis needs of the identified population in the local community.
DY4 – 100 individuals will have access to utilization of appropriate crisis alternatives in the community.
DY5 – 150 additional individuals will have access to utilization of appropriate crisis alternatives in the community.

Starting Point/Baseline:
The baseline for the project is to be established, since it will be a new program. The target population includes children and adults in Ellis and Navarro counties with IDD and co-occurring, mental and behavioral disorders. There are currently approximately 900 individuals being served in these counties by the public MH provider and by the IDD local authority. Currently there is no crisis respite/wraparound program in the Region 10 area. Thirty to thirty-five percent of IDD individuals are estimated to have a psychiatric disorder, with a projection of 200 IDD individuals served by private Waiver providers in the target area creates a sizable potential target population for the project. With the addition of referrals from school districts and community resource coordination groups (CRCGs), the number of targeted individuals to be served potentially in the program is 250 for the various program interventions within the project scope over the waiver period. Lakes Regional data indicates that approximately 65% IDD/ASD-diagnosed clients in these counties have a psychiatric diagnosis, or receive psychotropic medication for psychiatric symptoms. Currently we have one provider trained in the project; a board certified behavior analyst (BCBA). The project calls for 12 additional professional staff to be hired.

Rationale:
Consumers lacking appropriate behavioral health crisis resolution mechanisms often end up resolving the situation in the ED, jail or inpatient hospital bed. For the IDD/ASD/MH population, this problem is intensified due to an even greater limitation on settings that are available and appropriate for managing crises. Ellis and Navarro counties are designated as official Mental Health Professional Shortage Areas, and MHMR Centers are lacking provider capacity, as well as staff trained in providing culturally competent care with over 40% of the population in the Region being African-American or Hispanic. Due to this project, the target population will:

- Receive behavioral health management interventions through the provision of comprehensive wraparound services;

[23] Hassiotis. A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disability Management and Health Outcomes* 10 (7): 409-417.

- Have access to a community-based interdisciplinary intensive behavior supports response team hired and trained in cultural competence to decrease barriers to care;
- Have access to nursing services within the crisis/respite team in addition to a psychiatrist, improving physical and mental health outcomes;
- Have access to early intervention and crisis services, enabling them to be better equipped for crisis situations, thus avoiding unnecessary and costly ED visits and inpatient treatment.

Project Components:
Currently there is no community-based crisis alternative service in this Region. To determine the need and appropriateness of the intervention, the project involves these core components:

a. Convening community stakeholders to conduct a gap analysis of the current community crisis system, and to develop a specific action plan to address the identified gaps this will allow the project to establish a baseline of need.

b. Analysis of the current system of crisis stabilization services available in the community – this will allow the project to establish a baseline of need and design of a program that fits the needs of the target population in the local area.

c. Assessing the behavioral health needs of the target population with IDD/ASD/MH currently receiving crisis services in a variety of settings to: (1) Determine the types and volume of services needed to resolve crises in community-based settings; (2) Conduct a gap analysis that will result in a data-driven plan to tailor community-based crisis stabilization alternative services to the behavioral health needs of the target population.

d. The project has identified the community-based crisis respite model with wraparound services, including telepsychiatry, nursing services, BCBA services, service coordination, community supports/skills training, short-term day habilitation, assertive community treatment (ACT) and intensive case management, which is an evidence-based practice that ensures medication and treatment adherence, and links the patient with resources.[24] The wraparound crisis and ACT model is a highly researched evidenced-based approach for delivering behavioral health services; it is listed in the Texas Administrative Code, Community Standards, and Best Practices.

e. The project will also involve sharing and disseminating findings to other agencies, providers and stakeholders in the Region.

Process milestones listed for the project are designed to establish baseline need for a crisis services alternative in the Region, to gather data on the current community crisis system and to design a program tailored to the needs of the target population with IDD/ASD/MH. Process milestones also encompass hiring of staff and creation of policies and procedures prior to program implementation. Improvement milestones address measurement of an incremental

[24] Kolbasovsky, A., Reich, L, Meyerkopf, N. (2010). Reducing six-month inpatient psychiatric recidivism and costs through case management. *Care Management Journals* 11: 2-10. DOI; 10. 1891/1521-0987. 11.1.2.

increase in utilization of the program in DYs 4 and 5. Metrics in DYs 4 and 5 will measure an increase in utilization of the program by 250 individuals at the completion of DY5.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.4 – Lack of access to mental health services
- CN.10 – Overuse of emergency department (ED) services
- CN.11 –Need for more care coordination

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

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-6.1 Percent improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status (stand-alone.

The program staff will monitor mental and physical health status and outcomes to facilitate integrated care, improvement of patient satisfaction and outcomes for the target population.[25] Research has shown that the use of intensive case management reduced the number, confidence interval and duration of inpatient admissions, reducing the number of reported needs and increasing patient satisfaction, as well as the cost of care borne by the health sector. [26] The CGCAHPS survey produces ". . . comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers."[27] Sharing survey results with other agencies and providers in the Region regarding consumer satisfaction with overall health and functional status will bring about improvements in the overall health system for individuals with IDD/ASD/MH; sharing survey results with stakeholders will result in a greater awareness of the efficacy of the crisis respite wraparound model in improving life satisfaction, following better self-management skills and follow-up to care.

Relationship to Other Projects:

1.7.1 Telemedicine Project

The Lakes Regional telemedicine project will allow access to remote provider services, psychiatric counseling and primary care services. Telemedicine technology will be utilized as an integral focus of the provision of care proposed in the Crisis Stabilization project.

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[25] Jansen D., Krol B., Groothoof J. and Post D. (2006). Towards improving medical care for people with intellectual disability living in the community: possibilities of integrated care. *Journal of Applied Research in Intellectual Disabilities.* 19: 214-218

[26] Hassiotis. A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disability Management and Health Outcomes* 10 (7): 409-417.

[27] RHP Planning Protocol, Attachment 1, 398.

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

Tarrant County MHMR is proposing a similar project to the same target population for Crisis Avoidance; Pecan Valley MHMR is also providing crisis respite as an aspect of a project in collaboration with their internal behavioral health provider. Lakes Regional has been participating in collaborative teleconference calls with the other MHMR providers in the RHP 10 to share resources and best practices surrounding this expansion, and will propose to continue this collaboration in some capacity pending project funding and implementation.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaborative along with a list of participating provider projects for each.)

Project Valuation:

Rationale/Justification: Currently, there is no community-based alternative crisis service for the dually diagnosed IDD/ASD/MH target population (children and adults) in Ellis and Navarro counties. The goals described in this project will be accomplished via the collaborative involvement of providers in the public behavioral health system, private Waiver providers, physical health and the developmental disabilities service system, resulting in a potentially significant decrease in preventable behavioral health events that typically result in hospitalization, incarceration and institutional care for the target population. The anticipated valuation addresses a priority need in the community that allows for cost avoidance, supporting individuals in the community at a lesser cost than institutional care, avoiding costs in emergency departments, psychiatric hospitals and the criminal justice system. The project also addresses the barrier to care related to lack of transportation in a large, primarily rural geographic area by providing access to transportation to critical community resources. Size factor: There are currently approximately 900 individuals with IDD being served in these counties by the public MH provider and by the IDD local authority. Currently there is no crisis respite alternative program in the Region 10 area. With 30 to 35% of IDD individuals estimated to have a psychiatric disorder and with the projection of 200 IDD individuals being served by private Waiver providers in the target area, the number of targeted individuals to be served potentially in the program would be approximately 250 over the waiver period.

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Lakes Regional MHMR has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

In addition, this project was valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: "Valuing the Program to Create an Assertive Community Treatment (ACT) Team for People with Intellectual and Developmental Disabilities (IDD)" and "Valuing the Crisis Respite for Children Program." These studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis, which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency department 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. Complete write-up of project research is available at performing provider site.

Total Five-Year Valuation: $6,421,291

Unique Identifier: 121988304.1.1	***RHP PP REFERENCE NUMBER: 1.13.1***	***PROJECT COMPONENTS: 1.13.1 (A-E)***	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION; DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM – (CRISIS RESPITE BEHAVIORAL SUPPORT WRAPAROUND PROGRAM)***	
Performing Provider Name: Lakes Regional MHMR Center				*TPI –121988304*
Related Category 3 Outcome Measure(s):	*121988304.3.1*	*IT-6.1*	*Percentage improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.*	
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: Minimum meeting once a month. Data Source: Attendance lists Milestone 1 Estimated Incentive Payment: $764,099 **Milestone 2** [P-2]**:** Conduct mapping and gap analysis of current crisis system. Metric 1 [P.2.1]**:** Produce written analysis of community needs for crisis services. Baseline/Goal: Gaps in the current crisis system and community need for crisis services identified.	**Milestone 3** [P-4.]: Hire and train staff to implement identified crisis stabilization services. Metric 1 [P-4.1]**:** Number of staff hired and trained Baseline/Goal: Hire 4 staff Data Source**:** Staff rosters and training records; training Curricula Milestone 3 Estimated Incentive Payment: $797,121 **Milestone 4** [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: Operational protocols and clinical guidelines developed. Data Source**:** Internal Policy and Procedures documents and Operations manual. Milestone 4 Estimated Incentive Payment: $797,121		**Milestone5** [I-12]: Increase utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives by 50. Goal: Increase in utilization of appropriate crisis alternatives measured Data Source: Patient records and # of encounters. Milestone 5 Estimated Incentive Payment: $852,734 **Milestone 6** [I-12]: Increase utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives by 50 additional individuals. Goal: Increase in utilization of appropriate crisis alternatives measured. Data Source: Patient records and # of encounters.	**Milestone 7** [I-12]: Increase utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives by 75 additional individuals. Goal: Increase in utilization of appropriate crisis alternatives measured. Data Source: Patient records and # of encounters. Milestone 7 Estimated Incentive Payment: $823,898 **Milestone 8** [1-12]: Increase utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Increase in utilization of appropriate crisis alternatives by 75 additional individuals. Goal: Increase in utilization of appropriate crisis alternatives measured. Data Source: Patient records and

Unique Identifier: 121988304.1.1	***RHP PP REFERENCE NUMBER: 1.13.1***	***PROJECT COMPONENTS: 1.13.1 (A-E)***	***DEVELOPMENT OF BEHAVIORAL HEALTH CRISIS STABILIZATION SERVICES AS ALTERNATIVES TO HOSPITALIZATION; DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM – (CRISIS RESPITE BEHAVIORAL SUPPORT WRAPAROUND PROGRAM)***	
Performing Provider Name: Lakes Regional MHMR Center				*TPI –121988304*
Related Category 3 Outcome Measure(s):	*121988304.3.1*	*IT-6.1*	*Percentage improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.*	
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)**
Data Source: Written plan Milestone 2 Estimated Incentive Payment: $764,099			Milestone 6 Estimated Incentive Payment: $852,735	# of encounters. Milestone 8 Estimated Incentive Payment: $823,898
Year 2 Estimated Milestone Bundle Amount: **$1,528,198**	Year 3 Estimated Milestone Bundle Amount: **$1,594,242**		Year 4 Estimated Milestone Bundle Amount: **$1,705,469**	Year 5 Estimated Milestone Bundle Amount: **$1,647,796**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: **$6,475,705**				

Project Option 1.7.1 – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region (Lakes Regional Ellis/Navarro Telemedicine/Telehealth Project)

Unique Project ID: 121988304.1.2
Performing Provider Name/TPI: Lakes Regional MHMR Center / 121988304

Provider: Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. This project will target individuals in Ellis and Navarro counties. Ellis County has a population of 149, 610 with a span of 952 square miles; Navarro county has a population of 47,735 with a span of 1,086 square**.** Lakes Regional's community programs serve over 9,500 individuals each year Over 95% of our consumers are either Medicaid eligible or indigent.

Intervention: This project will implement telemedicine and telehealth services to provide consultations and increase capacity for behavioral health and other specialty provider services to the Medicaid and indigent target population. This is a new project intervention for Lakes Regional in Ellis and Navarro Counties.

Need for the project: There is a lack of provider capacity to serve the Medicaid and indigent population for these behavioral health and other specialty services. Both counties targeted by this project have been designated as behavioral health occupations shortage areas. The project will improve provider capacity and access to services (specialists) for remote populations/communities.

Target population: The target population is our clients needing specialty consultations. Approximately 95% of our patients are either Medicaid eligible or indigent, so we expect they will benefit from the majority of the consults. We estimate that Lakes Regional will serve 210 patients over the course of the waiver period. This project will provide access to services (specialists) for remote populations/communities in these counties and is specifically targeting these services to Medicaid and indigent clients in rural areas of Ellis and Navarro Counties.

Category 1 or 2 Expected Benefit: The project seeks to provide for a minimum of 210 individuals for telemedicine e-consultations with a specialist over the course of the waiver and to maintain an annual increase tend of 40% (over baseline) for the numbers of patients served.

Category 3 outcomes: : IT-6.1 The project goal is to achieve a 30% improvement by DY5 in patient satisfaction with health status/functional status related to improving access to care, quality of care, and health outcomes, as well as improving overall health for the target population.

Project Option 1.7.1 – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region (Lakes Regional Ellis/Navarro Telemedicine/Telehealth Project)

Unique Project ID: 121988304.1.2
Performing Provider Name/TPI: Lakes Regional MHMR Center / 121988304

Project Description:
There currently exists a significant gap in behavioral health (psychiatric specialist referral services) and health and wellness services in many Texas counties, including Ellis and Navarro in Region 10, which have been federally designated as Mental Health Professional Shortage Areas.[28] Lakes Regional MHMR Center proposes to improve patient access to these services in Ellis and Navarro counties through telemedicine/telehealth technology. This approach is a cost-effective alternative to face-to-face communication, especially for individuals in remote/rural areas where access is difficult and/or unavailable. The planned telemedicine/network technology for this project will include the deployment of high-definition video/audio equipment, virtual private network (VPN) Internet cloud-based connectivity and server-based video session management technology, allowing for the management of multiple client/specialist sessions across many different provider sites and mobile devices. Successful implementation of this technology will ensure more flexible and timely delivery of needed health care and specialist services to individuals in rural areas of Ellis and Navarro counties.

Goals and Relationship to Regional Goals:
Specific goals for this project include:
1. Successful planning and implementation of a telemedicine/telehealth infrastructure program to provide and enable expansion of behavioral health services (including psychiatric specialist referral services, and health and wellness services with improved, flexible, and cost-effective access to these services needed in Ellis and Navarro counties.
2. Continuous program of monitoring and analysis of the delivery system performance (use of the technology).
3. Measurable and continuing improvement in the expansion of access to specialty services, improvement in clinical outcomes, increasing patient satisfaction with the services they receive, and a 40% annual increase trend (over baseline) for the number of individuals seeing a specialist through the telemedicine program.

[28] U.S. Department of Health and Human Services Shortage Designation Branch (http://bhpr.hrsa.gov/shortage/)

This project meets the following Regional goals:

The Region is looking for ways to feasibly and effectively improve provider capacity and access to services (specialists) for remote populations/communities. By improving expanded access to mental health services, the Region anticipates improvements in patient outcomes and quality; a reduction in emergency department utilization; and an overall cost savings. Our telemedicine/telehealth project will implement a means to move past current barriers toward helping the Region achieve these goals. The application of this technology is very flexible, and will allow connectivity between all kinds of service providers, including doctors' offices, hospitals, specialty clinics, law enforcement and crisis care providers such as respite clinics with wraparound services for IDD (another Lakes Regional implementation project). According to several studies,[29] there have been upwards of 50 different medical subspecialties successfully served via telemedicine and the number is growing. These new services will help to reduce emergency department visits and the need for hospitalization by getting crucial /crisis care and preventive care where needed in the Region.

Challenges:
The use of telemedicine/telehealth technology for the expansion of behavioral health services (including psychiatric specialists), and health and wellness services has not yet been fully explored by Lakes Regional in Ellis and Navarro counties. The number of individuals in need of specialist psychiatric and other services in the penetration area around current Lakes Regional offices has not been established. A thorough needs assessment/services gap will be conducted to provide the information necessary to determine infrastructure requirements and the appropriate level and types of services needed from the telemedicine/telehealth start-up and expansion program. Access to specialty services in Ellis and Navarro counties are limited by funding and travel time, and the technology for the data lines currently deployed for the Lakes Regional core network into these counties have very limited bandwidth (T1 level and below). The data transfer speeds between sites and is slow and very limited for an effective deployment of high-definition, Internet cloud and server-based telemedicine technology. Successful implementation of the telemedicine/ telehealth technology will require infrastructure improvements including the latest advancements in technology for telemedicine/ telehealth hardware and server based software. Data network improvements will include high speed data transmission through the deployment of VPN internet cloud capabilities and mobility options. Completion of the necessary analysis and implementation of the required improvements will insure our success with being able to meet the clinical and technological challenges for this project.

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5-Year Expected Outcome for Provider and Patients:
Through the implementation of this telemedicine/telehealth project, Lakes Regional expects five-year outcomes to include: 1) Expanded access to behavioral health services (including

[29] American Telemedicine Association (http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333)

psychiatric specialist referral services), and health and wellness services for the target population (low-income, rural areas of Ellis and Navarro counties). The projected outcome for the second half of DY-5 is an 80% improvement in the number of individuals over baseline (established in the second half of DY-3) in the target population gaining access to a specialist/ specialist services. 2) Continuous quality improvement effort in the technical and clinical processes with documented improvement in the satisfaction of individuals receiving services over baseline/start-up results.

Starting Point/Baseline:

Lakes Regional has experience with providing services through telemedicine; however, we have not implemented or expanded the program into Ellis and Navarro counties. Providing these telemedicine/ telehealth services in the Region will be a start-up program and baseline data for the quality of services and the expansion of the kinds of services provided and the number of individuals served will need to be established. We will begin providing specialist services via telemedicine during the 2nd half of DY-3 and are setting our baseline at a minimum of 30 individuals/e-consultations with a specialist during that period. As soon as our implementation and assessment phase is completed, we will begin data collection to capture ongoing data in many areas of the program. After the first six months of providing specialist services, we will have actual numbers from which quality improvement metrics will be measured against.

Rationale:

One of the biggest challenges facing the U.S. health care system is to provide quality care to the areas currently underserved and lacking access to specialty physicians due to geographic and socioeconomic conditions. With the implementation of a telemedicine/telehealth infrastructure /program, we are certain that Lakes Regional MHMR Center will be able to close a significant gap in behavioral health and health and wellness services for individuals in the rural areas of Ellis and Navarro counties. The time frames for implementation and management of the new telemedicine/telehealth program are well within our capabilities. The project milestones and metrics are based on the telemedicine program infrastructure deployment, the introduction of new and specialty services and the corresponding growth and continuous improvement in the quality of those services (technically and clinically). With successful implementation of the telemedicine/telehealth program, we plan to reach and exceed the goals we have set for the introduction of new services, service locations, and improvement in the quality of our services and the number of individuals served. The technology will provide the needed flexibility in how and where we provide services. This flexibility will contribute to a significant projected growth rate every year for the number of telemedicine/telehealth e-consultations/visits, while continuously improving the quality of the program. We expect the growth to be significant with an increase of 80% over baseline numbers for the 2nd six months of DY5 for the number of Telemedicine/ Telehealth specialist e-consultations/visits for individuals. Along with our growth, our daily monitoring of the program will enable us to continuously improving the management and quality of the services we provide.

Project Components:

Core project components:
A. Provide patient consultations by medical and surgical specialists as well as other types of health professionals using telecommunications.
B. Conduct quality improvements using methods such as rapid cycle improvement, including but not limited to, identifying project impacts, identifying lessons learned, opportunities to scale all or part of the project to a broader patient population, identifying key challenges associated with expansion of the project including special considerations for safety net populations.

The selected project components are in line with the five-year goals we have set and are achievable within planned time frames. The project will provide access to psychiatric specialty services using telecommunication, and includes the use of quality improvement methodologies involving identification of project impacts, lessons learned, key challenges associated with project expansion, and opportunities to scale all or part of the project from dually diagnosed individuals to the broader safety net population.

Project milestones and metrics are based on our experience with telemedicine program infrastructure deployment, the introduction of new and specialty services, and planned growth and continuous improvement in the quality of services, technically and clinically. Successful implementation of the telemedicine/telehealth project plan will enable Lakes Regional to reach and exceed the goals we have set for the introduction of new specialist services, new service locations, and improvement in the quality of our services and the number of individuals served (210 at the completion of DY5).

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.3 – Shortage of specialty care
- CN.4 – Lack of Access to mental health services
- CN.7 – Need to address geographic barriers that impede access to care
- CN.10 – Overuse of emergency department (ED) services
- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Lakes Regional is currently providing services through telemedicine at some of our larger clinics, but we have not implemented or expanded the program into Ellis and Navarro counties. Providing these telemedicine/telehealth services is a new initiative for us in this Region, and will be a start-up program that will significantly enhance our existing service delivery system, enabling flexible delivery of care and improved delivery times for services. Lakes Regional will

be able to set up multiple connections to include private physicians, hospitals, other MHMR Centers, and other providers or resources in the community wherever they may be located.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-6.1 Percent improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status.

Although this Telemedicine/Telehealth Introduction/Expansion Project will enable services from multiple provider specialties, it will share significant focus with the Lakes Regional Crisis Respite – Behavioral Support Wraparound Program Project. Within the IDD population, research has shown that there is a much greater instance of health problems.[30] With the help of telemedicine/telehealth technology, program staff will monitor mental and physical health status and outcomes to facilitate integrated care, improvement of patient satisfaction and outcomes for the target population.[31] The specific ACT model planned for the program will result in better control of psychiatric symptoms, better quality of life overall, and greater consumer and family member satisfaction.[32] The projected outcomes relate to an improvement in access to care, the quality of care and health outcomes, as well as an overall improvement in health for the target population. The CGCAHPS survey produced comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers[33] The sharing of consumer satisfaction data (overall health survey results) between agencies (IFF, SDF, MH) and providers in the Region regarding consumer satisfaction, will result in a greater awareness of the efficacy of the crisis respite wraparound model in improving life satisfaction, following better self-management skills and follow up to care.

Relationship to Other Projects:

121988304.1.1 – Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system, Crisis Respite – Behavioral Support Wraparound Program. Telemedicine technology will be utilized as an integral focus of the provision of care proposed in the respite project. .

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

This project is related to the JPS Health Network Virtual Psychiatry Project, which will provide virtual support to primary care physicians specifically to support screening, diagnosis and treatment of depression.

[30] Journal of Intellectual Disability Research 48 (2): 93-102, 2004
[31] Journal of Applied Research in Intellectual Disabilities. 19: 214-218
[32] Phillips et al, 2001. . .Teague et al, 1995
[33] RHP Planning Protocol, page 398

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Lakes Regional MHMR has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

In addition, the project intervention was valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: "Valuing Access to Timely Services Through Telemedicine." These studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis, which measure 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 department 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. The reviewed research cited Hollinghurst et al. (2010), among others, which yielded a QALY gain equal to 264,000 per 100 patients served for a similar project population. Utilizing this formula of QALY with an estimation of 700 clients over the course of this Waiver project yielded the total valuation of **$1,782,072.** Complete write-up of project research are available at the performing provider site. Additional cost effectiveness savings can also be assumed through avoidance of higher cost crisis emergency-based services and transportation costs resulting from increased access due to this project.

121988304.1.2	*1.7.1*	*1.7.1 A- B*	*1.7.1 IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED A NEEDED TO THE REGION. – (LAKES REGIONAL ELLIS/NAVARRO TELEMEDICINE/TELE-HEALTH PROJECT)*	
Lakes Regional MHMR Center				*TPI# 121988304*
Related Category 3 Outcome Measure(s):	*121988304.3.2*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.*	
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 needed specialties that can be provided via telemedicine. Metric 1 [P-1.1]: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel. Baseline/Goal: Personnel needs assessed. Data Source: Needs Assessment Milestone 1 Estimated Incentive Payment: *$210,275* **Milestone 2** [P-7]: Create plan to monitor and enhance technical properties, bandwidth, or telemedicine/Telehealth program. Metric 1 **[P-7.1]**: Documentation of bandwidth capacity in relationship to program needs. Baseline/Goal: Capacity plan completed. Data Source: Bandwidth assessment and program plan. Milestone 2 Estimated Incentive Payment: *$210,275*	**Milestone 3** [P-3]: Implement or expand telemedicine program for selected medical specialties, based upon Regional and community need. Metric 1 [P-3.1]: Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents. Baseline/Goal: Telemedicine program implemented. Data Source: Program documents and records. Milestone 3 Estimated Incentive Payment: *$219,363*		**Milestone 5** [I-17]: Improved access to specialists care or other needed services, e.g., community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time. Goal: 20% improvement over baseline (or 36 individuals) for seeing a specialist. Data Source: Program records. Milestone 5 Estimated Incentive Payment: *$234,667*	**Milestone 7** [I-17]: Improved access to specialists care or other needed services, e.g., community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using for the first time. Goal: 60% improvement over baseline (or 48 individuals) for seeing a specialist. Data Source: Program records. Milestone 7 Estimated Incentive Payment: *$226,732*

121988304.1.2	*1.7.1*	*1.7.1 A- B*	*1.7.1 IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED A NEEDED TO THE REGION. – (LAKES REGIONAL ELLIS/NAVARRO TELEMEDICINE/TELE-HEALTH PROJECT)*	
Lakes Regional MHMR Center				*TPI# 121988304*
Related Category 3 Outcome Measure(s):	*121988304.3.2*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.*	
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 4 [I-17]: Improved access to specialists care or other needed services, e.g., community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17-1]: Percentage of patients in the telemedicine/telehealth program that are seeing a specialist or using the services for the first time. Goal: Baseline set - minimum of 30 individuals/ e-consultations with a specialist. Data Source: Encounter records from telemedicine program Milestone 4 Estimated Incentive Payment: *$219,362*		**Milestone 6** [I-17]: Improved access to specialists care or other needed services, e.g., community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time. Goal: 40% improvement over baseline (or 42 individuals) for seeing a specialist. Data Source: Encounter records from telemedicine program Milestone 6 Estimated Incentive Payment: *$234,667*	**Milestone 8** [I-17]: Improved access to specialists care or other needed services, e.g., community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time. Goal: 80% improvement over baseline (or 54 individuals) for seeing a specialist. Data Source: Encounter records from telemedicine program. Milestone 8 Estimated Incentive Payment: *$226,731*
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* **$420,550**	Year 3 Estimated Milestone Bundle Amount: **$438,725**		Year 4 Estimated Milestone Bundle Amount: **$469,334**	Year 5 Estimated Milestone Bundle Amount: **$453,463**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***: $1,782,072**				

Project Option 1.12.2 – Expand number of community-based settings where behavioral health services may be delivered in underserved areas: (Lakes Regional Depression/Trauma Counseling Centers)

Unique Project ID: 121988304.1.3 (Pass 2)
Performing Provider Name/TPI: Lakes Regional MHMR Center/121988304

Provider: Lakes Regional MHMR Center's service area includes 12 Texas counties with a total population of 633,045 and spans an area of 6,762 square miles. Our service area crosses four Regional Healthcare Partnership (RHP) areas and is mostly rural. Lakes Regional's community programs serve over 9,500 individuals each year. Over 95% of our consumers are either Medicaid eligible or indigent. This specific project will target individuals in Ellis and Navarro counties. Ellis County has a population of 149, 610 with a span of 952 square miles; Navarro county has a population of 47,735 with a span of 1,086 square miles. Lakes Regional provides community-based, out-patient services to adults with serious mental illness, chemical dependency; to children and adolescents with serious mental illness or emotional disorders; to persons with autism, pervasive developmental disorders or intellectual disabilities; and to infants and toddlers with developmental delays. Over 95% of our consumers served are Medicaid eligible or indigent.
Intervention: This project will create a clinic for provision of evidence-based services for individuals who suffer from depression or trauma related disorders not meeting the state mandated diagnostic criteria for eligibility for state funded behavioral health services primarily residing in Ellis and Navarro counties in RHP 10. This project intervention is new; there is no such clinic in the area oriented to the targeted population of low income and Medicaid recipients in the proposed service area.
Need for the project: The project relates to the Region 10 goals: to improve access to behavioral health services and to reduce the unnecessary use of Emergency Department services (CN.4, CN.10). The project - - will improve access to care and - improve overall quality of care for the targeted safety net population, and lower- the cost of care by decreasing demand on Emergency Department services.
Target population: The target population is low income and Medicaid eligible citizens (not meeting the state funded criteria) who have diagnosable symptoms or a behavioral health crisis. Estimated number of patients to be served over course of waiver period: a minimum of 263**.** Medicaid and indigent individuals and/or families will have access to evidence-based depression and trauma counseling services; Ellis and Navarro counties are designated as Mental Health Professional Shortage areas.
Category 1 or 2 expected patient benefits: Benefit milestones are to establish behavioral health services in a new community-based setting in an underserved area, increased utilization of community behavioral healthcare and improved consumer satisfaction with access. Access to behavioral health and satisfaction with care (indicative of improved ability to self-manage in the community) will improve life for participants, reduce their health related costs, and increase the likelihood of continued use or return to use of behavioral health as opposed to seeking Emergency Department services for emotional related concerns.
Category 3 outcomes: IT-10.1 Quality of Life/ Functional Status: - The goal is to achieve and maintain a mean 10% improvement as measured in a multi-dimensional standardized survey

consistent with the therapeutic goals of the project for the aggregate population in treatment services through the Waiver. Minimum unique participants per year will be: - DY-3=70 , DY-4=84 and DY-5=109; totaling 263.

Project Option 1.12.2 – Expand number of community-based settings where behavioral health services may be delivered in underserved areas: (Lakes Regional Depression/Trauma Counseling Centers)

Unique Project ID: 121988304.1.3 (Pass 2)
Performing Provider Name/TPI: Lakes Regional MHMR Center/121988304

Project Description:
Rural communities are underserved in behavioral health (Hogg Foundation, 2010). This is true for Navarro and Ellis counties where Lakes Regional Mental Health Mental Retardation Center (LRMHMRC) provides services to Intellectually Developmentally Delayed (IDD) individuals in RHP 10. The National Association of State Mental Health Program Directors (NASMHPD) estimated that states have cut $3.4 billion in mental health and IDD funding since FY 2009, while the demand for services has increased. Since FY 2009, demand for community-based services has increased by 56%, and the demand for emergency department (ED), state hospital, and emergency psychiatric care has climbed 18% (Womble 2012). Texas-funded services are restricted to the severely mentally ill (SMI) population by diagnostic code. Others in the community who do not meet the state criteria for supported services other than the local hospital emergency department (ED) need an appropriate place to obtain effective depression and trauma services to lower the overall cost of health care in the county by providing the proper care in the proper context.

LRMHMRC will develop and establish a behavioral health Depression/Trauma Clinic for individuals with a primary need for mental health (MH) screening and treatment for symptoms of depression and mental anguish or trauma. Members of the community similarly affected who do not meet State criteria for SMI services will be able to access the appropriate level of service without engaging the ED. The Screening – Brief Intervention Referral and Treatment (S-BIRT) evidence-based tools to screen and intervene for substance use disorder will be used as well. Screening services will be able to identify and link clients who present with comorbid substance use disorders for effective treatment. Evidence-based individual and group counseling services will be rendered by personnel prepared specifically for depression and trauma screening and interventions.

Goals and Relationship to Regional Goals:

Project Goals:
The goal for the citizens not eligible for State-supported behavioral health services due to diagnostic restrictions is to have an available clinic to provide evidence-based screening and/or treatment services for the array of depression, substance abuse and trauma-related anxiety concerns. Greater satisfaction with appropriate and effective services is a goal for all community participants. Greater personal sense of enhanced quality of life as an outcome will deter participants from use of higher levels of care and increase the likelihood of returning in moments personal crisis to appropriate services rather than ED use.

This project meets the following Regional goals:
The project relates to (CN.4) – Lack of access to mental health services. This contributes to inappropriate ED utilization and (CN.10) – Overuse of emergency department (ED) services.

Challenges:
Access to state-supported mental health services is restricted to those individuals with SMI and the service array narrow in scope around the restricted diagnostic criteria. Members of the broader community in mental and emotional distress due to symptoms related to moderate depression or trauma and who do not have financial resources for private care seek relief through the ED, increasing the overall cost of health services to the community (aside from the costs of other emergency and law enforcement services). Local hospitals seek a solution to the pressure on the ED to serve what are regarded as psychologically related, symptom-driven presentations. There is no apparent mental health trauma treatment available to indigent non-SMI populations in the Region as an alternative to the current pattern of ED usage. RHP 10 has recognized the communities-at-large dearth of MH service in the Community Needs Assessment (CNA) as (CN.4) – Lack of access to mental health services. This contributes to inappropriate ED utilization and (CN.10) – Overuse of emergency department (ED) services. Having a Depression Trauma Clinic as a referral source for the emergency, health and public services personnel in the region will be a valuable niche addition to the health services array.

5-Year Expected Outcome for Provider and Patients:
The five-year expected outcome of the project is clinic resources in the rural underserved county providing outpatient evidence-based screening, counseling and group - services to at least 263 community members, thereby contributing to the overall health delivery system by appropriately and effectively addressing mental health concerns that contribute to inefficiencies, possibly preventable hospitalizations, inappropriate ED utilization, and increased costs. Services will start in DY3 with a minimum unique participant objective of 70 in that year. A 20% increase in DY4 of 84 new unique participants. A 30% increase in DY5 over DY4 will result in 109 unique new participants seen during that year; thus a 263 minimum clientele served over the course of the waiver. Individuals served will experience greater satisfaction and improved personal

efficacy from their state of entry into services. There will be measureable improvement in quality of life from program participation.

Starting Point/Baseline:
While the local hospital personnel in the communities served by LRMHMRC have urged the development of a referral resource for their ED patients who present with behavioral health-driven complaints, no such low-cost solution exists. Program development will require researching all aspects and creating an operational plan: community resources, selection parameters, protocols, evidence-based programming choices, location, hiring and training qualified staff. However, LRMHMRC is well familiar with the community and will be able to extend the services of the Information Technology (IT) and business departments to support accounting, reporting, quality improvement, electronic medical records and telemedicine to cover prescriber service access. Following these DY2 preparations and staffing selections, provider competence in the chosen intervention models will be trained and services initiated in DY3. Continuous improvement strategies will guide the refinement of operations and services from DY3 through DY5. LRMHMRC will seek to collaborate with primary care providers for more integration of care where possible.

Rationale:
Category 1.12, [Option 1.12.2 Expand the number of community-based settings [for] behavioral health services]. Rural communities need adequately trained resources to respond to the demand for care for trauma recovery and depression for populations where those services do not exist. LRMHMRC chose this project category and option due to the restrictions in state budgeted mental health services and the obvious access needs of the unserved populations in these RHP 10 counties. The vast majority of patients with behavioral health problems go without care, visit the ED in emotional/somatic crisis or visit primary care providers without behavioral health specialty care, either because the patient doesn't meet entry criteria into the mental health system (limited to the severely mentally ill) or because the patient refuses behavioral health specialty care due to the stigma attached. The requirements of the State services are often viewed as cumbersome and private care is too costly. Adults with mental illnesses were more likely to use an ED or be hospitalized in the past year (at least one visit) than adults without mental illnesses. Compared with adults without mental illness, adults with SMI were more likely to use an ED (38.8 vs. 27.1%) in the past year and to be hospitalized (15.1 vs. 10.1%) (SAMHSA, 2012).

The milestones and metrics chosen for the introduction of a new clinic serving a niche unavailable in the current health delivery system are in keeping with the Community Needs Assessment (CN.4) – Lack of access to mental health services. Category 1.12, Option 1.12.2. Expand the number of community-based settings [where] behavioral health services also fit this project. The milestones chosen to inform and prepare the project are:

P-3. Process Milestone: Develop administrative protocols and clinical guidelines for projects selected (i.e., protocols and clinical guidelines).

P-4. Process Milestone: Hire and train staff to operate and manage projects selected.

P-6. Process Milestone: Establish behavioral health services in new community-based settings in underserved areas.

Once services are initiated, expanded community presence and access milestones will be:

I-11 Improvement Milestone: Increased utilization of community behavioral health care

I-14 Improvement Milestone: Improved consumer satisfaction with access

Project Components:
Having a clinic in the community available with trained personnel in appropriate service delivery for these concerns will be a new addition to overall community health resources. Many primary care providers feel poorly equipped to handle significant behavioral health issues. "The impact of psychological interventions on the use of medical services was evaluated by examining the outcome of 91 studies published between 1967 and 1997 using meta-analytic techniques and percentage estimates. Results provided evidence for a medical cost-offset effect, specifically in the domain of behavioral medicine. Average savings resulting from implementing psychological interventions was estimated to be about 20%. About one-third of the articles demonstrated that dollar savings continued to be substantial even when the cost of providing the psychological intervention was subtracted from the savings." (Chiles 1999).

LRMHMRC currently serves individuals who receive only medication prescription services for their depressive symptoms and are not interested in other required services under State protocols for enrolled participants, accounting for a large portion of serial failed appointments and wasted professional staff time. Treatment in this type of clinic will allow greater satisfaction with the level of care desired by clients, and the existing SMI clinics to better serve individuals in need of more intense services.

Unique community need identification numbers the project addresses:
CN. 4 Lack of access to mental health services
CN. 10 Overuse of emergency department (ED) services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The Depression/Trauma Clinic provides a needed level of care in the continuum filling an important gap. The milestones and metrics chosen for the introduction of a new clinic serving a niche unavailable in the current health delivery system are in keeping with the Community Needs Assessment item "CN. 4 Lack of access to mental health services" , and to the degree

effective as an alternative will contribute to lower "CN10 – Over use of emergency department (ED) services".

Related Category 3 Outcome Measures:

OD- 10 LRMHMRC chose the outcome domain OD-10 Quality of Life/Functional Status and Improvement target IT-10.1 on the rationale that the sense of greater quality of life and identifiable improvements in functioning along with the satisfaction improvement measure will result in a greater likelihood of continued use of this appropriate level of care as a chosen alternative.

Relationship to Other Projects:

121988304.1.2 Introduce, Expand or Enhance Telemedicine/Telehealth

121988304.1.1 Crisis Respite Behavioral Support –WRAP Project

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

Other providers are proposing projects to reduce ED use for behavioral crisis, but in other counties. The target group for these other projects does not overlap with the area served by LRMHMRC. However, LRMHMRC will seek to share experiences in approach and lessons learned within the Region toward discovering best practices.

This project will participate in the Region's learning collaborative. Please refer to Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of all participating provider projects for each collaborative.

Additionally, Lakes Regional will collaborate with 39 other MHMR centers across the state 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 data through shared data sources in local communities; centers are currently in the process of engaging a consultant to provide leadership and consultation for the project.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Lakes Regional MHMR has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rural communities need adequately trained resources to respond to the demand for care for trauma recovery and depression for populations where those services do not exist. LRMHMRC chose this project category and option due to the restrictions in state budgeted mental health services and the obvious access needs of the unserved populations in the counties The scope of this project could impact at least 100 patients per year, in a largely rural medically underserved geographic area.

In addition, this project was valued based upon three valuation research studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research:

- Valuing the Program to Expand Behavioral Health Outpatient Capacity (ATCIC) – Travis County Region 7, Central Health (2012)
- Valuing the Youth Counseling Program (BTCS) – Fayette County Region 7, Central Health (2012)
- Valuing the Substance Abuse Treatment Program (BTCS) – Guadalupe County Region 6 , University Health System (2012)

These valuation studies used cost-utility analysis, which measures program cost in dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency department visits 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. A complete write-up of project will be available at performing provider site.

Total Five-Year Valuation: $ 2,768,495

References:

Chiles JA et al. The impact of psychological interventions on medical cost offset: a meta-analytic review clinical psychology: *Science and Practice*, June 1999, Vol. 6.

Pallak MS, et al. Medical costs, Medicaid, and managed mental health treatment: the Hawaii study. *Managed Care Q*, 1994 Spring; 2 (2).

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (April 5, 2012). The NSDUH Report: Physical Health Conditions among Adults with Mental Illnesses. Rockville, MD.

Womble K. budget cuts for state mental health programs lead to crowded emergency rooms, Think Progress Health, 2012, thinkprogress.org/health.

121988304.1.3	***1.12.2***	***N/A***	Depression/Trauma Counseling Centers	
Lakes Regional MHMR Centers				121988304
Related Category 3 Outcome Measure(s):	*IT-10.1*	*121988304.3.3*	***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. Metric 1 [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines. **Baseline/Goal:** Project Plan - Stakeholder survey data gathered. Data gathered on Treatment models. EMR reports for client transfer eligibility. Software options gathered. Location information for real estate/leasing agents gathered. **Data Sources**: Program Plan and files. Survey data pool. HR records. **Milestone 1 Estimated Incentive Payment: $326,359** **Milestone 2 [P-4]:** Train existing staff to operate and manage project selected. Metric 1 [P-4.1]: Number of staff secured and trained. **Goal:** Support staff and management hired and trained in new employee orientation and state requirements. **Data Source**: HR records **Milestone 2 Estimated Incentive**	**Milestone 3** [P-4]: Hire and train counseling staff. Metric 1 [P-4.1]: Number of staff secured and trained **Goal:** Hire and train counseling staff in basic requirements of operational and clinical software. Clinicians are additionally trained in chosen evidence-based therapy models, screening and referral. **Data Sources:** HR records, training certificates. **Milestone 3 Estimated Incentive Payment: $340,505** **Milestone 4 [P-6]:** Establish behavioral health services in new community-based setting in underserved area. Metric 1 [P-6.1]: Number of new community-based settings where behavioral health services are delivered **Goal:** Open and provide services rendered. Enhanced professional training accomplished. Target number of clients served 70-). PDSA process cycles in place to inform project development, efficiency and effectiveness. **Data Source:** Client records, schedules Reports of PDSA reviews. **Milestone 4 Estimated Incentive**	**Milestone 5** [I-11]: Increased utilization of community behavioral healthcare. Metric 1 [I-11.1]: Percent utilization of community behavioral healthcare services **Goal:** Expansion of population target of 20% over DY3=84 new unique individuals served is met. PDSA cycle complete with report and improvement targets. **Data Source**: Schedules, client rosters, chart reviews. PDSA document. **Milestone 5 Estimated Incentive Payment: $364,860** **Milestone 6 [I-14]**: Improved Consumer satisfaction with Access Metric 1 [I-14.1]: [>40% of people reporting satisfaction with access to care **Goal:** Satisfaction scores on participant surveys using the MHSIP instrument. PDSA cycle improvements. **Data Source**: Participant surveys and reports. PDSA improvement reports. **Milestone 6 Estimated Incentive Payment: $364,861**	**Milestone 7** [I-11]: Increased utilization of community behavioral healthcare. Metric 1 [I-11.1]: Percent utilization of community behavioral healthcare services **Goal:** Expansion of population target of - 30% over DY4= 109 new unique individuals served is met. PDSA cycle complete with report and improvement targets. **Data Source:** Schedules, client rosters, chart reviews. PDSA document. **Milestone 7 Estimated Incentive Payment : $352,522** **Milestone 8 [I-14]**: Improved Consumer satisfaction with Access Metric 1 [I-14.1]: > 60% of people reporting satisfaction with access to care **Goal:** Satisfaction scores on participant surveys using the MHSIP instrument. PDSA cycle improvements. **Data Source:** Participant surveys and reports. PDSA improvement reports. **Milestone 8 Estimated Incentive Payment: $352,522**

Payment: $326,360	**Payment: $340,505**		
Year 2 Estimated Milestone Bundle Amount: **$652,719**	Year 3 Estimated Milestone Bundle Amount: **$681,010**	Year 4 Estimated Milestone Bundle Amount: **$729,721**	Year 5 Estimated Milestone Bundle Amount: **$705,044**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***: $2,768,494**			

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 1.12.1 – Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the Region where access to care is likely to be limited.

Unique Project ID: *126675104.1.1*
Performing Provider Name/TPI: JPS Health Network/*126675104*

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: JPS Health Network will design and develop the full continuum of behavioral health capacity to improve accessibility to appropriate levels of behavioral health services for population health needs. The project's ultimate benefits and goals are to expand hours and services, provide a more patient-centered focus, manage more patients in an outpatient setting and avoid preventable inpatient admissions and readmissions and emergency department (ED) utilization. This project is a new initiative that will build upon the existing infrastructure of the currently established behavioral health clinics which will result in newly operational operating hours.
Need for the project: This project addresses the following community needs: a) CN.4 Lack of access to mental health services.
Target population: Additional patients accessing outpatient behavioral health services in expanded hours/services - 457 unique patients annually (1,371 unique patients for DY3, DY4, and DY5). This project will expand hours and services, provide a more patient-centered focus, reduce the "no-show rate, manage more patients in an outpatient setting and avoid preventable inpatient admissions and readmissions and emergency department (ED) utilization for the significant number of Medicaid and Uninsured psychiatric patients treated at JPS.
Category 1 or 2 expected benefit: Milestones P-2.1, P-3.1, P-4.1, P-5.1, P-7.1, I-1.1, -, I-13.1, I-40.1, and I-42.1 were selected. Each milestone selected was due to their natural progression to project implementation. The improvement milestones selected are all considered to be indicative of increased behavioral health service capacity.
Category 3 outcomes: Outcomes IT-1.18 and IT-9.2 were selected. There is an evidence base to suggest that increased capacity will have positive impact on each of these outcome areas.

Project Option 1.12.1 – Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the Region where access to care is likely to be limited.

Unique Project ID: *126675104.1.1*
Performing Provider Name/TPI: JPS Health Network/*126675104*

Project Description:
This project will serve a large group of mentally ill patients in Tarrant County through expanded outpatient services. Specifically, this project will offer a larger scope of behavioral health services with expanded hours, increased appointment availability, individual therapy, group therapy, local support groups, improved staffing for throughput and collaboration with primary medical care, enabling the adoption of a more cohesive and patient-centered approach to behavioral health care for 457 unique patients annually (1,371 unique patients for DY3, DY4, and DY5). This project will enhance behavioral health service availability by utilizing multiple evidence-based strategies that will result in expanded depth and breadth of outpatient behavioral health services, including:

- Expanding clinic capacity through enhanced scheduling and increased staffing;
- Increasing the days and hours of operation at existing behavioral health clinics to provide medication management and psychiatric evaluation services;
- Adding counseling/psychology services at selected locations to help with follow-up; provide resource identification and referral; transition groups from inpatient to outpatient services; deliver brief problem-focused cognitive behavioral therapy (CBT); conduct screening, brief intervention, and referral to treatment (SBIRT); and coordinate family and patient support groups; and
- Creating a therapy academy that incorporates licensed professional counselor (LPC) and licensed master social worker (LMSW) students from local universities and other appropriate clinical practicum sites to provide supervised, short-term counseling.

Goals and Relationship to Regional Goals:
Project Goals:
JPS Health Network will design and develop the full continuum of behavioral health capacity to improve access to appropriate levels of behavioral health services for population health needs. The project's ultimate benefits and goals are to expand hours and services, provide a more patient-centered focus, manage more patients in an outpatient setting and avoid preventable inpatient admissions and readmissions and emergency department (ED) utilization.

This project meets the following Regional goals:
This project directly addresses Tarrant County's critical behavioral health care access needs. Specifically, we propose to offer expanded outpatient behavioral health services and increased access to these services to Tarrant County residents struggling with mental illness.

Challenges:
JPS Health Network is located in Tarrant County, which accounts for 74% of the Region's population. There are significant behavioral health needs within Tarrant County, particularly for the uninsured and socioeconomically disadvantaged. The Region's community health needs assessment identified inadequate follow-up care as a major behavioral health need. Further, the assessment indicated that approximately 19% of Tarrant County residents experienced five or more "bad" mental health days in a 30-day period. It has also been established that on average one in four adults experiences a mental health disorder in a given year.[34] There is currently a delay until next available behavioral health appointment for a new patient of over 120 days in some clinic locations. Patients in the MHMR system experience similar and, sometimes longer, waiting periods. The expansion of the existing location hours and services will allow us to reduce this time until next available appointment substantially.

JPS Health Network has emergency psychiatric services, inpatient psychiatric beds and behavioral health clinics that provide psychiatric medication management services, but lacks a fully developed continuum of care, particularly in the outpatient setting. Behavioral health clinics have limited hours of operation and availability for follow-up, limiting their focus to medication management, with no available outpatient therapeutic or counseling support offered at this time. As a result, most ongoing behavioral health issues are addressed in the inpatient setting, which is more costly and designed for more acute health needs. Further there are likely additional unidentified and unmet needs in Tarrant County. National data suggests that as many as two-thirds of those with a diagnosable mental health disorder do not currently receive treatment.[35]

5-Year Expected Outcome for Provider and Patients:
At the end of the Waiver, we expect a significant increase in the depth and breadth of behavioral health services we offer as outpatient services, resulting in a decrease in emergency department utilization and improved access to outpatient services for mentally ill patients.

Starting Point/Baseline:
Currently, behavioral health patients wait up to 90 days for follow-up and new patient appointment for medication management in the behavioral health clinics. There is no access to counseling or psychology-related services beyond those delivered while managing the patients'

[34] "NIMH: The numbers count—Mental disorders in America" National Institutes of Health. www.nimh.nih.gov/publicat/numbers.cfm.
[35] U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, Md., U.S. Department of Health and Human Services, Substance Abuse and Mental- Health Services Administration, Center for Mental Health Services,1999, pp. 408409, 411.

medications. JPS Health Network operates outpatient behavioral health service at four locations for a combined count of 12 days each week (two clinics are open two days each weekend two clinics are open four days each week). In fiscal year 2011, these existing clinics served 8,224 unique patients with a total of 22,908 visits. There is no counseling or social work support available. The clinics do not utilize medical assistants to improve patient flow and throughput.

Rationale:

This project was selected due to the lack of access to mental health services in our Region (CN.4). All but one county in Region 10 are recognized as Health Professional Shortage Areas for mental health providers. The project's therapy academy will allow for the training and development of additional behavioral health providers. Additionally, this project will enable JPS Health Network to take full advantage of internal opportunities related to improving access to behavioral health services. Finally, we selected the collection of strategies associated with this project because they are well-established best practices. The therapy resources will rely heavily upon motivational interviewing, SBIRT, CBT, cognitive behavioral social skills training, and Wellness Recovery Action Planning. All of these therapeutic approaches are recognized in SAMHSA's National Registry of Evidence-Based Programs and Practices[36,37]. Increasing capacity through additional, more flexible hours and days of operation is clearly a best practice to create increased access and throughput. The utilization of supportive counseling is also a well-recognized approach to the treatment of mental illness.[38,39]

Project Components:

Evaluating existing transportation programs was not a milestone, but the project's core component will be accomplished in DY2 through the P-2 process milestone of identifying licenses, equipment requirements and other components needed to implement. We will fulfill the requirement to review the interventions' impact on access to behavioral health services and identify lessons learned, opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety net populations through our ongoing department quality improvement processes.

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[36] Cook JA, Copeland ME, Jonikas JA, Hamilton MM, Razzano LA, Grey DD et al. (2010). Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning. www.samhsa.gov.

[37] Bach P, & Hayes, SC. (2002). The use of Acceptance and Commitment Therapy to prevent the re-hospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 70(5), 1129-1139.

[38] Granholm E, Holden J, Link PC, McQuaid JR, & Jeste DV. (2011). Randomized controlled trial of Cognitive Behavioral Social Skills Training for older consumers with schizophrenia: Defeatist performance attitudes and functional outcome. *American Journal of Geriatric Psychiatry.*

[39] Cook JA, Copeland ME, Jonikas JA, Hamilton MM, Razzano LA, Grey DD et al. (2010). Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning.

We selected most of the recommended process milestones for this project. These will be utilized as significant markers along the project implementation timeline. We consider them a series of methodical measures of progress to successful project implementation. Selected milestones include identification of operational requirements and necessary administrative protocols, hiring and training of staff, establishment of additional hours, continuous improvement efforts, and increasing utilization of community behavioral health services while reducing unnecessary ED utilization.

Additionally, these milestones will enable us to specifically assess our progress in meeting the documented need for increased behavioral health services and access in our community (CN.4). Respondents to the Regional Stakeholder Survey identified accessing behavioral health services as "very difficult" with a very significant impact on overall population health

Unique community need identification numbers the project addresses:

- CN.4 – Lack of access to mental health services. All but one county in Region 10 are recognized as Health Professional Shortage Areas for mental health providers.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new that initiative has not received any other federal funding.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

- **IT-1.18** Follow-Up After Hospitalization for Mental Illness – NQF 057620 was selected because between 25 and 50% of patients who miss mental health appointments disengage from treatment entirely.[40] Dropping out of treatment after a psychiatric hospitalization increases the likelihood of rehospitalization from one in 10 to one in four.[41] This project will improve follow-up by improving the availability and accessibility of outpatient behavioral health services to be utilized following hospitalization. This measure also directly impacts our identified community needs. There is limited access to mental health services (CN.4) and failure to follow up after discharge creates increased missed appointment rates, resulting in poor utilization of available resources. Additionally, there is insufficient integration of mental health care in the primary care medical care system (CN.5). Improving follow-up after hospitalization allows for the integrated care project and transition managers to assist in better integrating care for these individuals as they begin to receive community-based services. Finally, there is a need for more care coordination (CN.11). Increasing follow-up

[40] Killaspy H. (2007). Why do psychiatrists have difficulty disengaging with the out-patient clinic? Invited commentary on: Why don't patients attend their appointments? *Advances in Psychiatric Treatment*, 13, 435- 437.
[41] Mitchell AJ, & Selmes T. (2007). Why don't patients attend their appointments? Maintaining engagement with psychiatric services. *Advances in Psychiatric Treatment*, 13, 423-434.

rates after hospitalization will create the opportunity for better coordination of care between inpatient and outpatient behavioral health service delivery systems.

- **IT-9.2** ED appropriate utilization was selected because 97% of adults and children receiving public community-based mental health services have avoided a crisis episode.[42] JPS Health Network experiences over 24,000 psychiatric emergency visits per year. The availability of additional outpatient behavioral health services will ensure patients engaging in their individualized care plan, enhancing stabilization and service utilization outside of the emergency system. This measure also directly impacts our identified community need to reduce overuse of emergency department services (CN.10). Increased outpatient behavioral health services will result in reduced utilization of emergency services, because patients will have more care options in community-based services.

Relationship to Other Projects:

- 1.12.2 – Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care). Expansion under this project is necessary to accommodate the additional demand likely experienced by adding additional locations with more structured care. Additionally, the more structured programs will be utilized by these expanded services when patients begin to deteriorate, potentially avoiding inpatient admissions.
- 2.15.1 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services (integrated care). Integrated care projects will incorporate newly expanded sites and associated patients.
- Project 126675104.2.7 – Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders. The expanded hours and continuum will be utilized as a resource by the behavioral health transition management team. The new services/hours will accommodate patient needs upon hospital discharge and avoid readmissions.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project.

[42] Department of State Health Services Behavioral Health Data Book, FY 2010, 4th Quarter, Figures 1.6, 1.7, 1.9, 2.6, 2.7.

JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as mentally ill patients in Tarrant County. The percentage of the population expected to be positively impacted by the project is 100% of patients discharging from Trinity Springs Pavilion. JPS Health Network will improve over baseline the number of patients who received care within 30 days and 20% of patients will reduce emergency department visits for target conditions – behavioral health and substance abuse. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that the value of this project is a 4 on a scale of 1 to 5. We believe this to be the correct number because when a person is positively impacted, his or her ability to control behavioral illness is significantly improved.

To determine the value to the community of each individual positively impacted, we concluded that the value of this project is a 3, on a scale of 1 to 5. We believe this to be the correct number because when a person is positively impacted, - he or she will be likely to relapse and need follow-up care in a limited psychiatric inpatient area and will be less likely to use the ED allowing more access for other community members.

Specifically, 1371 unique patients (457 unique patients annually for DY3, DY4, and DY5) receiving outpatient behavioral health service from expanded locations/hours will be positively impacted in the following quantifiable ways:

- Increased utilization of community behavioral health care by 5% over life of project.
- Decreased number of cancelled or “no-show” appointments for individuals receiving services through expanded access sites by two percentage points over life of project.
- Improved number of patients who received care within 30 days of hospitalization by a percentage to be determined in DY3.
- Improved number of patients who received care within 7 days of hospitalization by a percentage to be determined in DY3.
- Reduced emergency department visits for Behavioral Health/Substance Abuse conditions by a percentage to be determined in DY3.

126675104.1.1	***1.12.1***		*Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the State where access to care is likely to be limited.*
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.1* *126675104.3.2*	*IT-1.18* *IT-9.2*	Follow-Up After Hospitalization for Mental Illness- NQF 0576 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 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. Baseline/Goal: Project Plan Data Source: Project Documentation, Regulatory Requirement Documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $803,225	**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: Currently 0 to improve to 5 -. Staff count will not include student counselors. Data Source: Project records, Training documentation Milestone 3 Estimated Incentive Payment *(maximum amount):* $410,755 **Milestone 4** [P-5]: Establish extended hours, transportation and / or mobile clinic options Metric 4 [P-5.1]. Number of areas prioritized for intervention with options in operation Baseline/Goal: 4 areas prioritized for intervention with options in operation Data Source: Project documentation, Scope of Service	**Milestone 7** [I-1]: Increased utilization of community behavioral health care Metric 1 [I-1.1]: Percent utilization of community behavioral health care services. Baseline is 8224 unique patients receiving community behavioral health services. Goal is -3.5% increase from baseline in utilization of community behavioral health services. Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 7 Estimated Incentive Payment *(maximum amount):* $878,826 **Milestone 8** [I-13]: Adherence to scheduled appointments. Metric 1 [I-13.1]: X% decrease in the	**Milestone 9** [I-1]: Increased utilization of community behavioral health care Metric 1 [I-1.1]: Percent utilization of community behavioral health care services. Baseline is 8224 unique patients receiving community behavioral health services. Goal is - 5% increase from baseline in utilization of community behavioral health services. Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 9 Estimated Incentive Payment *(maximum amount):* $725,987 **Milestone 10** [I-13]: Adherence to scheduled appointments.

126675104.1.1	***1.12.1***		*Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the State where access to care is likely to be limited.*
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.1* *126675104.3.2*	*IT-1.18* *IT-9.2*	Follow-Up After Hospitalization for Mental Illness- NQF 0576 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 2 [P-3]: Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for a transportation program). Metric 1 [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline/Goal: Manual of Operations Data Source: Project Documentation, Regulatory Requirement Documents Milestone 2 Estimated Incentive Payment *(maximum amount):* $803,224	documentation, Encounter Data, Milestone 4 Estimated Incentive Payment *(maximum amount):* $410,755 **Milestone 5** [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: Complete PDSA cycles and report to standing department PI meeting. Data Source: Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Milestone 5 Estimated Incentive Payment *(maximum amount):* $410,755 **Milestone 6** [P-X]: Establish baseline and improvement	number of cancelled or "no-show" appointments for individuals receiving services through expanded access sites from. Baseline/Goal: Baseline is 32.36% / Goal is to reduce to 31.36% Data Source: Encounter data, EMR, Utilization Report Data Source; Claims data and encounter data from expanded access sites Milestone 8 Estimated Incentive Payment *(maximum amount):* $878,826	Metric 1 [I-13.1]: X% decrease in the number of cancelled or "no-show" appointments for individuals receiving services through expanded access sites from. Baseline/Goal: Baseline is 32.36% / Goal is to reduce to 30.36% Data Source: Encounter data, EMR, Utilization Report Data Source; Claims data and encounter data from expanded access sites Milestone 8 Estimated Incentive Payment *(maximum amount):* $878,826

126675104.1.1	***1.12.1***		*Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the State where access to care is likely to be limited.*	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.1* *126675104.3.2*	*IT-1.18* *IT-9.2*	Follow-Up After Hospitalization for Mental Illness- NQF 0576 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)**
	target for I-12.1 – Use of emergency department Metric 1 [P-X.1.]: Baseline and Improvement percentage for 1-12.1 for DY4 and DY5 Baseline/goal: PEC (ED) Utilization Report Data Source: Encounter Data, EMR Milestone 5 Estimated Incentive Payment *(maximum amount):* $410,758			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,606,449	Year 3 Estimated Milestone Bundle Amount: $1,643,023		Year 4 Estimated Milestone Bundle Amount: 1,757,652	Year 5 Estimated Milestone Bundle Amount: $1,451,974
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $6,459,097				

Project Option 1.6.2 – Enhance Urgent Medical Advice

Unique Project ID: 126675104.1.2
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: This project will establish a 24/7 call center with nurse advice to direct patients to the right care at the right place and reduce ED admissions. This project is a new initiative.
Need for the project: Reducing unnecessary ED utilization is a regional need.
Target population: Patients and family members that access network services within the Tarrant County Hospital District will benefit from the 24/7 nurse advice line and call center. - There are approximately 67,000 patients receiving care in our outpatient primary care clinics and just over 1200 patients that were readmitted for all cause within 30 days or less during the FY2011. While the outcomes of the project are specifically targeted at the medical home population for the potential preventable ED outcome, the All Cause Readmission is targeted at the 1200 plus patients (all payers) that were readmitted to the hospital within 30 days or less. Some of these patients are not enrolled in the Connection program and are not patients receiving care in the outpatient clinics.
Approximately 25-50 new patients are enrolled each week in the Connection program. All patients visiting the network will be directed to the Call Center by utilizing discharge summaries, enrollment documents and other advertising media.
Expected patient benefits: The project will connect patients to urgent medical advice, provide first call resolution to most questions and assist patients with access to the JPS Health Network outpatient clinics or other community resources to receive appropriate care. Providing urgent nurse advice has been shown to reduce unnecessary ED admissions in other systems.
Category 1 or 2 expected patient benefits: Milestones involve establishing metrics, training nurses by establishing clinical protocols, measuring patient satisfaction with the nurse advice line and increasing the number of patients that use the advice line.
Category 3 outcomes: Category 3 outcomes measure potentially avoidable ED admissions with a planned reduction of 10% over the waiver period (2100 visits) and 30-day all-cause hospital readmissions for all payers are expected to be reduced by 15% or 265 fewer readmissions over the waiver period. These outcomes are based on data from FY2011.

Project Option 1.6.2 – Enhance Urgent Medical Advice

Unique Project ID: 126675104.1.2
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
In order to increase patient access to timely medical advice and medical care, JPS Health Network will implement a centralized call center with a focus on one call resolution including a nurse advice team to direct callers to the right place for the right level of service.

Building on current existing infrastructure, technology, people and processes, JPS Health Network will implement a system that allows customer concerns to be addressed as quickly as possible. In order to embed standard protocols and a customer focus, the current decentralized telephone entry points will be centralized under one director of pre-arrival services. Customer service will be standardized and implemented for call center employees, technology will be optimized to improve efficiencies and the nurses will be trained on recognized clinical triage protocols (Schmitt-Thompson) so that medical advice is consistent and timely. [1] Partnering with primary care physicians to develop standard protocols and expectations, the nurse triage program will become an extension of the medical home.

The nurse advice team, working under physician approved guidelines, will be available 24/7 to provide timely medical advice, triage need for urgent or emergent medical care, assist with needed same day or next day appointment scheduling in the patient's medical home (if appropriate),and assist with prescription refills.

The call center will focus on all pre-arrival services including general public inquiries, outpatient appointment scheduling, pre-registration, referrals/outpatient authorization for specialty appointments, and centralized call routing for other network services or individuals.

Goals and Relationship to Regional Goals:
Project Goals:
The five-year goals of this project are to:

- Improve patient access to timely medical advice and medical care;[43]
- Improve triage so that patients receive care in the most appropriate setting;
- Increase patient satisfaction by providing one call resolution whenever possible; and
- Enhance performance metrics, standardize employee training, and align resources to achieve operational efficiencies.

43 Thompson, DA, Schmitt, B. Clinical Content. Revised 4/2010

This project meets the following Regional goals:
A major goal of the Region is to reduce overutilization of emergency departments for potentially preventable admissions. If a potential patient can be provided appropriate medical advice in a timely manner, many patients will be appropriately directed away from non-urgent care in the ED. Another goal of the Region is to overcome financial barriers to care. The nurse advice program will be a free service provided to the community. The nurse advice team will be a resource for linking patients to all services available in the community.

Challenges:
From an infrastructure starting point, JPS Health Network has recently implemented an EMR (Epic) and a robust telecommunications system (NEC). There are currently over 40 monitored telephone entry points that are advertised to the community at large. With so many decentralized entry points, staffing and standardized customer service expectations are difficult to manage.

A commitment to improvement is not yet ingrained in the culture and registration staff does not understand their role in the patient care experience. Customer service expectations are not aligned to national benchmarks. A phone call is the first entry point to the system and can shape a patient's expectation of care or guide a patient to the appropriate place to seek care.

Through this project, the organization seeks to embed an understanding of the systemic impact of customer service at every entry point as well as emphasize one call resolution in making sure the patient is directed to the right place for care.

As the safety net provider for the county, JPS Health Network provides care for a large number of uninsured or underinsured patients. The Connections program provides medical care, both chronic and acute, to residents of Tarrant County whose income is less than 300% of poverty level.

Having a 24/7 centralized call center with nurse advice available provides timely access to both our current and prospective patient population. Patients will be directed to one phone number and using the EMR and standardized protocols, a team of call center representatives (both clinical and non-clinical) can triage and direct patients to the appropriate level of care. Patients will access via one number to all the services they need. Patients can be directed to the right place for care. The nurse triage system will capture needed clinical information so that specialists and primary care providers are better able to coordinate care across this very large system. Once implemented the system should reduce inappropriate ED visits as well as readmissions. This project is linked to several other projects in the network designed to improve coordination of care.

5-Year Expected Outcome for Provider and Patients:
The five year expected outcome is to:

- Decrease utilization of the ED for potentially preventable ambulatory care sensitive conditions by -10%-or 2100 visits;-and
- Reduce all-cause 30-day readmissions by 15% or 265 less readmissions for all payers.

Starting Point/Baseline:

In the current decentralized phone system, JPS Health Network has an abandonment rate that reaches as high as 40% at our monitored telephone entry points during high census. In a 12-month period (FY2011), the system recorded over 2.6 million phone calls received with an overall abandonment rate of 16%. The abandonment rate represents 437,000 potential customer encounters that did not have resolution.

Patient concerns received during regular business hours are forwarded electronically to nurses who are providing patient care, and often go unanswered for several days if not identified as urgent by staff taking the phone call. During evening and weekend hours, a nurse triage system is available for primary care patients. The triage service is receiving about 450 phone calls per month. About 10% of those patient encounters result in a visit to the ED. Based on survey results, the remaining 90% of patients calling the evening service report they would have gone to the ED if the service was not available.

In an initial pull of discharge claims data for fiscal year 2011, there were over 40,000 ED encounters attributed to our JPS Connections participants. Of these visits, over 54% or 21,000 admissions have been identified as potentially preventable ED encounters based on the NYU preventable ED algorithm.[44]

In addition, the JPS Network had a readmission rate of 14% in our Connections population for hospital fiscal year 2011, accounting for 621 readmissions. For all payers, a total of 1,211 patients accounted for 1,767 readmission encounters.

Rationale:

Lack of coordinated primary care and overutilization of the ED are both addressed in our Community Needs Assessment. This project was selected to both improve access to timely care and coordination of care using a nurse advice team to direct patients to appropriate care. The project also extends the primary care provider reach, as the team can provide 24/7 appointment scheduling for acute care needs, provide additional instructions after appointments or discharge and help to get prescriptions refilled in a timely manner.

[44] http://wagner.nyu.edu/faculty/billings/nyued-background.php

Our system has recently recognized the importance of building continuity of care between our inpatient, ED and outpatient system of care. With the implementation of the EMR in May 2012, an opportunity exists to build a coordinated care system for current and prospective patients and their families. Providing 24/7 nurse triage has been shown to reduce ED admissions and improve patient satisfaction.[45,46]

Project Components:
This project was chosen to improve the patient experience, extend primary care capacity by providing enhanced access to timely medical advice and to reduce unnecessary utilization of the ED as well as reduce potentially preventable readmissions.

The project includes all key components identified. Our milestones measure a reduction in potentially preventable ambulatory care sensitive conditions, and reduction in preventable 30-day readmissions.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.8 – Lack of access to health care due to financial barriers
- CN.10 – Overuse of emergency department (ED) services.
- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and no federal funding has been received.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale For Selecting The Outcome Measures:
IT-9.2 ED Appropriate Utilization

By the end of the Waiver, our goal is reduce avoidable ED visits by 10% for the JPS Health Network medical home population. An initial pull from our EMR shows that our Connections patients had a high percentage of potentially preventable ED admissions using the New York University Avoidable ED algorithm. There have been studies showing a reduction in ED utilization when timely medical advice and access to primary care are readily available in a community.[3,4] Access to 24/7 medical advice is required by patient-centered medical home

[45] Bunn F, Byrne G, Kendall S. Telephone consultation and triage: effects on health care and patient satisfaction The Cochrane Library 1(2009)
[46] Bogdon G et al. Evaluating patient compliance with nurse advice line recommendations and the impact on healthcare costs. *American Journal of Managed Care* 2004. 10, 8:534-542.

certification agencies including NCQA and the Joint Commission.[47,48] Moreover, numerous studies have found that nurse telephone triage is safe and effective and does not jeopardize patient safety.[49,50,51]

IT- 3.1 All-cause 30-day Readmission
Call centers providing medical advice have been shown to be a cost-effective care delivery model. Several articles have been published that show both a reduction in cost and a reduction in avoidable ED visits in pediatric populations.[52,53,54] Over 75% of the inpatient admissions at JPS Health Network originate in the ED. When reviewing factors contributing to all-cause 30-day readmissions, a study of 18 hospitals noted that transitions care planning, availability of clinical follow-up care, medication management and advanced end-of-life care are directly related to readmissions.[13vi]Planned interventions for the call center include timely medical advice, urgent appointment scheduling in the medical home and timely prescription refills. The call center nurse advice team will link the caller to appropriate resources and reduce potentially preventable admissions.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**: This project will support Project 126675104.2.2 (Expand/enhance medical homes) by providing 24/7 access to medical advice. The project also supports Project 126675104.2.11 (Improve patient experience) by providing a customer service center that will provide one call resolution for most patient inquiries. Projects 126675104.2.5 (Enhance care transitions) and 126675104.1.3 (Enhance/expand specialty care) will also benefit from the availability of 24/7 medical advice, and an opportunity to connect patients to the right place for care. The following projects will have a subset of the targeted populations reported in Category 3 (Reducing ED

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[47] https://www.ncqa.org

[48] https://www.jointcomission.org

[49] Frisbee S, Malloy M, Meurer J et.al. Urban Wisconsin pediatric patients using an after hours telephone triage service: outcomes and compliance. *Wisconsin Medical Journal*. 2001;100(5):55-57.

[50] Kempe A, Kempsey C, Whitefiled J et al. Appropriateness of urgent referrals by nurse at a hospital-based pediatric call center. *Archives of Pediatric and Adolescent Medicine*. 2000;154:355-360.

[51] Kempe A, Luberti A, Belman S et.al. outcomes associated with pediatric after-hours care by call center: a multicenter study. *Ambulatory Pediatrics*. 2003:3(4),211-217.

[52] Kempe A, Lubeti A, hertz A et.al. The delivery of pediatric after-hours care by call centers: a multicenter study of parental perceptions and compliance. *Pediatrics*. 2001;108:107.

[53] Bunik M, Glazner J, Chandramouli V et.al. pediatric telephone call centers: how do they affect health care use and costs? *Pediatrics*. 2007 Feb;119(2):e305-13.

[54] Barber JW, King WD, Monroe KW et.al. Evaluation of emergency department referrals by telephone triage. *Pediatrics.* 2000;105:819-821.

utilization): 126675104.2.-8 (MedStar Patient Navigator) will manage a subset of 778 medical home high utilizers and Project 126675104.2.4 (CHF Heart Failure) will manage a subset of 263 CHF patients.

- **Related Category 4 Population-focused improvements**: This project will support and reinforce reporting domains RD 1.1, RD 1.2, RD 1.3, RD 1.4, RD 1.5, RD 1.6 by providing timely medical advice to direct a patient to care at the right place.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as patients who dial 911 for medical assistance. The percentage of the population expected to be positively impacted by the project is 41%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that the value of this project is a 2 on a scale of 1 to 5. We believe this to be the correct number because when a person is positively impacted, - they will have improved access to scheduling appointments and speaking directly to a nurse for medical questions in a more efficient manner.

To determine the value to the community of each individual positively impacted, we concluded that the value of this project is a 3 on a scale of 1 to 5,. We believe this to be the correct number because when a person is positively impacted, - the patient experience throughout the community will be improved through lower wait times on the phone and the ability to call one number to achieve multiple basic patient needs, like urgent medical advice and scheduling doctor appointments.

126675104.1.2	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.
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.3 126675104.3.4	IT-3.1 IT-9.2	*All-cause 30-day Readmissions* *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]**:** Collect baseline data, if medical advice line currently exists in RHP; Develop metrics specific to the medical advice line in use by the performing provider to track access to specified patient population determined by RHP. Metric 1 [P-2.1]: Documentation of baseline assessment Baseline/Goal: Establish and verify baselines for the following: • Number of patients who access the nurse advice line • Number of patients given an urgent appointment when appropriate • Number of patients referred to the ED when appropriate • Number of patients provided a medical home appointment when care was not urgent • Proportion of ED visits that	**Milestone 4** [P-3]: Train nurses on clinical protocols Metric 1 [P-3.1]**:** Number of nurses trained Baseline/Goal: 50% of nurses employed in the primary care clinics and nurse advice team will be trained on adopted protocols Data Source: Training documents, evidence of course completion Milestone 4 Estimated Incentive Payment: $1,251,033 **Milestone 5** [P-6]: Inform and educate patients on the nurse advice line Metric 1 [P-6.1]: Number or percent of targeted patients informed/educated Baseline/Goal: 80% of new patients empaneled in a Medical Home will receive information on the nurse advice line Data Source: After visit summary from the EMR, new patient orientation information, and other materials	**Milestone 10** [I-13]**:** Increase in the number of patients who accessed the nurse advice line Metric 1 [I-13.1]: Utilization of nurse advice line. Goal: Using validated and verified baseline data from DY2, expand use of the nurse advice line by 25% of unique patients Data Source: EMR and telephone system Milestone 10 Estimated Incentive Payment: $2,230,524 **Milestone 11** [I-14]: Increase patients in defined population who utilized the nurse advice line and were given an urgent medical appointment via the nurse advice line when needed Metric 1 [I-14.1]: Number of urgent medical appointments scheduled via the nurse advice line Goal: Increase utilization by 25%of patients using the nurse advice line and needing an urgent medical appointment as validated	**Milestone 13** [I-15]: Increase patient satisfaction Metric 1 [I-15.1.]: Increase surveyed patients who believed the advice provided was appropriate Goal: Survey will be developed in DY2, and administered starting in DY3. Increase by 10% over DY3. Data Source: Survey tool Milestone 13 Estimated Incentive Payment: $2,763,910 **Milestone 14** [I-16]: Increase patients in defined population who utilized the nurse advice line and were given a medical home appointment via the nurse advice and appointment line when the condition was not urgent Metric 1 [I-16.1]: Number of medical home appointments scheduled via the nurse advice line Goal: Increase by 25% over baseline that number of patients scheduled in a medical home when medical advice was not urgent as validated in DY2

126675104.1.2	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.
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.3 126675104.3.4	IT-3.1 IT-9.2	*All-cause 30-day Readmissions* *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)
used the Nurse Advice Line versus those that did not access the Nurse Advice Line • Patient Satisfaction with nurse advice line Data Source: EMR, nurse triage software, claims data and documented/validated patient satisfaction survey Milestone 1 Estimated Incentive Payment: $2,038,651 **Milestone 2** [P-1]: Establish clinical protocols for an urgent medical advice line within 4 years of the demonstration period with a vetting process within the RHP. ED clinical protocols are currently used by several hospitals and hospital councils in Texas to determine appropriate and non-appropriate ED visits. <u>Metric 1</u> [P-1.1]: Submission of complete protocols. Baseline/Goal: Partner with	used to inform new patients in the Medical Home system Milestone 5 Estimated Incentive Payment: $1,251,033 **Milestone 6** [P-9]: Review project 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. <u>Metric 1</u> [P-9.1] Implementation of one of new idea, practice, tool, or solution tested per week by each provider. Data Source: Description/catalog of each idea, practice, tool, or solution tested by each provider each week. Milestone 6 Estimated Incentive Payment: $1,251,033	in DY2 Data Source: EMR and telephone system Milestone 11 Estimated Incentive Payment: $2,230,524 **Milestone 12** [P-12] Proportion of admissions/readmissions of ED visits that used the help line versus those who did not use the help line. <u>Metric 11</u> [P-12.1] Percent of ED visits for target population who did not use the call line and got admitted/readmitted to the hospital. Goal: Reduce by 10% those Medical Home patients that did not use the call line and got admitted/readmitted to the hospital from baseline as validated in DY2 Data Source: Claims, EHR Milestone 12 Estimated Incentive Payment: $2,230,525	Data Source: EMR and telephone system Milestone 14 Estimated Incentive Payment: $2,763,911

126675104.1.2	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.	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.3 126675104.3.4	IT-3.1 IT-9.2	*All-cause 30-day Readmissions* *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)**
physicians to adopt and implement standard clinical protocols Data Source: EMR and other recognized clinical protocols Milestone 2 Estimated Incentive Payment: $2,038,651 **Milestone 3** [P-4]: Establish/Expand nurse advice line by 20% of nurse availability base on baseline data to increase access to patients based on need within RHP. Metric 1 [P-4.1]: We will expand the nurse advice line availability by 20% either in hours of operation or additional staff based on patient need. Data Source: HR documentation, documentation of hours Milestone 3: Estimated Incentive Payment: $2,038,652	**Milestone 7 [P-11]** Develop standardized customer service policies/procedures and performance metrics for the call center Metric 1 [P-11.1] Implement orientation, training and accountability standards for all employees of the call center, share lessons learned Data Source: Orientation and training manual, training acknowledgement, documentation of shared lessons learned Milestone : Estimated Incentive Payment: $1,251,033 **Milestone 8** [P-12]: Develop and administer a validated patient satisfaction survey for those patients using the nurse advice line to determine satisfaction with advice given Metric 1 [P-12.1] Evaluate survey responses, implement interventions based on responses and share lessons learned			

126675104.1.2	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.	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.3 126675104.3.4	IT-3.1 IT-9.2	*All-cause 30-day Readmissions* *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)**
	Data Source: Documented intervention plan and lessons learned Milestone 8: Estimated Incentive Payment: $1,251,034			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $6,115,954	Year 3 Estimated Milestone Bundle Amount: $6,255,166		Year 4 Estimated Milestone Bundle Amount: $6,691,573	Year 5 Estimated Milestone Bundle Amount: $5,527,821
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $24,590,515				

Project Option 1.9.2 – Expand Specialty Care for Ophthalmology and Wound Care

Unique Project ID: 126675104.1.3
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hosptial is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.

Intervention: This project will increase capacity in targeted specialties within the JPS Health Network. This project represents a new initiative.

Need for the project: The demand for specialty care continues to increase along with wait times as patient satisfaction scores decline.

Target population: Current and future enrolled JPS Connection patients are the targeted population. -There are currently 17,000 diabetic patients in the network that will require a routine eye exam each year of the waiver period. In addition, all patients accessing specialty care will benefit from a reduction in wait times as a specialty access plan is developed. There are over 50,000 unique patients accessing specialty care each year in the network.

There were 794 admissions for either primary or secondary diagnosis of pressure ulcer in FY2011. The project is expected to reduce costs of stay for all patients admitted to the hospital during the waiver year period. With the implementation of a wound care program, cost of stay will be reduced by reducing inpatient days through increased training, standardization of care and the availability of outpatient follow-up care.

Expected patient benefits: The project will enhance access to specialty care for both the Medicaid and Connection population for both routine eye exams and wound care thereby reducing unnecessary hospital stays and improving compliance with routine eye exams. The project is focused on reducing wait times and enhancing operational efficiency for 6 additional specialty clinics during the waiver period.

Category 1 or 2 expected patient benefits: Milestones include establishing a specialty access plan, -, establishing and standardizing referral guidelines for specialty care, establishing a wound care clinic and increasing volumes and hours of availability in specialty clinics. Four additional ophthalmology clinic sites will be developed within the patient centered medical homes. Six clinics will be targeted for redesign to include referral standardization, enhancing operational efficiency and expanding both service hours and clinic capacity.

Category 3 outcomes: Category 3 outcomes include improving compliance with routine diabetic eye exams (8,597 patients in DY5) , reducing 3rd next available appointment for routine eye exams (17,000 diabetic patients annually) and - reducing costs for ulcers acquired both within and outside the hospital (approximately794 admissions annually).

Project Option 1.9.2 – Expand Specialty Care for Ophthalmology and Wound Care
Unique Project ID: 126675104.1.3
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
To improve access to specialty care for a vulnerable population, JPS Health Network will recruit optometrists to be housed in our primary care clinics for more general eye exams and diagnoses such as hypertensive and diabetic eye exams, glaucoma care, red eye, dry eye and minor traumatic eye injuries. Optometrists can also provide general eye exams and prescriptions for corrective lenses. The optometrists will be first responders and will work closely with our ophthalmology medical director for appropriate referrals. Standardized referral guidelines will be developed and disseminated. Referrals will be tracked for appropriateness and time from referral to consult visit with appropriate clinician. Four exam rooms will need to be appropriately equipped for the provision of retinal photography, visual acuity, refraction and tonometry. Support staff will need to be trained to deliver this care in the primary care office.

In addition, JPS Health Network will launch a Wound Care Center – an outpatient specialty currently not provided. JPS Health Network will recruit a medical director, a mid-level, and RN coordinator. Additionally, the following team members will need to be allocated/recruited, trained and integrated into the team: general and specialty surgeons, infectious disease physician, physical therapists, dietitians, pain management specialist, diabetes educator and general nursing and tech support. The medical director will work with administration to develop a comprehensive wound program for both inpatient and outpatient care and explore development of a shared teaching program. Referral guidelines will be developed and disseminated to referring providers. We expect introduction of a wound care clinic to reduce both inpatient days and cost of stay for patients with a primary or secondary diagnosis of pressure ulcer (707.xx).

The project also includes the development and implementation of a specialty care access plan for the 17 largest specialty clinics. As that plan is developed, six specialty clinics will be targeted for operational redesign to include referral standardization, enhancing operational efficiency and expanding hours of access to reduce 3rd next available appointment times. Currently the specialty clinics average between 50 and 65 days for next available appointment. No show rates are as high as 40% as patients are seeking temporary care in the emergency department or simply going without care in some cases.

Goals and Relationship to Regional Goals:
The five-year goals of this project are to increase timely patient access to targeted specialty services, reduce days to next available new patient appointment for the targeted specialty, increase compliance with diabetic eye exams, increase patient and provider satisfaction, and reduce the inpatient days and inpatient cost of stay for patients with a pressure ulcer.

This project meets the following Regional goals:
As noted in the RHP 10 Community Needs Assessment, lack of access to specialty care and lack of provider capacity likely contribute to poor patient satisfaction and potential overuse of emergency services.

Challenges:
Wait times for ophthalmology at JPS Health Network are increasing with current waits for new patients averaging over 100 days and 75 days for follow-up appointments. Long wait times for appointments contribute to low patient satisfaction scores and a general perception of outcomes impacted by delays in time to care. Long wait times from primary care physician referral to specialty consult also increase patient anxiety and prolong symptoms unnecessarily, as well as delay time to indicated procedures. For the purpose of this project, JPS Health Network will focus on expanding access to ophthalmology. With a larger diabetic population at JPS Health Network, the demand for service will continue to grow. In the United States, it is expected that between 40-45% of diabetic patients will develop diabetic eye disease.[55] Keeping this population in preventive care will reduce cost and improve quality of life.

In addition, JPS Health Network will launch an outpatient wound care program. Data is still being gathered for FY2012, but data for JPS Health Network patients in FY2011 revealed that 141 patients left the hospital with a wound vacuum, averaging $3,654 per patient in supplies and equipment rental. There is not currently an outpatient wound program to assist with managing these patients, so they are appointed randomly with the surgeon or medicine specialist who ordered the wound vacuum for care in the clinic. The Surgery Specialty clinic currently lacks supporting competency to care for this population. In addition to the patients placed on wound vacuums, 794 admissions were attributed to pressure ulcers of all locations resulting in 9,831 patient days. JPS Health Network has two inpatient wound care nurses. A wound care clinic would provide a coordinated care effort, more comprehensive care transitions from hospital to home to clinic for follow-up care, and will likely reduce cost and improve outcomes for this population. A study of data pulled from the U.S. wound care registry[56] states that the most significant cost of wound care in the outpatient setting is home nursing care and that the most common comorbid condition is diabetes. Non-healing surgical wounds were the most common wound listed in the registry. Diabetes foot ulcers were noted to require the most outpatient expense in the registry. JPS Health Network has a population of over 17,000 patients in our outpatient primary care clinics with a diagnosis of type 1 or 2 diabetes. Only 25% of these patients were seen in the ophthalmology service for an annual eye exam. With the implementation of the medical home and a new EMR, the network will refocus on preventive

[55] http://www/nei/nih.gov/halth/diabetic/retinopathy.asp.
[56] Fife C, Carter M, Walker D, Thomason B. Wound care outcomes and associated cost among patients treated in the U.S. outpatient wound centers: data from the U.S. Wound Registry. *Wounds* 2012;24(1):10-17.

care and wellness in our patient population. Because much of our population has limited resource and relies solely on the network for outpatient care, the addition of these services is needed to provide better access and improve patient satisfaction. Enhancing access to all specialty care programs should reduce inappropriate ED utilization and improve the overall health of our community. Expansion of the ophthalmology service and the addition of a wound care program will significantly impact quality of care for our diabetic population.

5-Year Expected Outcome for Provider and Patients:
The five-year expected outcome of this project is to reduce days to third next available appointment for routine ophthalmology care to 45 days or less and increase compliance with annual diabetic eye exams from a baseline of 22% to 35% overall compliance. The project has a goal of providing annual eye exams to over 8,597 unique patients by DY5. We expect to reduce inpatient cost of care for patients with a primary or secondary diagnosis of pressure ulcer by 30% based on the number of patients admitted during the waiver project. -**Starting Point/Baseline:**
In FY2011, just over 17,000 (or 25%) of primary care patients in the network had a diagnosis of type 1 or type 2 diabetes. About 22% of those diagnosed with diabetes or 3,728 patients had at least one visit in the ophthalmology service during that same year. Per the National Institutes of Health (NIH) almost 40-45% of diabetics will require some treatment for diabetic retinopathy.[57] The project will target the approximately 13,000 patients who did not receive routine eye exams due to capacity constraints in our ophthalmology program. In FY2011, there were 794 admissions with a primary or secondary diagnosis of pressure ulcer (707.xx). The average cost of care was $21,422.36.

Rationale:
According to the Behavioral Risk Factor Surveillance System report for Tarrant County 2009/2010, 8.5% of responders over age 18 reported being told by a physician that they had diabetes. This rate is similar to both state and national norms. The cost of preventable hospitalizations in Tarrant County related to diabetes for 2005-2008 was over $240 million. The proportion of adults receiving a diagnosis of diabetes is a much higher rate for those with annual incomes of $15,000 or less. The Connections patient population has a much higher incidence of diabetes than the county, based on our initial data pull from FY2011. The Region 10 Community Needs Assessment found a lower rate of health screening than the nation or state. This project aligns with our goals to improve overall health for our community.

Expanding ophthalmology services meshes with several of our other projects that also focus on improving the preventive health of our diabetic population. A diabetes registry is under development and a patient care committee is developing clinical protocols for managing patients across the continuum. The PCMH (Patient-Centered Medical Home) focus on wellness and preventive care (among other attributes) has been shown to reduce the cost of care by numerous

57 www.tarrantcounty.com/.../Tarrant_County_BRFSS_20092010.pdf

organizations.[58] Compliance with annual diabetic eye exams is a recognized quality measure in the PCMH and AHRQ HEDIS measures.[59] Expanding access to the service line with the use of optometrists will maximize the time and expertise of the subspecialist, improve access for routine preventive care and improve patient satisfaction scores for both the primary care physician and the specialty group.

The wound care program will further assist our diabetic population in achieving a better quality of life. Since the majority of wounds per the national registry are found in patients presenting with diabetes, an outpatient program will improve timely access to medical advice and treatment at the right place for care. Since we lack knowledge, expertise and clinical resources, JPS does not actively anticipate the patient who is most likely to develop a postoperative ulcer, and does not have a program for outpatient referral. Developing outpatient expertise would create an opportunity for additional education for both patients and referring physicians related to anticipating those patients who are likely to develop postoperative infections and wounds with a poor prognosis. A wound program is an essential component of a large safety net hospital. The development of a wound care program would improve patient care coordination from hospital to home to clinic. A standardized clinical program will be developed and shared between inpatient and outpatient caregivers. Clinical expertise and knowledge will be developed to support the new program. Organizations that have been successful in reducing hospital-acquired pressure ulcers have done so by having a focused effort, increasing knowledge and expertise and standardizing reporting and clinical care guidelines.[60] Studies have shown an increase in both inpatient days and cost of care for patients with pressure ulcers.[61,62]

Project Components:

To increase our ophthalmology service capacity, the network will add four optometrists to our Regional medical homes. Wait times for both routine eye care and specialty eye care will be reduced. In addition, a wound care program will offer outpatient care and treatment of postop surgical infections, diabetic ulcers and other non-healing insect bites and wounds. The wound care program will include additional staffing to include a medical director, program coordinator and support staff for the outpatient clinic. An outpatient wound care program will reduce admissions, decrease patient days for all admissions related with pressure ulcers, and decrease average cost of care for inpatient treatment. The milestones chosen include measuring compliance with a diabetic eye exam, patient satisfaction, reduction in third next available

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[58] Nielsen M, Langner B, Zema C, Hacker T, Grundy P. Benefits of implementing the primary care patient-centered medical home: a review of cost and quality results., 2012.

[59] http://www.ncqa.org.

[60] Gibsie L. Implementing evidence-based practice to prevent skin breakdown. *Critical Care Nursing Quarterly* 2008. 31(2) 140-149.

[61] Allman R, Goode P, Burst N et al. Pressure ulcers, hospital complications, and disease severity: impact on hospital costs and length of stay. *Adv Wound Care*. 1999 Jan-Feb;12(1):22-30.

[62] Graves N, Birrell F, Whitby M. Effect of pressure ulcers on length of hospital stay. *Infect Control Hosp Epidemiol*. 2005 Mar;26(3):293-7.

appointment for these specialty visits, and a reduction in - -cost of stay/admission for patients diagnosed with pressure ulcers -. To reach these milestones, we will collect data on backlogs and referrals, train staff and physicians on guidelines for specialty referrals, implement a referral tracking system to reduce patients lost in the system, and expand capacity by adding providers and/or extending hours in targeted specialties.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.2 – Shortage of specialty care
- CN.10 – Overuse of emergency services
- CN.11 – Need for more care coordination
- CN.15 – Need for education, resources and promotion of healthy lifestyles

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: The project is a new initiative. We have not received any other federal funding for the project.

Related Category 3 Outcome Measures:

IT 1.12 Diabetes care: Retinal eye exam – a retinal or dilated eye exam by an eye care professional in the measurement year or a negative eye exam in the year prior by an eye care professional. Expansion of the ophthalmology clinic and service hours will reduce wait times to third next available appointment and increase compliance with diabetic eye exam. Baseline data will be verified in DY2 to validate improvement percentage for DYs 3, 4 and 5.

IT 1.1 Reduction in third next available appointment for routine eye exams

Third next available appointment is the industry standard to measure access. Focused efforts in referral management and recruitment of specialists should improve the current 100-day wait for ophthalmology clinic. Baseline data will be verified in DY2 to validate expected improvement in DYs 3, 4, and 5.

-**IT 5.3** Other reduction in cost of stay for patients with a primary or secondary diagnosis of pressure ulcer (707.xx). The development and launch of a wound program for the health system will bring much needed knowledge, expertise and additional resources to the organization. Reduction of inpatient days will ultimately lead to a reduction in cost of care. *(See outcome measure 3.)*

Relationship to Other Projects:

- **Related Category 1 and 2 projects**: Project 126675104.2.2 (Enhance/expand medical homes) will be greatly enhanced as specialty care access is improved. Project 126675014.2.5 (Enhancing care transitions) will reduce inpatient days as patients are directed to the Wound Care clinic to receive outpatient care. Project 126675104.2.11 (Improving patient experience) will direct teams toward improving operational efficiency and reducing third next available appointment in an effort to improve patient satisfaction.

Project 126675104.1.2 (Enhancing urgent medical advice) includes a 24/7 call center for appointment scheduling and patient concerns.

- **Related Category 4 Population-focused improvements**: This project is aligned with RD 2.7 and RD 3. A wound care program will bring evidence-based treatment protocols and provide an alternative to readmission related to postsurgical infections.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

JPS Health Network defined the population that will be directly impacted by the project as Tarrant County diabetes patients in primary care settings. The percentage of the population expected to be positively impacted by the project is 60% of the Medical Home population with diagnosis of diabetes, and 2% of the patients with post-outpatient surgical infections and/or diabetic ulcers, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that the value of this project is a 4 on a scale of 1 to 5. We believe this to be the correct number because when a person is positively impacted, - the identification of early ophthalmology issues in diabetic patients is significantly improved.

To determine the value to the community of each individual positively impacted, we concluded that the value of this project is a 3 on a scale of 1 to 5. We believe this to be the correct number because when a person is positively impacted, - access to specialty care will be increased leading to an improved patient experience through lower wait times and improved clinical outcomes through specialized wound care initiatives.

126675104.1.3	***1.9.2***		**Expand Specialty Care for Ophthalmology and Wound Care**
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.5*** ***126675104.3.6*** *126675104.3.51*	IT-1.12 IT-5.3 IT – 1.1	Diabetes Care: Retinal eye exam Other Reduction in cost of stay Reduce 3rd next available appointment

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]: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1 [P-3.1]: Establish baseline for performance indicators Baseline/Goal: Validate and test data reliability for targeted specialties Data Source: EMR Milestone 1 Estimated Incentive Payment: $941,304 **Milestone 2** [P-6]: Develop and implement standardized referral and work-up guidelines Metric 1 [P-6.1]: Referral and work-up guidelines Baseline/Goal: Referral and work-up guidelines published and disseminated to district Data Source: Referral documentation, EMR and DocSpot Milestone 2 Estimated Incentive Payment: $941,304	**Milestone 4** [P-11]: Launch/expand a specialty care clinic (e.g.,, pain management clinic) Metric 1 [P-11.1]: Establish/expand two specialty care clinics Baseline/Goal: Hire medical director and staff (program coordinator, support staff) for wound care program, hire optometrists to expand ophthalmology service line and document business plan Data Source: Program /business plan, HR documents, scopes of service, referral guidelines Milestone 4 Estimated Incentive Payment: $722,047 **Milestone 5** [P-12]: Implement a specialty care access plan to include such components as statement of problem, background and methods, findings, implication of findings in short and long term, conclusions Metric 1 [P-12.1]: Documentation of specialty care access plan	**Milestone 8** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Increase appointment visits by 10% for 3 clinics utilizing specialty access plan to develop strategy Data Source: EMR and billing data Milestone 8 Estimated Incentive Payment: -$772,423 **Milestone 9** [I-27]: Patient Satisfaction with Specialty Services Metric 1 [I-27.1]: Demonstrate improvement over prior reporting period. Goal: Baseline is 2nd percentile, validate and test data after implementation of CGCAHPS/Improve baseline CGCAHPs by 2 mean score points	**Milestone 12** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Increase appointment visits by 10% for 3 additional clinics utilizing specialty access plan to develop strategy Data Source: EMR and billing data Milestone 12 Estimated Incentive Payment $1,276,178 **Milestone 13** [I-27]: Patient Satisfaction with Specialty Services Metric 1 [I-27.1]: Demonstrate improvement over prior reporting period. Goal: Baseline is 2nd percentile, validate and test data after implementation of CGCAHPS/Improve baseline

126675104.1.3	***1.9.2***		**Expand Specialty Care for Ophthalmology and Wound Care**	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.5*** ***126675104.3.6*** *126675104.3.51*	IT-1.12 IT-5.3 IT – 1.1	Diabetes Care: Retinal eye exam Other Reduction in cost of stay Reduce 3rd next available appointment	
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 3 [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: Train 50%of providers and staff trained on referral process. Data Source: Log of specialty care personnel trained and curriculum for training Milestone 3 Estimated Incentive Payment: $941,305	Rationale/Evidence: Plan to reduce wait times, monitor referral wait times and increase provider capacity will increase patient and provider satisfaction Baseline/Goal: Develop access plan Data Source: Documentation of provider plan Milestone 5 Estimated Incentive Payment: $722,047 **Milestone 6** [P-5]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment. Metric 1 [P-5.1]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians) Baseline/Goal: Reduce time from referral to appointment date to 7 days or less Data Source: EMR and other systems identified		per year to achieve a total of 6 points by DY4 Data Source: CGCAHPs vendor tool, baseline to be determined in DY2 Milestone 9 Estimated Incentive Payment: -$722,423 **Milestone 10 [P**-17] Implement the redesign of medical specialty clinics in order to increase operational efficiency, shorten patient cycle time and increase provider productivity. Metric 1 [P-17.1] Number of medical specialty clinics that have completed clinic redesign. Baseline/goal: 3 additional clinics will have completed clinic redesign and have cycle times less than the clinic average cycle time. Data Source: EMR and financial reporting Milestone Estimated Incentive Payment: $772,423	CGCAHPs by 2 mean score points per year to achieve a total of 8 points by DY5 Data Source: CGCAHPs vendor tool, baseline to be determined in DY2 Milestone 13 Estimated Incentive Payment $1,276,178

126675104.1.3	***1.9.2***		**Expand Specialty Care for Ophthalmology and Wound Care**	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.5*** ***126675104.3.6*** *126675104.3.51*	IT-1.12 IT-5.3 IT – 1.1	Diabetes Care: Retinal eye exam Other Reduction in cost of stay Reduce 3rd next available appointment	
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 6 Estimated Incentive Payment: $722,047 **Milestone 7** [P-17] Implement the redesign of medical specialty clinics in order to increase operational efficiency, shorten patient cycle time and increase provider productivity. Metric 1 [P-17.1] Number of medical specialty clinics that have completed clinic redesign. Baseline/goal: 3 clinics will have completed clinic redesign and have cycle times less than the clinic average cycle time. Data Source: EMR and financial reporting Milestone 7 Estimated Incentive Payment: $722,049		**Milestone 11** [P-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted specialties Metric 1 [P-22.1] Increase number of specialist providers, clinic hours and /or procedure hours in targeted specialties Baseline/goal: Targeted specialties will be determined when access plan is developed in DY3 Data Source: -Plan implementation, program development documents and EMR reporting for targeted clinics Milestone 12 11 Estimated Incentive Payment: -$772,423	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,823,913	Year 3 Estimated Milestone Bundle Amount: $2,888,191		Year 4 Estimated Milestone Bundle Amount: $3,089,693	Year 5 Estimated Milestone Bundle Amount: $2,552,355

126675104.1.3	***1.9.2***		**Expand Specialty Care for Ophthalmology and Wound Care**
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.5*** ***126675104.3.6*** *126675104.3.51*	IT-1.12 IT-5.3 IT – 1.1	Diabetes Care: Retinal eye exam Other Reduction in cost of stay Reduce 3rd next available appointment

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)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $11,354,152			

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 1.12.2 – Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create partial hospitalization programs and intensive outpatient programs as part of continuum of care)

Unique Project ID: 126675104.1.4
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: This project ensures adequate access to needed services by expanding the number of community-based settings where behavioral health services are delivered. This project will establish a full continuum of care by creating Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) to expand treatment availability in our Region in a way that matches level of care with a patient's needs and acuity. This project is a new initiative
Need for the project: This project addresses the following community needs: a) CN.4 Lack of access to mental health services.
Target population: Psychiatric patients who will be served in new PHP and IOP service locations - DY2 = 91, DY3 = 618, DY4 = 858, DY5 = 858. Total for DY2-5 is 2,425 patients. This project will provide greater management that will result in improved post-discharge engagement and treatment adherence, the rate of readmission for psychiatric services and the general availability inpatient and intensive services for the significant volume of Medicaid and Uninsured psychiatric patient discharging from Trinity Springs Pavilion (JPS' 96 bed psychiatric facility).
Category 1 or 2 expected patient benefits: Milestones P-2.1, P-3.1, P-4.1, P-6.1, I-36.1, I-11.1, and I-14.1 were selected. We selected the project's milestones and metrics to meet the needs of our target patient population and because they reflect an logical operational and impact stepping stones.
Category 3 outcomes: Outcomes IT-1.18, IT-3.8, and IT-9.2 were selected. There is an evidence base to suggest that increased behavioral health service locations and PHP services will have positive impact on each of these outcome areas.

Project Option 1.12.2 – Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create partial hospitalization programs and intensive outpatient programs as part of continuum of care)

Unique Project ID: 126675104.1.4
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
This project will expand the number of community-based settings where behavioral health services are delivered so that targeted mentally ill patients[63] can receive much-needed psychiatric treatment in an outpatient setting. Specifically, this project will create four new partial hospitalization and/or intensive outpatient programs in Tarrant County. Partial hospitalization programs (PHPs) are typically delivered four to six hours a day with patients attending five days a week. Intensive outpatient programs (IOPs) are typically delivered three hours a day with patients attending three days a week. One location will focus on delivering care to patients dually diagnosed with mental health and substance use disorders. This location will coordinate with Tarrant County Mental Health Mental Retardation (MHMR) to establish both a referring and step-down treatment option for their additional detoxification services. Psychiatric patients will be able to receive continued psychiatric treatment by participating in PHP and IOP without having to remain in the hospital. Services will include weekday medication administration, life skills education, assistance with referrals and resources regarding other community resources, group and individual therapy, and daily psychiatric management by a board certified psychiatrist. JPS Health Network will utilize a flexible treatment model that adapts evidence-based cognitive behavioral therapy (CBT) treatment interventions to the PHP context. JPS Health Network will create four PHPs strategically placed throughout Tarrant County that focus on adult PHP services. We will also utilize the PHP program group structure to offer more flexible IOP continuum of services without increasing resource levels.

Goals and Relationship to Regional Goals:
Project Goals:
This project ensures adequate access to needed services by expanding the number of community-based settings where behavioral health services are delivered. This project will establish a full continuum of care by creating partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs) to expand treatment availability in our Region in a way that matches level of care with a patient's needs and acuity.

This project meets the following Regional goals:

[63] Patients targeted are Tarrant County residents with a primary axis I, or clinical, mental health diagnosis that demonstrate the need for intensive therapy or partial hospitalization services beyond those typically delivered in non-structured outpatient settings.

This project will extend the continuum of behavioral health care available in Tarrant County to include more outpatient options.

Challenges:
Tarrant County is struggling with extensive demand that cannot be met with the available behavioral health resources. Increased access to behavioral health services was one of the highest needs identified in the Region 10 Community Health Assessment. An estimated 105,700 people (one in 17 county residents) struggle with a serious mental illness such as bipolar disorder, schizophrenia, or major depression.[64] JPS Health Network addresses these needs with emergency psychiatric services, inpatient psychiatric beds and psychiatric medication management services. However, the county's limited availability of psychiatric services does not include a continuum of care options for medically indigent patients with psychiatric conditions. Instead, these patients' needs must be met within the existing continuum of available services, which may result in patients receiving more or less intensive levels of care than the severity of their symptoms necessitates, or electing to go untreated and not access needed services. Additionally, the county has significant and increasing demand for psychiatric emergency services as well as inpatient services unmitigated by lower levels of care.

5-Year Expected Outcome for Provider and Patients:
JPS Health Network will operate four PHPs and/or IOPs in Tarrant County that will serve 1,567 patients. Expected outcomes are participation of the targeted population in PHP programs, utilization of least restrictive environments, and a reduction in inpatient readmissions.

Starting Point/Baseline:
JPS Health Network operates four outpatient behavioral health clinics, two school-based behavioral health clinics, a psychiatric emergency center, and an inpatient psychiatric facility. There are no structured levels of care in the outpatient service delivery system. Service capacity consists of inpatient beds and outpatient medication management only. Adding these expanded service locations will better serve patients needing partial hospitalization and intensive outpatient services. In 2011, our system served 8,824 patients in non-emergency outpatient locations.

Rationale:
This project option was selected due to lack of access to mental health services in a community-based setting (CN.4). This project addresses that need by moving the county closer to a full continuum of evidence-based behavioral health services. The project will enable us to validate the efficacy, cost effectiveness, greater accessibility and greater acceptance by individuals struggling with mental illness of partial hospitalization and intensive outpatient services, as well as a measurable impact in reducing overload in psychiatric emergency settings. Utilization of

[64] National Institutes of Health. The numbers count—mental disorders in America. www.nimh.nih.gov/publicat/numbers.cfm.

partial hospitalization is considered best practice by most of the nation's large behavioral health systems. Additionally, significant research documents the efficacy of partial hospitalization, the reduction in inpatient services, and the reduced costs associated with providing care in PHP settings.[65]

Project Components:
This project does not have core project components. We selected the project's milestones and metrics to meet the needs of our target patient population. We will measure patient satisfaction with access to behavioral health services after expansion, as well as increase of population served after expansion. The community has a documented need for expanded availability. Evaluating the community's perception of access and monitoring the increase in capacity will reflect improvements.

Unique community need identification numbers the project addresses:

- CN.4 – Lack of access to mental health services. All but one county in Region 10 are recognized as Health Professional Shortage Areas for mental health providers.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Addition of these behavioral health service locations will significantly enhance the existing delivery system. The focus on specialized services will further enhance the community benefit. The intended patient population will be able to utilize the least restrictive environment and have greater accessibility at new service locations. Instead of receiving resource-intensive inpatient services, patients who meet program criteria will transition to community-based care more quickly, reduce their inpatient length of stay, and be able to remain in the community for future treatment rather than being readmitted for inpatient services. These new treatment options will add further needed services within Tarrant County for mentally ill individuals and the hospitals that provide care for them. This project also will expand community resources that will function as part of the continuum care within the MHMR system. Physicians will experience greater access to care for their patients.

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[65] Continuum of Ambulatory Behavioral Health Services - Position paper by Association for Ambulatory Behavioral Health Services, 2010.
[65] Efficacy and Cost Effectiveness of Partial Hospitalization – International Journal of Partial Hospitalization, 1985. 3(1): 59-64.
[65] Partial Hospitalization Programs as a Resource to Reduce the Overload in Psychiatric Emergency Services – Journal of the American Association for Emergency Psychiatry, 2011.
[65] Partial versus Full Hospitalization for Adults in Psychiatric Distress: A Systematic Review of the Published Literature (1957-1997) – American Journal of Psychiatry, 2001; 158:676-685.
[65] Short Term Cognitive Behavioral Partial Hospital Treatment: A Pilot Study – Journal of Psychiatric Practice, 2007.
[65] The Effectiveness of Psychiatric Partial Hospitalization and Day Care – Current Opinion in Psychiatry, 2004. Volume 17 (4): 303-309

We are not receiving any other federal funding for this work.

Related Category 3 Outcome Measures:

IT-1.18 Follow-up after hospitalization for mental illness. NQF 057620 was selected because between 25 and 50% of patients who miss mental health appointments disengage from treatment entirely.[66] Dropping out of treatment after a psychiatric hospitalization increases the likelihood of re-hospitalization from one in 10 to one in four.[67] This project will improve follow-up by improving the availability and accessibility of structured outpatient behavioral health services to be utilized following hospitalization. This measure also directly impacts our identified community needs. There is limited access to mental health services (CN.4), and failure to follow up after discharge creates increased missed appointment rates and poor utilization of available resources. Additionally, there is insufficient integration of mental health care in the primary care medical care system (CN.5). Improving follow-up after hospitalization allows for the integrated care project and transition managers to assist in better integrating the care for these individuals as they begin to receive community-based services. Finally, there is a need for more care coordination (CN.11). Increasing follow-up rates after hospitalization will create the opportunity for better coordination of care between inpatient and outpatient behavioral health service delivery systems.

IT-3.8 Behavioral health/substance abuse 30-day readmission rate was selected because greater availability and accessibility of outpatient behavioral health services will enhance stability in the community and adherence to outpatient visits for patients, which reduces 30-day behavioral health readmission rates.[68],[69] This measure also directly impacts our identified community needs. There is limited access to mental health services (CN.4) and readmissions result in avoidable utilization of the very limited resources available for inpatient psychiatric beds.

IT-9.2 ED appropriate utilization was selected because 97% of adults and children receiving public community-based mental health services have avoided a crisis episode.[70] JPS Health Network experiences over 24,000 psychiatric emergency visits per year. The availability of additional outpatient behavioral health services will ensure patients engaging in their

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[66] Killaspy H. (2007). Why do psychiatrists have difficulty disengaging with the out-patient clinic? Invited commentary on: Why don't patients attend their appointments? *Advances in Psychiatric Treatment*, 13, 435- 437.

[67] Mitchell AJ & Selmes T. (2007). Why don't patients attend their appointments? Maintaining engagement with psychiatric services. *Advances in Psychiatric Treatment*, 13, 423-434.

[68] Killaspy H. (2007). Why do psychiatrists have difficulty disengaging with the out-patient clinic? Invited commentary on: Why don't patients attend their appointments? *Advances in Psychiatric Treatment*, 13, 435- 437.

[69] Mitchel, AJ & Selmes T. (2007). Why don't patients attend their appointments? Maintaining engagement with psychiatric services. *Advances in Psychiatric Treatment*, 13, 423-434.

[70] Department of State Health Services Behavioral Health Data Book, FY 2010, 4th Quarter, Figures 1.6, 1.7, 1.9, 2.6, 2.7.

individualized care plan enhancing stabilization and service utilization outside of the emergency system. This measure also directly impacts our identified community needs. There overuse of the emergency department services (CN.10). Increased outpatient behavioral health services will result in reduced utilization of the emergency services because patients will have more care options in community-based services.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**
  - 2.17.1 – Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders. The Behavioral Health Discharge Management Program team will be able to utilize the PHP programs and locations for patients who deteriorate after discharge but are still able to benefit from the structured services instead of readmission. Additionally, the care managers will be able to monitor high-risk patients who are continuing care through the continuum.
  - 1.12.1 – Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the State where access to care is likely to be limited. Patients who have deteriorated but are still able to benefit from the structured services being served in the new hours and services will be able to utilize the PHP programs and locations to avoid hospitalization.
  - This project to expand locations through partial hospitalization and intensive outpatient services meshes collaboratively with the projects MHMR of Tarrant County is proposing regarding telemedicine, expanded behavioral health services, RN case management, integrated primary care, and detox expansion. These programs will function as additional resources and tools available to patients who require additional behavioral health coordinated care options. It is anticipated the substance use disorder treatment and detox expansion will be particularly integrated, as we have agreed that one partial hospitalization program site will target patients with both a mental illness and a substance use disorder. Patients in this program will enter by stepping down from the expanded detoxification beds as well as stepping up from unsuccessful efforts at lower levels of outpatient care.

- **Related Category 4 Population-focused improvements**: This project will impact RD-2.3. It is expected this project will improve follow-up rates after hospitalization for mental illness. This is expected to reduce behavioral health 30-day readmissions.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as patients who utilized JPS Health Network outpatient behavioral health clinics. The percentage of the population expected to be positively impacted by the project is 100%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that the value of this project is a 4 on a scale of 1 to 5. We believe this to be the correct number because when a person is positively impacted, her ability to manage her own care plan is significantly improved.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, his or her dependence on the community is reduced.

Specifically, 2425 patients (DY2 = 91, DY3 = 618, DY4 = 858, DY5 = 858) receiving care from new PHP & IOP service locations will be positively impacted in the following quantifiable ways:

- Increased utilization of community behavioral health care by 7.5% over life of project.
- Improved Consumer satisfaction with Access by 30% over life of project.
- Improved baseline number of patients who received care within 30 days of hospitalization discharge by a percentage to be determined in DY3.
- Improved baseline number of patients who received care within 7 days of hospitalization discharge by a percentage to be determined in DY3.
- Improved baseline number of behavioral health/substance abuse 30-day readmission rate by a percentage to be determined in DY3.

- Reduced Emergency Department visits for Behavioral Health/Substance Abuse conditions by a percentage to be determined in DY3.

126675104.1.4	***1.12.2***		12.2 – Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care)
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.7 126675104.3.8 126675104.3.9	*IT-1.18* *IT-3.8* *IT-9.2*	Follow-Up After Hospitalization for Mental Illness- NQF 0576 Behavioral Health /Substance Abuse 30-day readmission rate 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 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. Baseline/Goal: Project Plan Data Source: Project Plan Milestone 1 Estimated Incentive Payment: $1,553,505	**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: Hired/Trained 5 Staff Data Source: Project records, Training curricula as developed in P-2 Milestone 3 Estimated Incentive Payment: $1,588,866 **Milestone 4** [P-6]: Establish behavioral health services in new community-based settings in underserved areas. Metric 1 [P-6.1]: Number of new community-based settings where behavioral health services are delivered Baseline/Goal: Four new	**Milestone 5** [I-11]: Increased utilization of community behavioral health care Metric 1 [I-1.1]: Percent utilization of community behavioral health care services. Goal: 5% increase from baseline of 8224 Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 5 Estimated Incentive Payment: $1,699,717 **Milestone 6** [I-14]: Improved Consumer satisfaction with Access Metric 1 [I-14.1]: X% of people reporting satisfaction with access to care	**Milestone 7** [I-11]: Increased utilization of community behavioral health care Metric 1 [I-11.1]: Percent utilization of community behavioral health care services. Goal: 7.5% increase from baseline of 8224 Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 7 Estimated Incentive Payment: $1,404,114 **Milestone 8** [I-14]: Improved Consumer satisfaction with Access Metric 1 [I-14.1]: X% of people reporting satisfaction with access to care Goal: 30%

126675104.1.4	***1.12.2***		12.2 – Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care)
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.7 126675104.3.8 126675104.3.9	*IT-1.18* *IT-3.8* *IT-9.2*	Follow-Up After Hospitalization for Mental Illness- NQF 0576 Behavioral Health /Substance Abuse 30-day readmission rate 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 2 [P-3]: Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for a mobile clinic or guidelines for a transportation program). Metric 1 [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline/Goal: Operations Manual Data Source: Administrative protocols, Clinical guidelines Milestone 2 Estimated Incentive Payment: $1,553,506	service locations established Data Source: Program documentation, Encounter Data Milestone 4 Estimated Incentive Payment: $1,588,867	Goal: 25% Data Source: Survey data from CAHPS, MHSIP or other validated instrument. Milestone 6 Estimated Incentive Payment: $1,699,718	Data Source: Survey data from CAHPS, MHSIP or other validated instrument. Milestone 8 Estimated Incentive Payment: $1,404,115
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $3,107,011	Year 3 Estimated Milestone Bundle Amount: $3,177,733	Year 4 Estimated Milestone Bundle Amount: $3,399,435	Year 5 Estimated Milestone Bundle Amount: $2,808,229
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $12,492,408			

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 1.10.2- – Innovation and Transformation Center

Unique Project ID: 126675104.1.5 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104
Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: The purpose of the project is to erect and staff a continuous quality improvement infrastructure for JPS Health Network. The infrastructure will include: a) Governance and oversight structure for performance improvement initiatives; b) Centralized experts trained in Lean, Six Sigma, Rapid Cycle Improvement and Project Management; c) Resources to educate and expand internal capabilities in PI skills; d) Decision Support resources. Waiver initiatives requiring these resources will be staffed through the ITC. The decision support infrastructure within the ITC will support JPS' internal performance improvement reporting, the reporting of the Medicaid Waiver projects and JPS Anchor reporting requirements. This is a new initiative.
Need for the project:

The need for this project was defined in part by the JPS Quality Program Assessment which surveyed through interviews, Network's Board, Executive and Medical Leadership and operational team members(1.10.3.b). The results indicated the skills and infrastructure necessary to support continuous quality improvement and complex process re-design at JPS are inadequate to support the degree of change necessary to successfully drive improvement and support the twenty-plus new transformational projects encompassed in the Waiver project portfolio. The core component of this project is to provide training and education to clinical and administrative staff on process improvement strategies, methods and culture(1.10.3.a).

a) Reducing Inpatient Potential Preventable Conditions (PPC) and cost of care associated with harm is a regional priority. The Innovation and Transformation Center's initial inpatient projects are aimed at reducing hospital acquired conditions, CAUTI, CLABSI, SSI, VTE, and Falls. The population represented across all five conditions is 32,894 patients by 2011baseline. The estimated number of lives impacted across all five HACs is 119 (baseline validation is a milestone included in the project).
b) The Innovation and Transformation Center provides essential support for the twenty plus JPS Health Network Waiver Projects. These improvement and population management initiatives will not succeed without the infrastructure, e.g. a governance structure for deploying resources in Lean, Six Sigma and project management and decision support.
c) As the Anchor, JPS will support 26 other providers.

Target population: The population includes all patients served by and within JPS Health Network. Instilling performance improvement skills, instituting an oversight structure with

decision support ensures improvements in care for the entire JPS acute care facility and each of the 43 clinics.

Category 1 and 2: Because the ITC contributes to the success of all of the Waiver projects and specifically to reducing harm for our inpatients, Medicaid and uninsured patients will benefit from increased access, improved care coordination, safer, reliable and more cost effective care. The ITC creates the necessary infrastructure to improve organizational performance and reporting capacity. The project includes the development of an Executive Data Warehouse and implementation of web-based reporting infrastructure. The decision support system and dashboard will support rapid-cycle improvement for the PPCs and all Waiver initiatives.

The Innovation and Transformation Center's initial inpatient projects are aimed at reducing hospital acquired conditions, CAUTI, CLABSI, SSI, VTE, and Falls. The population represented across all five conditions is 32,894 patients by 2011baseline. The estimated number of lives impacted across all five HACs is 119.

Category 3 outcomes: The Category 3 outcomes selected include reduction of five PPC's, CAUTI, CLABSI, VTE, Falls, and SSI.

Project Option 1.10.3 – Innovation and Transformation Center
Unique Project ID: 126675104.1.5 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
JPS Health Network will establish a System Transformation Center to be the central authority for organizing, evaluating, and documenting change efforts. The Transformation Center will be an internal training, education and capacity development resource for JPS Health Network and will lead initiatives to improve reporting, accelerate the use of data for process improvements, and to achieve efficiency using the Lean/Six Sigma methods. The Innovation and Transformation Center (ITC) will promote and manage continuous quality improvement throughout the organization that is driven by a culture that encourages change, supported by accurate and timely data and managed and reported in a way that ensures project success.

Goals and Relationship to Regional Goals:

Project Goals:
The three-year goals are to:

- Create a **JPS Health Network Innovation and Transformation Center** that will coordinate the implementation of major organizational performance improvement and transformational activities and spread learning and capacity at all levels of the organization.
- Complete internal assessment to determine the resources, e.g., project managers, Lean facilitators, etc. needed initially to support the 1115 Waiver projects and JPS in creating a culture of continuous improvement, one that manages by measuring and reporting. Additionally, the assessment will define the resources needed to improve and sustain JPS Health Network patient experience initiatives.
- Adopt and deploy a uniform approach to managing change that utilizes proven methods such as Lean, Six Sigma, rapid-cycle improvement.
- Adopt processes for prioritizing, chartering, resourcing, determining ROI, and ensuring projects achieve intended outcomes.
- Develop and implement a curriculum which addresses the role of executives, management and performance improvement specialists and project managers in managing change and using tools, e.g., Lean, Six Sigma and rapid-cycle improvement.
- To develop and implement a Quality College as part of all clinicians' orientation and ongoing education; the curriculum will integrate quality improvement principles specific to the role of the clinicians, include basic PDSA methodology, share performance of improvement projects and lessons learned from patient safety.
- Erect a decision support center, led by a council of data owners that will achieve the following:

  - Process for continuously auditing the accuracy, efficiency, and completeness of all systems used to gather and report quality and safety performance data
  - Implement an online Intranet Quality and Performance Dashboard with all organizational quality measures reported and displayed
- Successfully executed the 1115 Medicaid Waiver projects.
- Reduce JPS' aggregate harm rate resulting from hospital-acquired conditions, central line infections, catheter-associated infections, surgical site infections, venous thrombosis and falls.
- By DY5, improve compliance with best practice processes and achieve:
  - CLABSI rate at NHSN IQR1
  - CAUTI event rate at or below CDC NHSN Benchmark pooled mean or not significantly different, based on p-value analysis
  - Surgical site infection rates less than or equal to NHSN rates
  - Fall with injury rate of less than or equal to X/1,000 patient days
  - Total fall rate of less than or equal to X/1,000 patient days
  - VTE rate reduction by 20% of 2011 baseline

<u>This project meets the following Regional goals</u>:
This project is in line with the Region's goal to execute the deployment of 1115 Medicaid Waiver projects aimed at increasing access and adding value to the health system. Tools such as project management, Lean, etc. provide a framework for successful design, implementation and managing performance.

Challenges:
Many workflows and care processes at JPS are not highly efficient or reliable, wasting human and financial resources. We encounter daily evidence of waste and inefficiency in clinical and administrative processes. Failure to proactively evaluate and redesign patient care processes with the implementation of the electronic medical record in May 2012, accentuated the unreliability and resulted in increased rates of non-compliance with best practice bundles of care for HACs. Whether it is patients showing up the morning of surgery without prior medical clearance, days in accounts receivable, low compliance rates with evidence-based bundles and/or failure to follow established procedures, we need tools to help us work smarter, reduce our costs without taking it out of quality, service, or access and execute clinical care processes more consistently. The Innovation and Transformation Center will create internal capabilities through training and certification for Lean, Six Sigma, rapid-cycle improvement and other methodologies.

JPS Health Network has poorly developed internal communication structures. Divisions between the silos of administration, nursing, support services, and medical staff have resulted in a multiplicity of parallel and overlapping improvement efforts. There is no clearinghouse or vetting process for improvement efforts and the work of communicating across the functional

divisions is not assigned to any particular unit. Meanwhile, dedicated and creative staff members who see the need for improvement forge ahead, resulting in many ad hoc efforts within the organization. It is essential to retain and encourage this goodwill and energy for improvement, while ensuring that all efforts are aligned and working synergistically to move the institution overall toward a vision of high-quality, patient-centered, coordinated and efficient care.

The Clinical Decision Support capabilities prior to implementing the EMR were mediocre at best; the ability to get stakeholders to mobilize based on data was impaired because of the data validity and accuracy. Clinical Decision Support since May 2012 was brought to a standstill. Clinical Decision Support is under design and will be one of the operational units within the Innovation and Transformation Center.

5-Year Expected Outcome for Provider and Patients:

- High-performing Innovation and Transformation Center
- Decision Support Center
- Robust change management, Lean, Six Sigma internal training program
- Culture of continuous improvement
- Measurement system accessible by any team member on the intranet

Starting Point/Baseline:

The JPS Health Network's Quality Department has traditionally focused on regulatory compliance and case review. The Network has outstanding quality professionals, with excellent qualifications and training in this approach, and as a result, has done exceedingly well in regulatory review. While desiring to maintain this expertise, JPS Health Network also recognizes they will need a broader approach to quality based on models of organizational Performance Improvement. JPS Health Network will have to accelerate the learning of a new set of skills within the organization: meeting facilitation, team leadership, expertise in the tools of performance improvement, data analysis and graphic display, communication, organizational development and project management.

JPS recently launched a system-wide harm reduction effort aimed at reducing harm in five key areas by December 31, 2016. Each area has a multidisciplinary team working to develop aim statements, measures, tests of change, and ultimately to spread successful improvement strategies. Performance improvement coaches will need to be secured through a contractual relationship, because we do not have this skill set internally. The Innovation and Transformation Center will ensure these teams have the appropriate skill set and organizational support to succeed and spread what they learn; the center will also ensure the implementation of mechanisms to continuously recruit and train internal team members in this area of expertise.

Rationale:

Fragmentation and lack of coordination is a systemic issue for JPS. The Innovation and Transformation Center directly addresses this issue. By aligning improvement efforts and improving communication across the organization and building competencies in performance improvement, JPS Health Network will increase efficiency, reduce redundancy and turn the frustration of multiple uncoordinated change efforts into progressive movement toward objectives.
The selected milestones measure our effectiveness in deploying the various components of the Innovation and Transformation Model; separating each component will allow us to understand barriers and success factors for the specific components.

Project Components:
The project is aimed at enhancing improvement capacity within the Network. The project encompasses the component 1.10.3(a) providing training and education to clinical and administrative staff on process improvement strategies, methodologies, and culture. Component (a) includes development of Innovation and Transformation Governance Council to support prioritization, oversight of all PI initiatives; development and oversight of the plan for educating and training JPS team members and physicians in PI; deployment of the internal PI professionals certified in advanced change management. (Addressed in Milestones 1(P-1), Milestone 2(p-2), Milestone 3(P-6))

Component 1.10.3(b) was met through the JPS Quality Program Assessment conducted during DSRIP Y2 which surveyed/ interviewed the Network's Board, Executive and Medical Leadership and operational team members. The results indicated the skills and infrastructure necessary to support continuous quality improvement and complex process re-design at JPS are inadequate to support the degree of change necessary to successfully drive improvement and support the twenty-plus new projects.

Component 1.10.3(c) design data collection systems to collect real-time data that is used to drive continuous quality improvement, is addressed with the development of the Knowledge Management/ Decision Support System. The sub-components of data component include: formation of Knowledge Management Council, enhancing the existing, creating or acquiring decision support system; developing near-real-time gap closure reports and intranet access to a comprehensive Network dashboard. The first priorities for inclusion in the s measurement and reporting system are the five hospital acquired conditions addressed in this project, the measures supporting the Waiver projects and CMS measure sets. (Addressed in Milestones 4(P-5), Milestone52(I-10)p-2), Milestone 6(I-7) Milestone 7(1-10) Milestone 8(I-7)

Best practice systems such as Denver Health, Virginia Mason, Geisenger, etc. - have demonstrated success in health system transformation with the adoption of programs with these components.
Unique community need identification numbers the project addresses:
CN 11: Need for more care coordination. All counties identified CN11as a need. Barriers include complexity of coordination, lack of staff, lack of financial integration, fragmented system service, and practicing in silos. Providers did not feel there was strong care coordination

between primary care providers, hospitals, and specialists. Care coordination is a challenge within the single provider's inpatient arena and contributes to the variation in clinical care and health care acquired conditions.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received funding for it.

Related Category 3 Outcome Measures:

- CLABSI rate at NHSN IQR1
  An estimated 41,000 central line-associated bloodstream infections (CLABSI) occur in U.S. hospitals each year. These infections are usually serious infections typically causing a prolongation of hospital stay and increased cost and risk of mortality.
  CLABSI can be prevented through proper management of the central line. Improvement efforts at JPS are aimed at adopting the techniques recommended by CDC's Healthcare Infection Control Practices Advisory Committee (CDC/HIPAC) Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011 and the NHSN CLIP practices.

- CAUTI event rate at or below CDC NHSN Benchmark pooled mean or not significantly different, based on p-value analysis.
  CAUTI is the most common UTI HAI infection, accounting for 30% of infections reported by acute care hospitals. CAUTI can lead to such complications such as: cystitis; pyelonephritis, gram negative bacteremia; prostatitis, epididymitis; and orchitis in males and less commonly, endocarditis, vertebral osteomyelitis, septic arthritis, endophthalmitis, and meningitis in all patients. Complications associated with CAUTI cause discomfort to the patient, prolong hospital stay and increase cost and mortality. Each year more than 13,000 deaths are associated with UTIs. Reference: CDC/HIPAC document—Guideline for Prevention of Catheter Associated Urinary Tract Infection.

- Surgical site infection rates less than or equal to NHSN rates**.**
  While advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSI remain a substantial cause of morbidity and mortality among hospitalized patients. In one study, among nearly 100,000 HAIs reported in one year, deaths were associated with SSIs in more than 8,000 cases.

- -Fall with injury goal for DY5 is less than 72 falls with injury and 0.49 falls/1,000 patient days

- -Total fall rate of less than or equal to 20% less than the 2011 JPS fall experience (468 falls; 3.18 falls/1,000 patient Days). Statistics indicate patient falls occur in approximately 1.9 to

8.9 % of all acute care hospitalizations with anywhere from 2 – 15% of inpatients experiencing at least one fall. An estimated 30% of inpatient falls result in serious injury. According to the Institute of Healthcare Improvement (IHI), falls are a leading cause of death in people ages65 or older and 10% of fatal falls for the elderly occurs in hospitals. Preventing patient falls is a top priority for caregivers in the clinical setting. Implementing a more comprehensive falls prevention program ensures interventions can be applied to all patients at risk.

- VTE rate reduction by 20% of 2011 baseline
  According to the AHRQ, one in 10 of the more than 2 million Americans developing DVT goes on to die from PE. These 200,000 patient deaths represent more annual deaths than those from breast cancer, AIDS, and traffic accidents combined. Many of these VTE deaths contribute to hospital mortality. PE is the most common preventable cause of death in the hospital. An estimated 10 percent of inpatient deaths are secondary to PE. Patients who survive the initial diagnosis of PE face a mortality rate of 17.5 percent at 90 days. Not only do patients with VTE suffer a 30 percent cumulative risk for recurrence, they are also at risk for the potentially disabling post-thrombotic syndrome. While many VTEs are clinically silent, symptoms of hospital-acquired VTE often require ongoing therapy and represent a significant morbidity.

Relationship to Other Projects:
The Innovation and Transformation Center's Governance Council will resource the 1115 Medicaid Waiver projects with Lean, Six Sigma and rapid-cycle skill sets; the ITC will provide oversight for all strategic PI teams chartered through its Governance Council.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as patients who are affected by potentially preventable complications. We used historical cost data from JPS Health Network patients to determine the avoidable cost savings per patient through the improvement of clinical outcomes.

To determine the value to each individual positively impacted, we concluded that the value of this project is a 4 on a scale of 1 to 5. We believe this to be the correct number because when a person is positively impacted, their clinical outcomes are improved and their patient experience is improved by a decreased length of stay in the hospital.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, additional ICU and med/surge beds will be available for other patients in need and cost savings will be realized for the hospital district.

126675104.1.5	*1.10.2*	*-1.10.2(A-C)*	*ENHANCE PI AND REPORTING CAPACITY - CREATE AN INNOVATION AND TRANSFORMATION CENTER*
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.36*** ***126675104.3.37*** ***126675104.3.38*** ***126675104.3.39*** ***126675104.3.40***	*3.IT-4.2* *3.IT-4.3* *3.IT-4.4* *3.IT-4.5* *3.IT-4.6*	*Central-Line Associated Bloodstream Infections* *Catheter-associated Urinary Tract Infections* *Surgical Site Infections* *Patient Fall Rate* *Hospital-acquired deep vein thrombosis*

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]: Establish a performance improvement office to manage data, improvement trajectory and improvement activities across the Performing Provider's delivery system (Develop and approve a plan to create an Innovation and Transformation Center at JPS that will coordinate implementation of, spread learning from, and report progress on major organizational PI and transformational activities, including but not limited to Waiver implementation, Lean, and Harm Reduction; Restructure the Quality Division to include Knowledge Management, Process Improvement, Clinical Quality in order to centralize and manage data, improvement trajectory and improvement activities across JPS Network) **Metric [P-1.1]:** Documentation of the establishment of performance improvement office(Documentation of the ITC Charter, Governance, Staffing and Reporting Structures, prioritizing and chartering tools; evidence of Decision Support Strategic Plan and Knowledge	**Milestone 2 [P-2]:** Establish a program for trained experts on process improvements to mentor and train other staff, including front-line staff, for safety and quality care improvement. All staff trained in this program should be required to lead an improvement project in their department within 6 months of completing their training (Determine and redeploy existing capabilities for supporting Waiver and other high-priority projects with experienced PM and PI skill set; Conduct market research to identify and visit best practice organizations that have successfully implemented Innovation and Transformation processes; **Metric [P-2.1]:** Train the trainer program established (Engage external vendors to develop and implement a curriculum which addresses the roles of executives, management and PI specialists in managing change and using tools, e.g., Lean and Six Sigma, etc. Initial Lean Champion (executives) and Lean Expert training is conducted) Baseline No Activity/Goal: In-house MBB/Sensei;	**Milestone 5 [I-10]:** Enhance performance improvement and reporting capacity. The following metrics are suggested for use with an innovative project option to enhance performance improvement and reporting capacity but are not required. **Metric [I-10.1]:** Increase the number of reports generated through these quality improvement data systems Goal: 50% Waiver Projects reporting to ITC Data Source: Internal documentation Milestone 5 estimated incentive payment: $2,222,773 **Milestone 6 [I-7]:** Implement quality improvement data systems, collection, and reporting capabilities **Metric [I-7.1]:** Increase the number of reports generated through these quality improvement data systems Goal: Published Indicator inventory(data sources, numerators, denominators, owner, audience, frequency) approved by stakeholders; Intranet Quality);	**Milestone 7 [I-10]:** Enhance performance improvement and reporting capacity. The following metrics are suggested for use with an innovative project option to enhance performance improvement and reporting capacity but are not required. **Metric [I-10.1]:** Increase the number of reports generated through these quality improvement data systems Goal: 75% Waiver Projects reporting to ITC Data Source: Internal documentation Milestone 7 estimated incentive payment: $1,836,203 **Milestone 8 [I-7]:** Implement quality improvement data systems, collection, and reporting capabilities **Metric [I-7.1]:** Increase the number of reports generated through these quality improvement data systems Published Indicator inventory - data sources, numerators, denominators, owner, audience,

126675104.1.5	*1.10.2*	*-1.10.2(A-C)*	*ENHANCE PI AND REPORTING CAPACITY - CREATE AN INNOVATION AND TRANSFORMATION CENTER*
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.36*** ***126675104.3.37*** ***126675104.3.38*** ***126675104.3.39*** ***126675104.3.40***	*3.IT-4.2* *3.IT-4.3* *3.IT-4.4* *3.IT-4.5* *3.IT-4.6*	*Central-Line Associated Bloodstream Infections* *Catheter-associated Urinary Tract Infections* *Surgical Site Infections* *Patient Fall Rate* *Hospital-acquired deep vein thrombosis*

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)**
Management Dpt) Baseline/Goal: Establish a PI office Data Source: Office documentation **Metric [P-1.2]:** Documentation that the performance improvement office is engaged in collecting, analyzing, and managing real-time data (Monthly dashboards supporting 1115 Waiver projects, 5 HACs included in ITC project). Baseline: Executive Scorecard 6 CMS Core Measures and HCAPS Goal: Baseline plus Category 4 Measures Data Source: Internal Dashboard **Metric [P-1.3]:** Documentation of quality improvement activities implemented by the performance improvement office (Minimally evidence of RIEs, with documentation of the participants in the RIE, as appropriate, value-stream maps, Kaizens for 1115 Waiver projects and 5 HACs included in ITC project). Baseline: No documentation/ Goal: A3 Report for each 1115 Waiver Project and 5 HAC	Evidence of Training 75% Executive Suite; 15 Belts or Belts in Training Data Source: Internal Documentation **Metric [P-2.2]**: Improvement projects led by staff trained through the train the trainer program**.** Baseline: zero/Goal: Minimally 1115 Waiver Projects and the 5 HACs included in ITC projects will be staffed by individual with certification or individual being mentored by MBB Data Source: Internal documentation Milestone 2 estimated incentive payment: $1,382,931 **Milestone 3 [P-6] :** Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid-cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends) **Metric [P-6.1]:** Increase Number of	Dashboard with at least 75% of all of the quality metrics reported and displayed**;** Guidelines for overseeing the JPS purchasing of and participation applications and benchmarking activities Data Source: Internal Documents **Metric [I-7.2]:** Demonstrate how quality reports are used to drive rapid-cycle performance improvement. Goal: Minimally the 5 HAC outcomes associated with this project demonstrate improvement over baseline Data Source: Internal Documentation Milestone 6 estimated incentive payment: $2,222,773	frequency; Intranet Quality Dashboard with at least 85% - of all of the quality metrics reported and displayed**;** Guidelines for overseeing the JPS purchasing of and participation applications and benchmarking activities) Data Source: Internal documents **Metric [I-7.2]:** Demonstrate how quality reports are used to drive rapid-cycle performance improvement Baseline/Goal: 4 PI initiatives in addition to 5 HAC outcomes associated with this project demonstrate improvement over baseline Published Indicator inventory - data sources, numerators, denominators, owner, audience, frequency; Intranet Quality Dashboard with at least 75% of all of the quality metrics reported and displayed**;** Guidelines for overseeing the JPS purchasing of and participation applications and benchmarking activities) Data Source: Internal documents Milestone 8 estimated incentive

126675104.1.5	*1.10.2*	*-1.10.2(A-C)*	*ENHANCE PI AND REPORTING CAPACITY - CREATE AN INNOVATION AND TRANSFORMATION CENTER*	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.36*** ***126675104.3.37*** ***126675104.3.38*** ***126675104.3.39*** ***126675104.3.40***	*3.IT-4.2* *3.IT-4.3* *3.IT-4.4* *3.IT-4.5* *3.IT-4.6*	*Central-Line Associated Bloodstream Infections* *Catheter-associated Urinary Tract Infections* *Surgical Site Infections* *Patient Fall Rate* *Hospital-acquired deep vein thrombosis*	
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)**
Projects Data Source: ITC Documents Milestone 1 estimated incentive payment: $4,055,966	staff trained in quality and efficiency improvement principles Baseline: Two Black Belts Goal: 30 Belted or Belts in Training Data Source: Human Resource Training Records **Metric [P-6.2]**: Increase number of data analysts responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle performance improvement. Baseline: 1 Knowledge Management Analyst/Goal: 5 FTEs including Director Data Source: Human Resource Files/Departmental Records Milestone 3 estimated incentive payment: $1,382,930 **Milestone 4 [P-5.]:** Enhance or expand the organizational infrastructure and resources to store, analyze and share the patient experience data and/or quality measures data, as well as utilize them for quality improvement			payment: $1,836,203

126675104.1.5	*1.10.2*	*-1.10.2(A-C)*	*ENHANCE PI AND REPORTING CAPACITY - CREATE AN INNOVATION AND TRANSFORMATION CENTER*	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.36*** ***126675104.3.37*** ***126675104.3.38*** ***126675104.3.39*** ***126675104.3.40***	*3.IT-4.2* *3.IT-4.3* *3.IT-4.4* *3.IT-4.5* *3.IT-4.6*	*Central-Line Associated Bloodstream Infections* *Catheter-associated Urinary Tract Infections* *Surgical Site Infections* *Patient Fall Rate* *Hospital-acquired deep vein thrombosis*	
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)**
	Metric [P-5.1]: Increased collection of patient experience and/or quality measures data Baseline TBD/Goal: 45% Category 4 Measures are reported on the dashboard Data Source: Internal databases Milestone 4 estimated incentive payment: $1,382,930			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,055,966	Year 3 Estimated Milestone Bundle Amount: $4,148,791		Year 4 Estimated Milestone Bundle Amount: $4,445,546	Year 5 Estimated Milestone Bundle Amount: $3,672,406
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $16,322,709				

Project Option 1.1.1 – Establish more primary care clinics – Walk-in Care Clinic
Unique Project ID: 127304703.1.1
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Azle / 127304703
Provider: Texas Health Harris Methodist Hospital Azle's mission is to improve the health of the people in the communities we serve. The mission is the foundation for all of the facilities activities. Texas Health Harris Methodist Hospital Azle, a 36-bed hospital, is located on the border of Tarrant and Parker County, resulting in Texas Health Azle being the major source of primary health care to the area's 30,000 citizens since 1954.
Provider's Role in Region: The Tarrant County side has many resources, such as public health services; however, there is no public transportation from Azle to access these services. Parker County does not have a county hospital and only one clinic in Weatherford, which is approximately 20 miles from Azle. Again, there are no transportation options to Weatherford. Access for Medicaid patients is an equal concern. Although there are physicians in the large cities who accept Medicaid, there is not adequate transportation to these facilities.
Regional Need: The rural parts of Parker County provide an economic challenge. In fact, 18.7 percent of households in North Parker make less than $25,000 a year. In Parker County, the uninsured rate has jumped from 14.1 percent in 2007 to 24.8 percent in 2010[vii]. The percent of children without insurance is 11.8[i] percent. Lack of insurance increases their dependence on Medicaid As a result, 56% of the patients seen in the emergency room at Texas Health Azle were either unfunded or Medicaid. This translates into approximately 13,154 patients.
Project Intervention: Unfunded or Medicaid patients typically do not have access to primary care. With limited options, many patients utilize the emergency department for routine medical care. This is costly and, in many cases, inconvenient. Low acuity patients generally have to wait until the more emergent cases are treated. The proposed Walk-in Clinic is new.
Target Population and Benefit: Because of funding issues, there are few physicians in the Azle area, who have available appointments for Medicaid and unfunded patients. Azle area physicians most often limit the number of Medicaid and unfunded patients they will accept. Others are forced to see physicians in the large Metroplex areas, such as Fort Worth. Unfortunately, there are no public transportation options available from Azle to these urban areas. In addition, there will be a decrease usage of the Emergency Department for those patients who now use it for non emergent care, which can be better served in a clinic setting. The walk-in clinic will provide a lower cost alternative to the Emergency Department to enable greater continuity of care for Medicaid and low income patients.
Category 1 Expected Patient Benefits: The project seeks to provide a medical home for approximately 875 unfunded or Medicaid patients by DY5, resulting in higher quality of care in a more cost effective setting.
Category 3 Outcomes: By the end of waiver, there will be a 50% reduction in unfunded/ Medicaid and Medicare patients in the Emergency Department for non-emergent visits (~1490 visits) compared to baseline year, which translates to a 5.9% reduction in all ED visits. This would save in healthcare cost alone approximately $1,117,322.00.
Project Option 1.1.1 – Establish more primary care clinics – Walk-in Care Clinic

Unique Project ID: 127304703.1.1
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Azle / 127304703

Project Description:
These funds will be used to create a Walk-in Care Clinic in Azle (utilizing either unused clinical space in the existing building operated by JPS Health Network or the Professional Office Building on THAZ campus).

- Hours: This clinic will be open 10 hours a day, seven days a week.
- Staffing: staffed by a physician or mid-level provider along with at least one RN and one patient care technician.
- Population: Intervention population includes patients who are uninsured/Medicaid and Medicare patients who do not have a primary care provider residing in Northwest Tarrant, Northeast Parker, and Southwest Wise Counties who present for non-emergent[71] services as defined by level four or five on the ESI classification scale, and who need to see a provider the same day.

Goals and Relationship to Regional Goals:
Project Goals:
The goal of this project is to provide services to a minimum of 20-25 patients a day who otherwise would be treated by the Texas Health Harris Methodist Hospital Azle's Emergency Department for non-emergent services, or not be treated at all due to a lack of provider access.

Along with primary care services, the Walk-in Care Clinic will provide acute care services, disease prevention information, screening, early detection services, along with educational and referral resources such as specialty care. The mission of this service is to improve access to primary care services for the unfunded/Medicaid and Medicare patients, reduce the incidence and mortality of certain diseases in the community setting, as well as treating acute illnesses as presented.

This project meets the following Regional goals:
The focus areas of the Region are:
(1) to provide improved access to health care for people with financial barriers;
(2) address geographic barriers that impede access to care; and
(3) reduce overuse of emergency department services.
This project will contribute to achieving these goals by implementing a community-based innovative primary care clinic. There is no public transportation in Azle; therefore, there is limited access to the clinics located in the larger metropolitan areas. In addition, Azle has a

[71] Emergency Severity Index, 2012. The ESI Triage Research Team, LLC. http://www.esitriage.org/.

disproportionate population of low-income or uninsured patients. These factors combine to drive patients to the emergency department. This clinic will provide centrally located, cost-effective, high-quality care.

Challenges:
Parker County is located just west of Tarrant County, a large urban county containing the cities of Fort Worth and Arlington. Being close to a major metropolitan center would suggest increased access to health care. Unfortunately, this is not the case. Azle straddles the Tarrant/Parker county line. The Parker County side has little to no resources. There is no county hospital in Parker County and only one county-supported family practice clinic. The one clinic is located approximately 20 miles from Azle. Unemployment has almost doubled in the past three years, rising from 4.1% in 2007 to 7.7% in 2010.[72]

An uninsured rate has jumped from 14.1% in 2007 to 24.8% in 2010.[73] The percentage of children without insurance is 11.8. According to the Texas Medical Association, the uninsured are up to four times less likely to have a regular source of health care and are more likely to die from health-related problems. They are much less likely to receive needed medical care, even for symptoms that can have serious health consequences if not treated. About one in five Texans lives at or below the poverty level; for children, it's nearly one in three. Extending health coverage to the uninsured could improve their overall health by 7 to 8%. Lack of insurance increases their dependence on Medicaid.[74]

5-Year Expected Outcome for Provider and Patients:
The Walk-in Care Clinic will increase access to primary care. Patients will be able to choose where to receive health care based on the appropriate setting, instead of financial considerations. By the end of the Waiver, there will be a 50% increase of patient visits to the clinic as compared to baseline data.

Starting Point/Baseline:
From October 1, 2011 to September 30, 2012, there were 25,162 visits to the Emergency Department at Texas Health Harris Methodist Azle. There were 2,703 unfunded/Medicaid and Medicare patients treated for non-emergent care, who could have benefited from services provided in a primary care setting. In DY2 we will establish the clinic, and in DY3 we will review clinic usage to determine the baseline data for DYs 4 and 5.

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[72] Texas Association of Counties. (2011). *Parker County Profile*. http://www.txcip.org/tac/census/profile.php?FIPS=48367
[73] Texas Association of Counties. (2011). *Parker County Profile*. http://www.txcip.org/tac/census/profile.php?FIPS=48367
[74] Texas Medical Association. (2011). *The Uninsured in Texas*. http://www.texmed.org/template.aspx?id=5517

Rationale:
Texas Health Harris Methodist Hospital Azle Emergency Department's current payer mix is comprised of 21% Medicaid and 35% uninsured patients. The Walk-in Care Clinic will provide comprehensive preventive and acute health services to individuals in the communities where people live, work, and worship along Northwest Tarrant County, Northeast Parker County, and Southwest Wise County.

Project Components:
More than half of the patients using Texas Health Harris Methodist Hospital Azle's Emergency Department are uninsured or have Medicaid, lack a primary care provider, and could benefit from having access to primary care services. By establishing the Walk-In Care Clinic, these patients will be able to develop a medical home.

The lack of primary care services available to unfunded/Medicaid and Medicare patients create an environment where these patients have to use the emergency department for primary care and non-emergent treatment because they have limited options for their care (P-2). In DY3 we will determine the volume of patient visits based on the day of the week and hours utilized to determine the baseline for DYs 4 and 5. We believe that with marketing and patient education, we can increase the usage of the clinic by 50% by end of Waiver as compared to baseline data.

Unique community need identification numbers the project addresses:

- CN.7 – Need to address geographic barriers that impede access to care
- CN.8 – Lack of access to health care due to financial barriers
- CN.10 – Overuse of emergency department (ED) services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
JPS Health Network operates a currently underutilized clinic approximately 2 miles from Texas Health Harris Methodist Hospital Azle's campus. Because of its location near the Parker and Wise County lines, many patients in the surrounding areas are unable to receive treatment because they do not reside in Tarrant County. There are relatively few clinics where these patients can receive outpatient care. Many of them go without preventive and primary care services and ultimately end up in the emergency department seeking treatment. This project will expand access to primary care services for this patient population, reducing ED utilization, costs, and duplication of services. Sharing existing space with JPS makes better utilization of existing resources in a cooperative manner.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/rationale for Selecting the Outcome Measures:
IT-9.2 – ED appropriate utilization

The goal of the Walk-In Care Clinic is to provide unfunded, Medicaid and Medicare patients a more suitable venue to address their non-emergent primary health care needs. ED appropriate utilization will capture the redirection of these non-emergent ED visits to the Walk-in care clinic through the reduction of overall ED visits annually.

By focusing on this outcome, we'll be able to see how effectively we reach the targeted ED population and ultimately be able to improve their access to primary care services, disease prevention information and early detection services.

Relationship to Other Projects:

Related Category 1 and 2 projects: 127304703.2.1- Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – Healthy Education and Lifestyles Program (HELP) Chronic Disease Management Program

Related Category 4 population-focused improvements: N/A

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

- **Approach/Methodology:** For every non-emergent ED visit avoided, $150 is saved by the health care system. The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing health care costs, individual costs, and community costs.
- **Rationale:** ED visit outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with more than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already navigate frequent flyers away from the ED.

Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

127304703.1.1	*1.1.1*	*Project Components: N/A*	*Establish more primary care clinics – Walk-in Care Clinic*
Texas Health Harris Methodist Azle Hospital			*1273047-03*
Related Category 3 Outcome Measure(s):	*127304703.3.1*	*3.IT-9.2*	*Right Care, Right Setting: 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]: Implement a community clinic program Metric 1 [P-2.1]: Establish on new clinic Goal: Open one clinic with four full time staff. Data Source: Human Resources Record, Program Policies Milestone 1 Estimated Incentive Payment: $97,369	**Milestone 2** [P-X]: Establish baseline rates for clinic volume of visits. Metric 1 [P-X.1]: Determine volume of patient visits to the clinic. Goal: Determine usage of clinic based on hours/days of the week. Data Source: EHR, Registration data. Milestone 2 Estimated Incentive Payment: $94,274	**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 25% increase in patient volume as compared to baseline data. Data Source: Registry, EHR, claims Milestone 3 Estimated Incentive Payment: $99,431	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 50% increase in patient volume as compared to baseline data. Data Source: Registry, EHR, claims Milestone 4 Estimated Incentive Payment: $80,286
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $97,369	Year 3 Estimated Milestone Bundle Amount: $94,274	Year 4 Estimated Milestone Bundle Amount: $99,431	Year 5 Estimated Milestone Bundle Amount: $80,286
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $371,360			

Project Summary Template to be completed for each Category 1 and 2 project
Project Option 1.12.2 – Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Substance Abuse Expansion)

Unique Project ID: 127373205.1.1
Performing Provider Name/TPI: Helen Farabee Centers / 127373205

Provider: The Helen Farabee Center consists of 9 clinics in north-central Texas serving 19 counties across 16,705 square miles and a population of 318,665. The Helen Farabee Center is a Community Mental Health/Intellectual & Developmental Disability authority/provider. The Center serves primarily indigent clients and roughly 30% of them have Medicaid.
Intervention: This project involves hiring a program manager, two licensed substance abuse counselor and one support staff who will provide substance abuse services in the Wise county region. The project is an expansion of services provided within the Center's region and it is a new service for Wise County.
Need for the project: The project meets the following needs identified through a regional needs assessment: CN.4 Lack of access to mental health services; CN.7 Need to address geographic barriers that impede access to care.
Target population: The target population for this project includes Adults/Children with a single substance-abuse or dependence diagnosis who do not meet Co-Occurring Psychiatric and Substance Abuse Disorder (COPSD) service eligibility requirements per our contract with the Department of State Health Services. Estimated number of patients to be served in DY3 is 50 patients, increasing to 55 and 58 in DYs 4 and 5, respectively. The project represents a needed service that is currently absent in the identified service area and one that can be provided at low or no cost to Medicaid/ Indigent recipients.
Category 1 or 2 expected patient benefits: The benefit is the increase in substance abuse services. This benefit meets the purpose of establishing and providing substance abuse services in the identified service area.
Category 3 outcomes: The benefit of the project is a 5% and 10% improvement in quality of life as measured by substance abuse assessments in DY's 4 and 5, respectively. This meets the project purpose of meeting substance abuse needs for people in the identified service area.

Project Option 1.12.2 – Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Substance Abuse Expansion)

Unique Project ID: 127373205.1.1
Performing Provider Name/TPI: Helen Farabee Centers / 127373205

Project Description: This project involves hiring a program manager, two licensed substance abuse counselors and one support staff who will provide substance abuse services in the Wise county Region(ZIP codes 76431, 76225, 76234, and 76073). The target population for this project includes adults/children with a single substance abuse or dependence diagnosis who do not meet co-occurring psychiatric and substance abuse disorder (COPSD) service eligibility requirements per our contract with the Department of State Health Services. As referrals come in, individuals' treatment needs are assessed by the counselor, treatments are planned and conducted on an outpatient basis at center facilities in the Region. Continuous assessments are conducted that inform treatment or indicate discharge/referral services. Services are terminated when needs have been met. The project fits within the Project Area by enhancing the availability of substance abuse services in a location not currently providing them. The project fits the intervention through expanding the number of settings where substance abuse services are provided.

Goals and Relationship to Regional Goals:

Project Goals:
The goal is to establish a substance abuse division in Wise County by hiring four staff members (one program manager, two licensed chemical dependency counselors, and one support staff), and then providing substance abuse services in that county.

This project meets the following Regional goals:
The project is related to Regional Area of Focus One: Access to Care. The majority of Regional survey respondents indicated access to routine specialty care was difficult. Mental/behavioral health care services were the most difficult for low-income patients to access.

The project is related to Area of Focus Two: Care Coordination. The majority of respondents did not believe that low-income patients could access behavioral/mental health providers.

The project is related to Area of Focus Three: Community Health. Respondents felt that behavioral health, substance abuse and insufficient access to care were the top issues affecting population health.

The Helen Farabee Center primarily serves low-income individuals seeking mental/behavioral health care. The substance abuse project removes a major barrier to obtaining access to assessments for substance-related conditions and subsequent outpatient treatment locally.

Challenges:

Currently, substance abuse services are provided in only one county within Helen Farabee Center's catchment area. As a result, substance abuse services are not available for many communities we serve. This project addresses that challenge by expanding services to a community that has previously lacked services.

5-Year Expected Outcome for Provider and Patients:

The expected outcome for the provider is to have established a substance abuse division in additional counties, provide needed services in that community, and to see improved quality of life as measured through standard assessments.

Starting Point/Baseline:

There are currently no substance abuse services provided by the Wise County clinic. The expected outcome at the end of the Waiver is to have a staffed substance abuse division at the clinic, providing substance abuse services on a routine basis.

Rationale:

During May 2012, the Helen Farabee Center solicited feedback via a survey from local stakeholders to inform planning for expansion and improvement of behavioral health services. Access to mental/behavioral health care was identified as difficult by 41.2% of the respondents, and substance abuse services were ranked as the most important service not currently provided in all service areas. Access to mental health appointments occurs on a walk-in basis; however, if patients require substance abuse services we cannot provide them in Wise County. Enhancing service availability for substance abuse services will help meet this need. Based on substance abuse arrest records in Wise County provided by the DSHS Treatment Statistics website, a conservative estimate of the number of patients who would potentially access substance abuse services in Wise County is 50 in DY3.

When patients with behavioral health issues cannot get timely evaluations and care through a local mental health authority, they will likely visit a local emergency department. AHRQ reports that one in eight of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a substance abuse problem. Nearly 41% of these mental disorder and/or substance abuse-related visits resulted in hospitalization.[75]

[75] Agency for Healthcare Research and Quality, Rockville, MD. 2010. Statistical brief 92. Healthcare cost and utilization project (HCUP). www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

Many patients could be diverted from emergency departments if immediate substance abuse screenings/interventions were available.

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Project Components:

Enhancing substance abuse service availability for Wise County requires an expansion of those services into that underserved area.

The milestones and metrics were chosen based on the elements required in order to provide substance abuse services at a new location where none had been provided before. Substance abuse divisions require state licenses, equipment, administrative protocols/guidelines, hiring and training staff, evaluation and improvement activity and tracking utilization. A customizable improvement milestone was selected based on existing milestone I-11.1. This milestone (I-X.1) was customized by removing the mobile clinic aspect, since this project involves creating a new substance abuse division at an existing facility in Wise County. The customized milestone still measures increased utilization of behavioral health services using roughly the same data source (without referencing expanded transportation programs).

Unique community need identification numbers the project addresses:

- CN.4 – Lack of access to mental health services
- CN.7 – Need to address geographic barriers that impede access to care
- CN.8 – Lack of access to health care due to financial barriers (i.e., lack of affordable care)

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

The project enhances care delivery by providing the substance abuse intervention dimension that is currently lacking. It provides Center psychiatrists with immediate referral and coordination options if clinically indicated. It allows the local mental health authority to provide complete behavioral health care that includes substance abuse services.

<u>Related Category 3 Outcome Measures</u>:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-10.1 Quality of Life

This outcome is important since improvements in this measure correlate to increased time in a regular community setting versus seeking help through the emergency department or state hospital. When patients with behavioral health issues cannot get timely evaluations and care through a local mental health authority, they will likely visit a local emergency department.

AHRQ reports that one in eight of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a substance abuse problem. Nearly 41% of these mental disorder and/or substance abuse-related visits resulted in hospitalization.[76] Many patients reporting improved QOL ratings may also be diverted from emergency departments if immediate substance abuse screening/interventions were available. The outcome also reflects any impact substance abuse services will have in ensuring patients remain in the community and abstinent from drugs/alcohol. The expected improvement milestone for DY4 is to see improvement in quality of life, comparing assessments at first contact with assessments at three months, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of patients in Wise County. The milestone increases to 10% for DY5.

Relationship to Other Projects:

This Substance Abuse expansion project is related to project "127373205.1.2 Improve access to specialty care (Psychiatric Open Access)" in that it is providing access to a service that would otherwise require a long wait or not be available in Wise County.

The project relates to "127373205.2.1 Recruit, train and support consumers of mental health services to provide peer support services (Peer Support)" in that it also is establishing services that have previously not been provided in Wise County.

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

MHMR of Tarrant County (081599501.2.1)
Wise Regional Health System (130606006.2.3)

The target population for this project includes adults/children with a single substance abuse or dependence diagnosis who do not meet co-occurring psychiatric and substance abuse disorder (COPSD) service eligibility requirements per our contract with the Department of State Health Services. Part of this eligibility includes geographic location limited to Wise County. We do not believe the project duplicates another provider's intervention for the same target population in this county.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

[76] Agency for Healthcare Research and Quality, Rockville, MD. 2010. Statistical Brief 92. Healthcare cost and utilization project (HCUP). www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

Project Valuation:

Substance abuse imposes a heavy burden on emergency department and primary care settings. When individuals are screened for substance abuse and receive appropriate treatment, the related utilization and abuse of health care settings will go down 50% with a savings of $3.81 to $4.30 for every dollar spent on treatment services. We used the average of $4.05 saved for every dollar spent on treatment services. The savings of $4.05 was determined by the Texas Drug Demand Reduction Advisory Committee Report to state leadership.[77] That savings amount was determined based on costs saved from incarceration, hospitalization, emergency department usage, and homelessness.

[77] Texas Drug Demand Reduction Advisory Committee: Report to State Leadership, January 2009 (http://www.dshs.state.tx.us/sa/ddrac/)

127373205.1.1	***1.12.2***	***1.12.2***	Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Substance Abuse Expansion).	
The Helen Farabee Center/ Wise County				*127373205*
Related Category 3 Outcome Measure(s):	*127373205.3.1*	*3.IT-10.1*	Quality of Life (Substance Abuse Expansion)	
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. Baseline/Goal: Develop plan and secure licenses in preparation for delivery of Substance Abuse services. Data Source: Project Plan Milestone 1 Estimated Incentive Payment:$150,847 **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 Baseline/Goal: Hire and train one	**Milestone 3** [P-6]:Establish behavioral health services in new community-based settings in underserved areas Metric 1 [P-6.1]: Number of new community-based settings where behavioral health services are delivered Baseline/Goal: Provide Substance Abuse services to 50 consumers by 09-30-14. Data Source: Number of patients served at these new community-based sites Milestone 3 Estimated Incentive Payment: $164,689 **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: Complete first project report which includes a review of service encounters, analysis and recommended changes. Data Source: Project reports including examples of how		**Milestone 5** [I-11]:Increased utilization of community behavioral health care Metric 1 [I-11.1]: Percent utilization of community behavioral health care services. Numerator: Number receiving community behavioral health care services from new substance abuse division after access expansion Denominator: Number of people receiving community behavioral health services after access expansion. Goal: To increase the provision of Substance Abuse services by 10% over DY3 target by 09-30-15 (55 patients) Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 5 Estimated Incentive Payment: $352,139	**Milestone 6**[I-11]: Increased utilization of community behavioral health care Metric 1 [I-11.1]: Percent utilization of community behavioral health care services. Numerator: Number receiving community behavioral health care services from new substance abuse division after access expansion Denominator: Number of people receiving community behavioral health services after access expansion. Goal: To increase the provision of Substance Abuse services by 15% over DY3 target by 09-30-16 (58 patients). Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 6 Estimated Incentive Payment: $340,023

127373205.1.1	***1.12.2***	***1.12.2***	Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Substance Abuse Expansion).	
The Helen Farabee Center/ Wise County				*127373205*
Related Category 3 Outcome Measure(s):	*127373205.3.1*	*3.IT-10.1*	Quality of Life (Substance Abuse Expansion)	
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)**
Program Manager, two Licensed Chemical Dependency Counselors, and one Support Staff member to provide and support Substance Abuse services. Data Source: Project records; Training curricula as develop in P-2 Milestone 2 Estimated Incentive Payment:$150,847	real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 4 Estimated Incentive Payment: $164,689			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $301,694	Year 3 Estimated Milestone Bundle Amount: $329,378		Year 4 Estimated Milestone Bundle Amount: $352,139	Year 5 Estimated Milestone Bundle Amount: $340,023

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,323,234

Project Summary Template to be completed for each Category 1 and 2 project
Project Option 1.9.2 – Improve access to specialty care (psychiatric open access)

Unique Project ID: 127373205.1.2
Performing Provider Name/TPI: Helen Farabee Centers / 127373205

Provider: The Helen Farabee Center consists of 9 clinics in north-central Texas serving 19 counties across 16,705 square miles and a population of 318,665. The Helen Farabee Center is a Community Mental Health/Intellectual & Developmental Disability authority/provider. The Center serves primarily indigent clients and roughly 30% of them have Medicaid.
Intervention: This project expands the hours for psychiatric evaluation by expanding our current contract for telemedicine services in Wise County. The project is new.
Need for the project: The project meets the following needs identified through a regional needs assessment: CN.4 Lack of access to mental health services; CN.7 Need to address geographic barriers that impede access to care.
Target population: The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders). The estimated number of patients will be determined in DY2 per Milestone 1, Metric 1. An estimate is that 48 patients would be referred for psychiatric evaluation in DY2, increasing to 65 and 71 patients in DYs 4 and 5, respectively. The project represents a needed service that is currently absent in the identified service area and one that can be provided at low or no cost to Medicaid/ Indigent recipients.
Category 1 or 2 expected patient benefits: The benefit is the access to on-demand psychiatric evaluation and earlier treatment. This benefit meets the purpose of improving access to specialty services (psychiatry) in the identified service area.
Category 3 outcomes: The benefit of the project is a 5% and 10% improvement in quality of life as measured by assessments in DY's 4 and 5, respectively. This meets the project purpose of improving quality of life through immediate psychiatric access for people in the identified service area.

Project Option 1.9.2 – Improve access to specialty care (psychiatric open access)

Unique Project ID: 127373205.1.2
Performing Provider Name/TPI: Helen Farabee Centers / 127373205

Project Description:

This project expands the hours for psychiatric evaluation by expanding our current contract for telemedicine services in Wise County (ZIP codes 76431, 76225, 76234, and 76073). The expanded hours will provide for open-access (on-demand) routine psychiatric evaluations for individuals determined eligible to receive services under the Texas Recovery and Resiliency model. The target population for this project is adults/children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (adults with major depression, bipolar disorder, schizophrenia and children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders).The project fits within the Project Area, since psychiatry is considered specialty care and is being expanded. The project fits within the intervention in that the expansion of psychiatric availability improves access to these services by eligible individuals.

Goals and Relationship to Regional Goals:

Project Goals:

The project goals include collecting baseline data for wait times, completing and submitting a plan for electronic referrals, training medical staff, implementing referral technology to improve provider communications, and incrementally increasing the volume of specialty care visits via the open-access model.

This project meets the following Regional goals:

The project is related to Regional Area of Focus One: Access to Care. The majority of Regional survey respondents indicated access to routine specialty care was difficult. Mental/behavioral health care services were the most difficult for low-income patients to access.

The project is related to Area of Focus Two: Care Coordination. The majority of respondents did not believe that low-income patients could access behavioral/mental health providers.

The project is related to Area of Focus Three: Community Health. Respondents felt that behavioral health, substance abuse and insufficient access to care were the top issues affecting population health.

The Helen Farabee Center primarily serves low-income individuals seeking mental/behavioral health care. The open-access model removes a major barrier to obtaining access to quick and meaningful psychiatric evaluations and initial pharmacological treatments.

Challenges:

Currently the average wait time for an initial psychiatric evaluation is 10 weeks, making access to much-needed psychiatric medical care delayed at the Helen Farabee Center. The project addresses this barrier by creating on open-access (on-demand) model for psychiatric evaluation via telemedicine. The team implementing this project consists of initial intake clinicians who make the initial referrals for psychiatric evaluations, support staff who coordinate the video session, and contracted psychiatrists and other medical support personnel who conduct the evaluations.

5-Year Expected Outcome for Provider and Patients:

There is currently no mechanism for on-demand (walk-in) psychiatric evaluations for routine outpatient behavioral health services. The expected outcome during the Waiver period is to increase the number of psychiatric evaluations provided within one business day by creating an on-demand model. This is designed to have the anticipated effect of improving quality of life through removing a barrier to outpatient behavioral health services. Another expected outcome would be at least a 5% increase in the number of unique patients accessing services.

Starting Point/Baseline:

There are currently no on-demand psychiatric evaluations for routine behavioral health services.

Rationale:

Expediting services can decrease symptoms and increase functioning in individuals, ensuring timely access to initial evaluations and freeing other prescribers to provide quicker follow-up encounters. Neufeld et al. (2012)[78] used the mean time between appointments as potential indicators for measuring quality of life. An on-demand (walk-in) model of care would expedite services, potentially reduce psychiatric admissions,[79] and potentially reduce emergency department usage by individuals in Wise County.

[78] Neufeld, J. (2012). Walk-in telemedicine clinics improve access and efficiency: a program evaluation from the perspective of a rural community mental health center. *Rural Mental Health, Fall/Winter 2012,* 33-37. http://newprairiepress.org/journals.html.

[79] The American Psychiatric Association's 2012 Annual Meeting. Abstract SCR10-3, presented May 6, 2012.

Project Components:

The project component -- (a) "increasing service availability with extended hours" provides a cost-effective[80] and concrete way to improve access to psychiatric services. This is accomplished by extending the available hours for contracted psychiatric evaluation providers in order to meet on-demand needs (P-2, P-11). Core component (b) "Increase the number of specialty clinic locations" was not addressed since our region has an adequate number of physical access points at which on-demand evaluations can occur. The Center currently operates 9 existing sites which enable most of the population in our catchment area to drive to a location in less than an hour. This makes it unnecessary for us to increase the number of clinic locations. Component (c) "Implement transparent, standardized referrals across the" ensures efficient access to the new on-demand evaluation services. This is accomplished by creating an electronic standardized referral process and training staff on the process (P-7, P-8, P-9). Component (d) "Conduct quality improvement for project using methods such as rapid cycle improvement" is achieved by tracking and reporting on project impacts such as evaluation utilization and wait times compared to baseline data (P-3). This data is reported monthly to the Center's Improvement and Oversight Committee. Access to behavioral health care was identified as difficult by 41.2% of community stakeholder respondents and barriers to access in terms of long wait times were identified as most important by 40.9%.

Baseline data is being collected in order to know the extent to which access to psychiatric services has been improved through then open-access model. Implementation plans for e-referrals ensure process efficiency. Training specialty care providers is required with a new access model of care. Developing and implementing technical referral capabilities will enable improved and streamlined provider communications. The improvement milestone of increasing clinic volume and improving patient access will help remove access barriers perceived by the community.

Unique community need identification numbers the project addresses:

- CN.4 – Lack of access to mental health services
- CN.7 – Need to address geographic barriers that impede access to care

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

The project significantly enhances the existing delivery of psychiatric evaluations by eliminating the potential 10-week wait for medical interventions for routine behavioral health conditions.

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[80] Neufeld, J. (2012). Walk-In Telemedicine Clinics Improve Access and Efficiency: A Program Evaluation From the Perspective of a Rural Community Mental Health Center. *Rural Mental Health, Fall/Winter 2012,* 33-37. Retrieved October 12, 2012, from http://newprairiepress.org/journals.html

The open-access model is designed to provide psychiatric evaluations the same day or next business day following the determination that patients are eligible for services.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
IT-10.1 Quality of Life.

This outcome is important since improvements in this measure correlate to increased time in a regular community setting versus seeking help through the emergency department or state hospital. When patients with behavioral health issues cannot get timely evaluations and care through a local mental health authority, they will likely visit a local emergency department. AHRQ reports that one in eight of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a substance abuse problem. Nearly 41% of these mental disorder and/or substance Abuse-related visits resulted in hospitalization.[81] Many patients reporting improved QOL ratings may also be diverted from emergency departments if an immediate psychiatric evaluation were available. The outcome also reflects any impact psychiatric evaluation services will have in ensuring patients remain in the community. The expected improvement milestone for DY4 is to see improvement in quality of life, comparing assessments at first contact with assessments at three months, as measured by the ANSA, for 5% of patients in Wise County. The milestone increases to 10% for DY5.

Relationship to Other Projects:

The project relates to 127373205.2.1 Recruit, train and support consumers of mental health services to provide peer support services (peer support), in that it also establishes services that have previously not been provided in Wise County.

The Project relates to 127373205.1.1 Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (substance abuse expansion), in that it also provides a behavioral health service in an area that currently has very limited access to the service.

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

Lakes Regional MHMR Center (121988304.1.2)
Medical Center of Arlington (020950401.1.1)
North Hills Hospital (094105602.1.1)
Pecan Valley Centers (130724106.1.1)

[81] Agency for Healthcare Research and Quality, Rockville, MD. Statistical brief 92. Healthcare cost and utilization project (HCUP). 2010. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

The target population for this project is adults/children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (adults with major depression, bipolar disorder, schizophrenia and children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders). Part of this eligibility includes geographic location limited to Wise County. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. We do not believe the project duplicates another provider's intervention for the same target population.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years. Based on the literature, an estimated Quality of Life Year gained by this intervention is 0.0245 years. The result is a $1,225 quality of life improvement per patient impacted. The valuation is aligned with the Medicaid Waiver goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided, and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research). Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. Cost-utility analysis is a useful tool for assessing the value of new health service interventions because it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g., emergency department visits that are avoided). In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added. The number of life-years added is based on a review of the scientific literature. A search of the scientific literature identified the following two studies. The first study looked at telemedicine and mental health and was conducted by Pyne (2010)[82] which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. Another study by Hollinghurst et al. (2010)[83] examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the wait list

[82] Pyne JM, Fortney JC, Tripathi SP, Maciejewski ML, Edlund MJ & WilliamsDK (2010). Cost-effectiveness analysis of a rural telemedicine collaborative care intervention for depression. *Arch Gen Psychiatry,* 67(8), 812-821.

[83] Hollinghurst S, Peters TJ, Kaur S, Wiles N, Lewis G & Kessler D. (2010). Cost-effectiveness of therapist-delivered online cognitive-behavioral therapy for depression: randomized controlled trial. *Br J Psychiatry,* 197(4), 297-304.

control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245.

127373205.1.2	***1.9.2***	***1.9.2.A*** ***1.9.2.B*** ***1.9.2.C*** ***1.9.2.D***	Improve access to specialty care (Psychiatric Open Access)
[The Helen Farabee Center/ Wise County]			*[127373205]*
Related Category 3 Outcome Measure(s):	*127373205.3.2*	*3.IT-10.1*	*Quality of Life (Psychiatric Open Access)*

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]:Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1 [P-3.1]:Establish baseline for performance indicators Numerator: Total number of days patients waited from evaluation request to evaluation encounter. Denominator: Number of clients requesting psychiatric evaluations (current estimate is 48 for DY2). Baseline/Goal: To determine the average wait time for an initial psychiatric evaluation. Data Source: EHR, Internal Database Milestone 1 Estimated Incentive Payment*:* $18,647 **Milestone 2** [P-7]: Complete a planning process/submit a plan to implement electronic referral technology (choose at least one metric): Metric 1 [P-7.2]: Metric: Development of an implementation plan for e-referral Baseline/Goal: Develop a plan that	**Milestone 4**[P-8]: Develop the technical capabilities to facilitate electronic referral Metric 1[P-8.1]: Demonstrate technical mechanisms to be used to operate referral system are in place Baseline/Goal: Develop a Referral Management system that will enable providers to efficiently refer consumers for psychiatric evaluations in the on-demand model Data Source: Referral Management system Milestone 4 Estimated Incentive Payment*:* $22,377 **Milestone 5** [P-9]: Milestone: Implement referral technology and processes that enable improved and more streamlined provider communications Metric 1 [P-9.1]:Documentation of referrals technology Baseline/Goal: With improved technology and e-referral, to establish more efficient and fluid communication among providers	**Milestone 7** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2).Total number of visits for reporting period Goal: To increase the number of psychiatric evaluations by 5% over baseline by 09-30-15 (estimated to be 65 patients). Data Source: Registry, EHR, claims or other Performing Provider source Metric 2 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Total number of unique patients encountered in the clinic for reporting period. Goal: Increase unique number of patients by 2.5% over baseline. Data Source: patient registry	**Milestone 8** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2).Total number of visits for reporting period Goal: To increase the number of psychiatric evaluations by 10% over baseline by 09-30-16 (estimated to be 71 patients) Data Source: Registry, EHR, claims or other Performing Provider source Metric 2 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Total number of unique patients encountered in the clinic for reporting period. Goal: Increase unique number of patients by 5% over baseline. Data Source: patient registry

127373205.1.2	***1.9.2***	***1.9.2.A*** ***1.9.2.B*** ***1.9.2.C*** ***1.9.2.D***	Improve access to specialty care (Psychiatric Open Access)
[The Helen Farabee Center/ Wise County]			*[127373205]*
Related Category 3 Outcome Measure(s):	*127373205.3.2*	*3.IT-10.1*	*Quality of Life (Psychiatric Open Access)*

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)**
will guide the implementation and technical needs of e-referrals for the on-demand model Data Source: Referral plan, which describes the technical mechanisms needed to operate e-referral system. Milestone 2 Estimated Incentive Payment*:* $18,647 **Milestone 3** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties Metric 1 [P-2.1]: Training of staff and providers on referral guidelines, process and technology Numerator: Number of staff and providers trained and documentation of training materials Denominator: Total number of staff and providers working in specialty care and medical specialty clinics Baseline/Goal: To train providers on e-referrals so that the on-demand model of care is a more	for the on-demand model of care Data Source: Referral system Milestone 5 Estimated Incentive Payment*:* $22,377 **Milestone 6** [P-11]: Launch/expand a specialty care clinic (e.g.,, pain management clinic) Metric 1 [P-11.1]: Establish/expand specialty care clinics. Number of patients served by specialty care clinic. Baseline/Goal: To initiate the on-demand model of care for psychiatric evaluations. Data Source: Documentation of new/expanded specialty care clinic Milestone 6 Estimated Incentive Payment*:* $22,378	Milestone 7 Estimated Incentive Payment: $72,065	Milestone 8 Estimated Incentive Payment: $69,865

127373205.1.2	***1.9.2***	***1.9.2.A*** ***1.9.2.B*** ***1.9.2.C*** ***1.9.2.D***	Improve access to specialty care (Psychiatric Open Access)	
[The Helen Farabee Center/ Wise County]				*[127373205]*
Related Category 3 Outcome Measure(s):	*127373205.3.2*	*3.IT-10.1*	*Quality of Life (Psychiatric Open Access)*	
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)**
efficient and effective service for the consumer. Data Source: Log of specialty care personnel trained and Curriculum for training. Milestone 3 Estimated Incentive Payment:$18,647				
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $55,941	Year 3 Estimated Milestone Bundle Amount: $67,132		Year 4 Estimated Milestone Bundle Amount: $72,065	Year 5 Estimated Milestone Bundle Amount: $69,865
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$265,003				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 1.1.1 – Expand Pediatric Primary Care (WRHS - Pediatric Project)

Unique Project ID: -130606006.1.2 (Pass 3b)
Performing Provider Name/TPI: Wise Regional Health System/130606006

Provider: Wise Regional Health System (WRHS) is a health system licensed for 148 beds. The service area is Wise, Montague, Jack, Parker, and parts of Tarrant County. This service area holds 64,000 residents and is expected to grow to 74,000 by 2017. WRHS is the main hospital provider in the county. There are almost 15,000 children in Wise County. In DY1 there were 4,566 pediatric visits to WRHS with an estimated 5,600 between both hospitals in Wise County. There were 1,644 pediatric patients to clinics who will participate in the education opportunities of this project.
Intervention: This project will add a pediatrician to serve residents in the service area. This project is designed to reduce pediatric Emergency Department visits for preventable conditions or conditions that are suitable to be addressed in a primary care. This is a new initiative to address the lack of provider capacity and shortage of primary care services.
Need for the project: This project is related to the regional goals of improving access to primary and preventive care. The service area impacted by this project includes Northwest ISD, the fastest growing school district in Texas.
Target population: Wise County pediatric residents; namely the Medicaid/CHIP/uninsured population, who have limited access to primary care. - The number of patients impacted by this project are as follows DY1 5600, DY2 5650, DY3 5700, DY4 5800, and DY 5 5905.
Expected patient benefits: Between 2000 and 2010, the percentage of Texas doctors accepting Medicaid patients decreased from 67% to 31%. About 40% of the children in the North Texas Corridor have no or limited access to health insurance. The goal of our project is to increase availability of access to pediatric primary care for the Medicaid/CHIP/uninsured population, in order to decrease the over utilization of ED services.
Category 1 or 2 expected patient benefits: Category 1 Milestones call- for us to plan for and open a pediatric clinic including the recruiting of a pediatrician. A nurse line will also be made available to existing primary care physicians treating pediatric patients.
Category 3 outcomes: IT 1.1 Third next available appointment and IT-3.9.2 Reduce Pediatric Emergency Department Visits have been selected as the Category 3 outcomes for this project. The goal of this project is increase access to pediatric primary care while reducing the over utilization of the ED. The - estimated reduction in pediatric ED visits will be -13% by DY5

Project Option 1.1.1 – Expand Pediatric Primary Care (WRHS - Pediatric Project)

Unique Project ID: -130606006.1.2 (Pass 3b)
Performing Provider Name/TPI: Wise Regional Health System/130606006

Project Description:
Project Area: Expand pediatric primary care for Wise County to prevent unnecessary use of emergency department services.
Project Intervention: - Design and implement pediatric primary care services tailored towards individuals and families currently utilizing the Emergency Department for primary care services.

The goal of this project is to expand the capacity of pediatric primary care in Wise County through - Wise Regional Health System (WRHS) - and local primary care clinics, so that children receive the right care at the right time; have access to same-day appointments thereby reducing the unnecessary use of emergency department (ED) services. The additional capacity will be integrated with other community-based providers across a continuum of care to establish a virtual safety net for children's health care. Wise Clinical Care Associates physician group has five primary care providers in Wise County, who treated approximately 1,644 pediatric patients in DY1. The implementation of this project will include educating these providers on the addition of pediatric primary care services and the upcoming implementation of a pediatric primary care nurse line -. Many factors contribute to unnecessary ED use, including financial and language barriers and habitual overutilization of emergent healthcare resources. Unnecessary visits will be avoided through the expansion of primary care pediatric services and through education of Wise County residents about these new services and other available health care resources. This project will have far-reaching positive results. It will affect not only Wise County pediatric patients, but - other patients and families who will learn about other health care resources, preventive health care measures such as immunizations, and healthy habits. Unnecessary ED visits will decrease Region wide as a result. The Regional Health Partnership 10 Community Needs Assessment Report reveals that the need for pediatric care in Wise County will grow by 23% over the demonstration period. Without intervention such as the expansion and implementation of new pediatric primary care services, the overutilization of countywide EDs will continue to grow. -The number of patients impacted by this project are as follows DY1 5600, DY2 5650, DY3 5700, DY4 5800, and DY 5 5905. The estimated reduction in ED pediatric visits will be 13% by DY5.

Goals and Relationship to Regional Goals:

Project Goals:
The goals of the project are to increase the availability of pediatric primary care services in Wise County, by adding a clinic location and pediatrician and ensure the appropriate use of such

services by the population through support systems and - work with local primary care services. Incremental increases in local pediatric primary care clinics with after-hours availability will ensure availability and use of cost-effective, high-quality pediatric care and health advice, and reduce unnecessary ED use. This project will have far-reaching positive results, affecting not only Wise County pediatric patients, but other patients and families who will learn about other methods to obtain health care, preventive health care measures such as immunizations, and healthy habits. Unnecessary ED visits will decrease Region wide as a result. To improve accessibility to pediatric primary care services, we will measure and improve provider availability through the third next available appointment calculation. This proven measure correlates with improved access to care regardless of appointment type (e.g., new patient, established patient, routine care, sick visit).

This project meets the following regional goals:
This project is related to the Regional goals of improving access to primary and preventive care, decreasing potentially preventable admissions, decreasing potentially preventable readmissions, decreasing potentially preventable complications, increasing self-management skills, increasing adherence to self-care plans and increasing the availability of primary and preventive services. This project will have far-reaching positive results, affecting not only Wise County pediatric patients, but their families who will learn about other methods to obtain health care and maintaining healthy habits. Unnecessary ED visits should decrease Region wide as a result.

Challenges:
A major challenge will be changing the behaviors of families who have used emergency services for low complexity care. This challenge will be addressed through - education in the use of health literacy principles, language and culturally appropriate approaches the through the use of community health workers who reside in the community and understand the customs and speak the language. Another challenge will be recruiting sufficient numbers of staff who are bilingual and multicultural.

5-Year Expected outcome for Provider and Patients:
The five-year expected outcomes of the project include an increase in the number of children with recommended well-child visits, increase in children receiving immunizations on schedule, increase in availability of same day or next day "sick" visits, reduction in the inappropriate emergency department use and reduction in overall cost of health care for children in Wise County. The number of patients impacted by this project are as follows DY1 5600, DY2 5650, DY3 5700, DY4 5800, and DY 5 5905. The estimated reduction in pediatric ED visits will be 13% by DY5.

Starting Point/Baseline:

The baseline for this project is the number of pediatric providers in Wise County at the beginning of DY1. The Regional Health Partnership 10 Community Needs Assessment Report reports four pediatricians provided primary care pediatric services to Wise County residents at the beginning of DY1. In DY1 Wise Regional Health System had 4,566 pediatric ED visits; countywide it is projected that there were approximately 5,600 pediatric ED visits. With consideration of this data, WRHS will establish the baseline of countywide pediatric emergency department visits in DY2.

Rationale:
As concluded in the Regional Health Partnership 10 Community Needs Assessment Report, the demand for pediatric primary care services, which are both accessible and convenient for patients and their families, exceeds the available capacity, thus limiting health care access for many low-level acute care management or chronic conditions. Emergency departments are treating high volumes of pediatric patients with preventable conditions or conditions that are suitable to be addressed in a primary care setting. Additionally, many pediatric primary care physicians accept a limited number of the Medicaid/CHIP/uninsured population and may have limited or no extended hours, ultimately even further restraining the capacity of many families to access important primary care services. Between 2000 and 2010, the percentage of Texas doctors accepting Medicaid patients decreased from 67% to 31%. About 40% of the children in the North Texas Corridor have no or limited access to health insurance.

Project Components:
Project 1.1 "Establish more primary care clinics" does not contain core project components. Milestones and metrics are based on relevancy to the RHP 10's pediatric population, the community needs for additional pediatric primary care and the baseline data of non-emergent emergency department use by children.

The milestones and metrics selected for the project will provide a step by step integration of the expansion of pediatric primary care. During the selection of these measures, special consideration was made to illustrate the methods of - delivery using primary care services. As illustrated by the milestones and metrics selected, the implementation of this project will allow primary care clinics to be expanded through training and development and the addition of a nurse line, coupled with the establishment of a new pediatric practice. This project will require the addition of staff and providers in an effort to increase the volume of patients utilizing primary care clinics, while enhancing the abilities of the clinics to provide urgent care services. In DY 2, WRHS will conduct and participate in strategic planning and development with regard to the new primary care practice. DY 3 will include the recruiting, training and hiring of additional providers and staff, and the establishment of a new pediatric primary care clinic. In DY 4, WRHS will look to increase the volume of the newly established pediatric primary clinic by 10%

over baseline. A 20% increase in clinic volume over baseline is expected in DY 5. In addition, a patient experience survey will be implemented to measure and quantify patient satisfaction.

Unique community need identification numbers the project addresses:
CN 1 Lack of provider capacity
CN 2 Shortage of primary care services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new initiative to address the lack of provider capacity and shortage of primary care services. This - project - is designed to address the needs of our community by redirecting pediatric patients that are currently receiving treatment in the ED for preventable conditions or conditions that are suitable to be addressed in a primary care setting into clinics; while expanded said clinics ability to deliver pediatric focused primary care services. We have not received any other federal funding for this program.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale For Selecting The Outcome Measures:

Outcome Measure # 1: OD-9 Primary and Preventive Care. IT-3.9.2 ED appropriate utilization. (Stand alone measure)
This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children.

Outcome Measure # 2: IT-1.1 Third next available appointment.
This measure was selected because it is a proven measure of provider availability that improves access to care without regard of appointment type, e.g. new patient, established patient, routine care, sick visit, etc. thus, enabling us to truly evaluate provider availability and increases in availability.

Relationship to Other Projects:
2.1.1 Enhance/Expand Medical Homes
It is anticipated that through the coupling of these projects an optimal primary care environment will be established. While current clinics will be reworked to focus on patient centered care based on the Patient Centered Medical Home (PCMH) model, services will be expanded to provide pediatric primary care through the addition of pediatric focused primary care providers in an optimal environment for Wise County residents.

RD-1.6 Pediatric Asthma with a measure of pediatric patients that return to the ED for asthma treatment within 15 days.
The implementation of this project will reduce this measure by capturing the target population, pediatric patients currently the ED for low-level acute care management or chronic conditions, and redirecting them to pediatric primary care services. In turn pediatric primary care providers will manage patients with chronic conditions, such as asthma, resulting in a reduction of ED pediatric asthma related visits.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Wise Regional Health System has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)* When calculating the total value, this project is valued at $17,177,531.

Wise Regional Health System defined the population that will be directly impacted by the project as pediatric patients receiving care in two separate settings**.** One outcome measure is pediatric ED admissions and the other outcome measures clinic setting visits. The percentage of the population expected to be positively impacted by the project is 13% on the hospital side, which was determined based on studies of similar projects implemented elsewhere. The number of patients impacted by this project are as follows DY1 5600, DY2 5650, DY3 5700, DY4 5800, and DY 5 5905. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. We also estimated the number of pediatric patient visits and calculated value based upon third day next available appointments.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3**.** We believe this to be the correct number because, when a person is positively impacted, their whole family is impacted since this project targets pediatric patients. Not only is the health of the child improved but time efficiency for families is improved.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, dependence on the community is decreased.

References:

Cooley WC, McAllister JW, Sherrieb K, Kuhlthau K. Improved Outcomes with Medical Home Implementation in Pediatric Primary Care. *Pediatrics.* 2009; 124: 358-364.
Rust G, Ye J, Daniels E, Adesunloye B, Frier GE. Practical barriers to timely primary care access – Impact on adult use of emergency department services. *Archives of Internal Medicine.* 2008; 168: 1705-1710.
Simon TD, Berry J, Feudtner C., Stone BL, Sheng Z et al. (2010). Children with complex chronic conditions in inpatient hospital settings in the United States. *Pediatrics*, 126(4):647-655
Burns KH, Casey PH, Lyle RE, Bird TM, Fussell JJ & Robbins JM. (2010). Increasing prevalence of medically complex children in US hospitals. *Pediatrics*, 126(4):838-846
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Latimer V. Cost analysis of nurse telephone consultation in out of hours primary care: evidence from a randomized controlled trial. *BMJ*. 2000; 320: 1053-1057
Bunik M et al. Pediatric telephone call centers: how do they affect health care use and costs? *Pediatrics* (2007); e305 – e313.
http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=23918
http://www.ahrq.gov/cahps/clinician_group/

-130606006.1.2	*1.1.1*		***EXPAND PEDIATRIC PRIMARY CARE***	
Wise Regional Health System				*130606006*
Related Category 3 Outcome Measure(s):	*-130606006.3.7* *-130606006.3.8*	*IT-9.2* *IT-1.1*	*ED Appropriate Utilization* ***(Standalone measure)*** *Reduce pediatric Emergency Department visits* *Third next available appointment*	
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.1]: Plan for additional clinics or expanded hours or space Baseline/Goal: Establish project locations, chose site development Data Source: Documentation of plans Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,069,62.92		**Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: Hire personnel 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 2 Estimated Incentive Payment: $1,674,395.78 **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 project documentation Data Source: Documentation of plans Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,674,395.78	**Milestone 4** [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 increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Total number of unique patients encountered in the clinic for reporting period. Goal: -10% over baseline -Data Source: Registry, EHR, claims or other Performing Provider source Milestone 4 Estimated Incentive Payment: $1,679,263.21 **Milestone 5** [P-X]: Incorporate Patient Experience Surveying Metric 1 [P-X.1]: Measure patient experience Baseline/Goal: Establish project documentation Data Source: Documentation of plans Milestone 5 Estimated Incentive Payment *(maximum amount):*	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services -20% over - baseline. Metric 1 [I-12.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period. Total number of unique patients encountered in the clinic for reporting period. Goal: -20% over baseline -Data Source: Registry, EHR, claims or other Performing Provider source Milestone 6 Estimated Incentive Payment: $2,774,434.87

-130606006.1.2	*1.1.1*		***EXPAND PEDIATRIC PRIMARY CARE***	
Wise Regional Health System				*130606006*
Related Category 3 Outcome Measure(s):	*-130606006.3.7* *-130606006.3.8*	*IT-9.2* *IT-1.1*	*ED Appropriate Utilization* ***(Standalone measure)*** *Reduce pediatric Emergency Department visits* *Third next available appointment*	
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)**
			$1,679,263.21	
Year 2 Estimated Milestone Bundle Amount*:* $3,069,621		Year 3 Estimated Milestone Bundle Amount: $3,348,790	Year 4 Estimated Milestone Bundle Amount: $3,358,525	Year 5 Estimated Milestone Bundle Amount: $2,774,434
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$12,551,370				

Project Summary

Project Option 1.9.2 – Expand Specialty Care Capacity-Access Redesign to target quicker access to psychiatric services

Unique Project ID: 130724106.1.1

Performing Provider Name/TPI: Pecan Valley Centers for Behavioral and Developmental Healthcare / 130724106

Provider: Pecan Valley Centers is the Local Authority for mental health and developmental disability services for a six county region (5 of which are included in RHP 10). The total area covers 4267 sq miles and has a total population of 442,719. Pecan Valley Centers, as the local authority for the service area, is the safety net for mental health services for individuals without Medicaid or other funding source. Although we serve individuals with Medicaid, Medicare and other funding sources more than half of our population served do not have a funding source,

Intervention: This project will implement a redesign to access for services by expanding specialty care access to psychiatrists and other behavioral health providers. By decreasing wait times for services individuals will have less use of emergency rooms for behavioral health issues. This project is an expansion and enhancement of the current intake eligibility assessment process for mental health services. The expansion will be to add additional staff to impact the wait times to receive services.

Need for the project: Access to mental health services was identified as a community need for Region 10. By improving the intake process, individuals will be engaged into treatment in less time, thus increasing the opportunity for positive outcomes.

Target population: The target population is adults and youth with severe mental illness requesting routine services and meeting the diagnostic criteria for mental health services.

Estimated number of patients to be served over course of waiver period-Based the current monthly average number of individuals assessed for routine mental health services the estimated number of individuals to be served over the waiver period would be 2500 (including both adults and children/youth). Approximately 55% (1200 individuals) of our population has no funding source or are indigent and 25% (500) of adults and 75% (150) of youth have Medicaid, so this project will impact a large portion of both Medicaid recipients and uninsured individuals.

Category 1 or 2 expected patient benefits: The projects aims to see an increase of 15% in DY4 and 25% increase in DY5 of psychiatric events and

DY 2-Baseline collection and data collection plans with 4 hospitals

DY 3-two clinics and an estimated 10 new staff positions will be implementing the access redesign;

DY 3-The project aims to see a decrease from 40 days to 28 days to see a doctor from intake assessment. This will impact an estimated 900 individuals, who are seeking eligibility services during DY3.The prompt processing of request for services will improve access to other behavioral health providers in addition to the psychiatrist. This support from behavioral health clinicians in support of psychiatric services is beneficial since these staff have frequent and more intense involvement with the clients and can work with the psychiatrist to better meet the needs of the clients.

DY 4-75% or estimated 675 referrals will be processed and categorized correctly to ensure correct treatment.
DY 4-15% increase (or estimated 1495 events) of psychiatric visits
DY 5-25% increase (or estimated 1625 events) of psychiatric visits
DY 5-60% of new individuals will see a psychiatrist within 10 days of eligibility assessment.
Category 3 outcomes: IT-9.2- Our goal is to reduce emergency department visits for behavioral health/substance abuse by an estimated 25% by DY5. The improvement targets are yet to be fully determined for behavioral health services.

Project Option 1.9.2 – Expand Specialty Care Capacity-Access Redesign to target quicker access to psychiatric services

Unique Project ID: 130724106.1.1
Performing Provider Name/TPI: Pecan Valley Centers for Behavioral and Developmental Healthcare / 130724106

Project Description:
Project Area: Expand Specialty Care Access
Project Intervention: Improve access by increasing providers in order to decrease waiting times for psychiatric services

According to the dictionary, access can be defined as "the ability to approach, enter, exit, communicate or make use of." As this relates to behavioral health services it can be defined as the ability to receive a needed service with easy access. The lack of providers and cumbersome systems, have typically made access to behavioral health services difficult. As behavioral health services continue to be a great need, accessing these services is becoming more important to community members. This ease of access is complicated by the lack of behavioral health providers in the area. In 2011, 77% of counties in Texas were designated as Health Professional Shortage Areas.(1) Since Texas ranks highest among states in the number of uninsured individuals, and the lowest state of funding for behavioral health services per capita, the need greatly surpasses the resources. This need for behavioral health services continues to increase in Pecan Valley's six (including five counties in Region 10) county service area. Gaps in services exist, and this project will aim to close those gaps and provide a wider continuum of services. One identified gap is the absence of a behavioral health clinic in Somervell County. Currently those individuals must drive to another county to access their behavioral health services. This lack of engagement has the potential to be reflected in ED utilization or other more costly services. The goal of this project is to improve access by increasing capacity to specialty (psychiatry) services, to better accommodate the high demand for these services and decrease wait times for service engagement. In order to accomplish these goals, a clinic will be opened in Somervell County and additional providers will be added to the workforce in existing clinics to accommodate increased need for behavioral health services.

The aim of the program is to improve access to identified services in a timely fashion. Individuals requesting behavioral services typically want to receive those services as soon as possible. Often individuals wait to request a behavioral health service until their situation has reached the unbearable point, and asking them to wait to receive the services is not well-accepted. Expanded access will be implemented for individuals requesting routine psychiatric/behavioral health services (individuals needing crisis services will be seen immediately) and allow individuals access to the requested services. The access program will

include a team of individuals aimed toward client services. These individuals will include licensed professionals (LPHA) to complete an assessment to determine initial eligibility and diagnostics. Qualified mental health professionals community specialists (QMHP-CS) will be available to develop treatment goals and provide referrals for additional services. Team members will also include those providing counseling, nursing and psychiatric services. The teams will be located in five counties of Region 10, including Erath, Hood, Johnson, Parker and Somervell. Pecan Valley currently has behavioral health clinics in these counties, except Somervell. All service needs identified in the initial assessment and plan of care session will immediately be linked to appropriate referrals, and follow-up will be provided by QMHP-CS staff to ensure establishment of service connection. Upon completion of these assessments and referrals, a psychiatric evaluation will immediately be scheduled to be completed within 10 business days. This will improve access to psychiatric care.

Goals and Relationship to Regional Goals:

Project Goals:

The five-year goals of this project are: (1) to increase access to ongoing community-based behavioral health care services for the target population, and (2) early engagement with individuals with chronic mental health conditions. Increased access to psychiatry services will improve the quality of life for people, and reduce ED utilization, inpatient admissions and unnecessary involvement with law enforcement.

This project meets the following Regional goals:

The project meets the goals of RHP 10 to improve the quality of life for members of their family and their community. This will also result in improved health outcomes and decrease costs due to ED use and hospitalizations.

Challenges:

The national average of individuals waiting for mental health services is 47 days. Research shows that each day individuals must wait for a service lessens the likelihood that they will actually engage in services.[84] Pecan Valley's current initial intake process is structured so that individuals are required to make multiple appointments with multiple providers before receiving psychiatric services. Although these multiple appointments are necessary, the process is not effective in engaging individuals. Barriers such as transportation, employment, financial hardship and family commitments often result in many missed appointments. As a result, individuals do not receive the services they need. This can lead to encounters with hospitals for emergency medications and added life stressors. Reducing the number of appointments to two or

[84] Lloyd, D. Proven strategies for improving clinic operations, profits and the quality of care. M.T.M Services, LLC. 2010.

less lessens the hardship placed upon individuals requesting services, and provides better, quicker service continuity.

5-Year Expected Outcome for Provider and Patients:

The five-year expected outcome of this project is to provide psychiatric services within 10 days to 60% of eligible individuals requesting routine behavioral health services and increase the volume of psychiatric services by 25%.

Starting Point/Baseline:

Pecan Valley currently provides behavioral health services, including psychiatry. Since December 2011, an average of 2,173 clients (adults and youth) have been active clients. Of this population, 26% (adults) and 75% (youth) have Medicaid, and 55% of both adults and youth have no funding source.[85] Each month an average of 75 new clients are admitted through the regular intake process. Pecan Valley Centers has been participating in an Access Redesign project since May 2012 with consultant firm MTM.[86] The goal of this project is to reduce the number of days an individual waits for psychiatric services. Due to this project, data has begun to be collected regarding number of days from initial contact for services to the completion of a psychiatric evaluation. No changes have been made to the current intake process, as the main aim of the six months of this project has been to evaluate gaps and identify needs. The current average waiting period to access a psychiatrist from the first call to an initial visit is 40 days. In May, June and July 2012, less than 10% of individuals requesting routine services actually received a psychiatric evaluation within 10 days. The number of staff currently directly linked to access is eight. The proposed additional staff for expanded access would be 17 staff members.

Rationale:

The Pecan Valley Region is a rural, medically underserved community where there are aslo transportation issues. Often individuals are unable to access care in their own community due to lack of resources. Improving access to behavioral health services improves quality of life and decreases use of more costly services.

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. According to the Community Needs Assessment, behavioral health care is difficult to access. The primary barrier to behavioral health services is lack of capacity. By increasing capacity, improved client outcomes and client satisfaction will occur while also reducing ED use. This project addresses those gaps by adding an additional clinic in the community, and adding staff and clinicians to provider quicker access to requested services in all clinics.

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[85] www.texmed.org.

[86] Lloyd D. Proven strategies for improving clinic operations, profits and the quality of care. M.T.M Services, LLC. 2010.

Project Components:

The core components to increase service availability with extended hours will be addressed in project 1.12.1 not directly in this project. As access is improved for individuals to receive psychiatric services sooner, the extended hours will be impacted as more physician time as well as other behavioral health clinician time will be available.

The project will not include the core component of increasing the number of specialty clinic locations. As a result of the improved encounters to psychiatric services through access redesign, currently the need for a new clinic is not evident.

The core component of implementation of transparent and standardized referrals across the system will be evident by the implementation of referral a tracking process to shorten wait times from referral to appointment and ensure an accurate referral category.

Our milestones measures will assess the increased access to services by (1) adding an additional behavioral health clinic, and (2) providing quicker engagement to services. As a result of this increased capacity, we are measuring improved access to psychiatric services through the milestone of improved engagement and increase volume of psychiatric services.

Unique community need identification numbers the project addresses:

- CN.4 – Lack of access to mental health services
- CN.5 – Insufficient integration of mental health care in the primary care medical care system
- CN.11 – Need for more care coordination
- CN.10 – Overuse of emergency department (ED) services

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

This project is a new initiative and we have not received any other federal funding for it. The project will redesign access to services to by adding providers to engage clients in less time.

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Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-9.2 ED appropriate utilization

The goal of this project is to engage clients in fewer days. By accomplishing this, fewer people in services with Pecan Valley will seek behavioral health services from the ED. Cost containment is a goal for RHP 10 due to growing costs related to hospital and ED utilization. This discrepancy is evidence of the gap in behavioral health services. Pecan Valley's project will

improve access to behavioral health services by shortening wait times to access services. Improved access will decrease ED utilization for emergency medications.

Numerator: the number of ED utilizations by Pecan Valley clients within 30 days of intake assessment
Denominator: the number of individuals assessed for initial eligibility (intake) by Pecan Valley. By the end of the Waiver project, our goal is to show 25% reduction in emergency department utilization for behavioral health/substance abuse.

Relationship to Other Projects:

Improving capacity will increase the need for integrated care. As both medical and behavioral health care are integrated (2.15.1-Integrate Primary and Behavioral Health Care) more individuals will have access to needed services, thereby reducing costs and unnecessary ED visits.

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

Performing providers with similar projects related to specialty care, and more specifically, psychiatry have communicated via email to discuss the potential of collaborating, as well as project progress, challenges and impact.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

The valuing process developed by Pecan Valley includes both an evaluation of costs savings as well as impact on quality of life of individuals involved with the program. This project will impact individuals from five counties of Pecan Valley Region, who have been newly admitted into behavioral health services and require routine behavioral health services. The population will be identified as individuals with severe mental illness. These new admits will be tracked to determine ED use within 30 days of admission to behavioral health services, with the improvement outcome being decreased ED utilization and reduced costs. Based on a review by the Indigent Care Collaborative in Central Texas,[87] the average use of the emergency department by people with a behavioral health diagnosis is 7.085 visits per year, with the national average of an emergency department visit by a person with a behavioral health diagnosis is $1,500 per

[87] Impact of proposed budget cuts to community-based mental health. Health Management Associates Services, 2011.

visit,[88] On average, a person with a behavioral health diagnosis will have an annual cost of $10,628 in emergency department visits. On average, it costs $12 per day to provide community mental health services to adults[89] at an annual average cost of $4,380 per year, providing a cost savings of $6,248 per patient year. Utilizing the Region 10 Category 3 pricing Model, Pecan Valley values the reduction in emergency department use by clients with behavioral health at $13,706,550, as related to the priority population for community centers as defined by the Texas Department of State Health services. In addition to health care cost savings, there is an added value to the person suffering with behavioral health issues. According to a study performed for the Center for Health Care Service, access to telemedicine services increases the quality-adjusted life years by 2.45%.[90] Utilizing the cost-utility analysis at a rate of $50,000 per life year, the adjusted value per person is equivalent to $1,225 per year. Based on the Region 10 Category 3 pricing model, Pecan Valley values the impact to the individuals to be served at $2,149,875 over the course of the grant, for a total grant valuation of $15,856,425. This amount does not include a value for the community impact, which would reach across multiple areas and which is not limited to, but would include reducing lost wages and lost productivity in the community, increasing the access to emergency departments due to a reduction in improper utilization, and a reduction in incarceration the behavioral health-affected population.

[88] The Durham Center. (n.d.). Community hospital emergency department admissions for individuals with behavioral health disorders in Durham County.

[89] Health Management Associates. Impact of proposed budget cuts to community-based mental health services. 2011.

[90] Shelton Brown H. Hasanat Alamgir P & Bohman, P. Valuing the program to provide integrated care through telemedicine. 2012.

130724106.1.1	***1.9.2***	***1.9.2 A-C***	***EXPAND SPECIALTY CARE CAPACITY*** ***Access Redesign to target quicker access to psychiatric services***
Pecan Valley Centers for Behavioral and Developmental Health Care			*130724106*
Related Category 3 Outcome Measure(s): *OD.9*	*130724106.3.1*	*3.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-3]: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1 [P-3.1]: Establish baseline for performance indicators Baseline/Goal: Identify wait times from request for services to point of psychiatric evaluation Data Source: EHR, Administrative records. Milestone 1 Estimated Incentive Payment $ 1,463,400 **Milestone 2 [**P.X]: Implement a data collection and reporting mechanism between performing provider and community providers to enable the tracking of ED utilization in order to evaluate outcome measure. Metric 1 [P-X]: Operational procedures between stakeholders for data exchange, Baseline/Goal: Established data collection/exchange plan with four hospitals Data Source: data collection plan Milestone 2 Estimated Incentive	**Milestone 3 [**P-17]: Implement the redesign of medical specialty clinics in order to increase operational efficiency, shorten patient cycle time and increase provider productivity. Metric 1 [P-17.1]: Number of medical specialty clinics that have completed clinic redesign. Baseline/Goal: 2 clinics Data Source: Specialty clinic appointment tracking system. Milestone 3 Estimated Incentive Payment: $1,409,101 **Milestone 4 [**P-5]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment Metric 1 [P-5.1]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians) Baseline/Goal: New referrals will be processed and scheduled within 28 days of initiation Numerator: Sum, for all referrals, of the number of days between	**Milestone 5 [**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]: Proportion of referrals appropriately categorized. Goal: 75% increase or 675 Data Source: Patient's medical record, internal data records Milestone 5 Estimated Incentive Payment: $1,450,498 **Milestone 6 [**I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2) Goal: 15% increase Data Source: Encounter data, billing records Metric 2 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate	**Milestone 7 [**I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-1.23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2) Goal: 25% increase Data Source: Encounter data, billing records Milestone 7 Estimated Incentive Payment: $2,684,564

130724106.1.1	***1.9.2***	***1.9.2 A-C***	***EXPAND SPECIALTY CARE CAPACITY*** ***Access Redesign to target quicker access to psychiatric services***
Pecan Valley Centers for Behavioral and Developmental Health Care			*130724106*
Related Category 3 Outcome Measure(s): *OD.9*	*130724106.3.1*	*3.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)**
Payment: $ 1,463,400	when request for referral is received from referring provider and the referral appointment during the reporting period. Data Source: EHR, Referral Management system, Administrative records. (Generated Reports on file). Milestone 4 Estimated Incentive Payment: $1,409,102	improvement over prior reporting period (baseline for DY2). Goal: 15% increase Data Source: EHR, claims, encounter data Milestone 6 Estimated Incentive Payment: $1,450,499	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,926,800	Year 3 Estimated Milestone Bundle Amount: $2,818,203	Year 4 Estimated Milestone Bundle Amount: $2,900,997	Year 5 Estimated Milestone Bundle Amount: $2,684,564
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $11,330,564			

Project Summary
Project Option 1.12.1– Extending Services Beyond Normal Business Hours

Unique Project ID: 130724106.1.2 (Pass 2)
Performing Provider Name/TPI: Pecan Valley Centers for Behavioral and Developmental HealthCare/130724106

Provider: Pecan Valley Centers is the Local Authority for mental health and developmental disability services for a six county region (5 of which are included in RHP11). The total area covers 4267 sq miles and has a total population of 442,719. In the last 12 months, provider has served an average of 2173 individuals (adults and youth). Pecan Valley Centers, as the local authority for the service area, is the safety net for mental health services for individuals without Medicaid or other funding source. Although we serve individuals with Medicaid, Medicare and other funding sources more than half of our population served do not have a funding source and would go without mental health services without the local authority.
Intervention: This project will be the extending of clinic hours in some Pecan Valley Centers outpatient mental health clinics beyond 5:00 PM on certain days. Transportation will also be provided during these extended hours in an attempt to improve access and improve rates of kept appointments. Currently only one outpatient clinic has extended hours. This project will increase the number of clinics to a total of 3 clinics with extended hours. Transportation is not currently provided in any clinic.
Need for the project: Access to mental health services was identified as a community need for Region 10. By extending the hours of operations in clinics, more individuals will be able to access treatment without interfering with daily activities such as employment, school and family care commitments. After hour services will provide an opportunity for existing patients to continue to maintain services without being absent from employment. In addition, it will provide an opportunity for those in the community to receive services who would not otherwise do so due to scheduling conflicts. Various studies show that when patients are able to access and adhere to behavioral health treatment, it reduces the use of higher costing facilities such as hospitalization or incarceration. By providing transportation, a potential barrier to treatment will be addressed. Although Medicaid recipients have transportation available to them, it may not be accessible after 5 pm. For others, public transportation may not be available after 5 pm or is cost prohibitive.
Target population: The target population is adults and youth with severe mental illness needing appointments after 5 pm. Estimated number of patients to be served over course of waiver period:1500 (existing and potential new clients). Approximately 55% (1200 individuals) of our population has no funding source or are indigent and 25% (500) of adults and 75% (150) of youth have Medicaid, so this project will impact a large portion of both Medicaid recipients and uninsured individuals.
Category 1 or 2 expected patient benefits: The project will aim to improve adherence to scheduled appointments. For those individuals receiving services after 5pm, we expect to see a 10% decrease (from 27%) of cancelled or no-shows for appointments.
DY 2-Thorough assessment to enable the identification of two sites to expand services hours and transportation services to impact the most people

DY 3-Establish two clinic sites to expand operations after 5 pm and introduce transportation services servicing clients with appointments after 5 pm

DY 4-evidence of 5% (from 27%) decrease in no shows/cancellations for scheduled appointments

DY 5-10 % decrease (from 27%) in no shows/cancellations for scheduled appointments

Category 3 outcomes: IT-6.1 70% improvement over baseline of patient satisfaction scores. Studies through the American Medical Association affiliate Press Ganey reports that positive patient satisfaction equates into patient retention and that satisfied consumers are also more compliant with care. By improving client satisfaction and retaining patient engagement, Pecan Valley Centers will continue to minimize the population we serve in the community from receiving services in more restrictive and expensive environments such as hospitals (costs an average of $7,249 more than community services) or jails (costs an average of $6,580 more than community services). By extending hours of clinics, patients are able to receive services without interruption of their workday, allowing the patient to reach full wage earnings during that pay period. This benefit to the community will impact their service delivery satisfaction.

Project Option 1.12.1– Extending Services Beyond Normal Business Hours

Unique Project ID: 130724106.1.2 (Pass 2)
Performing Provider Name/TPI: Pecan Valley Centers for Behavioral and Developmental HealthCare/130724106

Project Description:

This project will result in a select number of Pecan Valley Centers outpatient mental health clinics remaining open past 5 p.m. on certain days for doctor appointments and related services. In addition, we will offer transportation services for people needing after-hours appointments, where transportation is a barrier from receiving services. The need for behavioral health services continues to increase in our Region. Positive behavioral health care outcomes are contingent on patients' ability to obtain routine examinations and health care services as soon as possible after a specific need for care has been identified. However, many Texans are unable to access either routine services or other needed care in a timely manner because they lack transportation or because they are unable to schedule an appointment due to work scheduling conflicts. Problems also arise from school scheduling conflicts in the case of children or because they have obligations to provide care for children or elderly relatives during normal work hours. Many individuals with behavioral health needs are hesitant to seek treatment, and such barriers may be sufficient to prevent access entirely. Any such delay in accessing services or any break or disruption in services may result in functional loss and worsening symptoms. These negative health outcomes come at great cost to the individual and result in increased costs to payers when care is finally obtained.

Goals and Relationship to Regional Goals:

Project Goals:

The five-year goals for this project are: (1) to enhance service availability to both adults and children and adolescents by expanding the clinic hours beyond normal business hours and increase access to services for the target population, and (2) to ensure that transportation service is available for those needing assistance during the expanded clinic hours. As a result, individuals will experience a higher level of satisfaction with their services due to timely care, appointments, and information.

This project meets the following Regional goals:

The project meets the goals of RHP 10 to improve the quality of life for members of their family and their community and access to services. This will also result in improved health outcomes and decrease cost due to ED use and hospitalization.

Challenges:

There is very limited public transportation service during normal business hours. It is expected that there is even more limited or possibly nonexistent transportation services currently available outside of normal business hours in most of our counties. Community transit providers will be contacted during the early phase of the project to see if they are able to expand outside of normal business hours with their services. If not, Pecan Valley will attempt to fill the gap for transportation outside normal business hours.

5-Year Expected Outcome for Provider and Patients:

By offering expanding clinical hours and transportation services, Pecan Valley expects to reduce cancellations and no-shows and to improve consumer satisfaction with access to care. A 10% reduction in cancellations and no-shows will occur during the extended hours, along with a 60% improvement in consumer satisfaction concerning timely care, appointments and information.

Starting Point/Baseline:

Currently only one location has extended clinic hours. An evaluation is required to determine staff needs for this expansion to other locations and to determine the number of individuals seen in each clinic. The expected outcome will be expansion of clinic hours in at least two new locations. The expansion of clinic hours beyond normal business hours will involve all clinic staff, including the psychiatrist.

Rationale:

It is well known the national supply of behavioral health providers does not meet the need for services. It is the goal of health care improvement to provide more access to care by enhancing service availability in order to assist more individuals and families with mental health support to avoid more costly ED and inpatient care. This enhancement of services can also increase patient satisfaction and encourage engagement into services. The Pecan Valley Region is a rural community, with challenges of being medically underserved as well as lacking in transportation. Often individuals are unable to access care in their own community due to lack of resources. Improving access to behavioral health services by expanding clinic hours beyond normal business hours of 8 a.m. to 5 p.m. can help cut down on more costly services and encourage patient engagement and increase satisfaction. Ensuring that transportation resources are available during these expanded hours will also help. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed. According to the Community Needs Assessment, behavioral health care is difficult to access. This project will help to fill some of these gaps in services.

Project Components:

a) The core components of increasing service availability with extended hours and ensuring transportation is available during those extended hours will be fulfilled by extending clinic hours beyond normal business hours in high-volume clinics and developing a transportation program to operate during those extended hours.

b) A review of this project to extend hours to increase access to services will occur. From this review key opportunities and challenges will be identified and determined if they can be implemented on a larger scale.

c) Our milestones and metrics will (1) assess the gaps in accessibility to prioritize the geographic areas in our Region where extended clinic hours and transportation services are needed most, and (2) establish extended clinic hours and transportation services in at least two of the high-volume clinics to a) measure the number of patients served during the extended clinic hours and b) measure the number of patients served by the transportation program during those extended hours. These milestones and metrics were selected to make more cost-effective community health services available to working individuals, and parents and caregivers who provide care for family members during normal business hours.

Unique community need identification numbers the project addresses:

CN.4 – Lack of access to mental health services
CN.7 – Need to address geographic barriers that impede access to care
CN.10 – Overuse of emergency department (ED) services
CN.11 – Need for more care coordination

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

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

a. **Outcome Measure 1:** IT-6.1 Percent improvement over baseline of patient satisfaction scores

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

The goal of this project will be provide access to behavioral health services beyond normal business hours in clinics. By improving access, individuals will have better outcomes and potentially reduce costs. Cost containment is a goal for RHP 10, as well as providing quality care at the right time. With the project, Pecan Valley expects to see improved client satisfaction in individuals' ability to have better access to needed services. By the end of the Waiver project, our goal is to show 60% of individuals reporting increased satisfaction with getting timely care, appointments, and information during the extended clinic hours.

Relationship to Other Projects:

Extending clinic hours and providing a transportation service will shorten the wait for behavioral health services (1.9.2-Expand Specialty Care Capacity) which, in turn, will help reduce costs and unnecessary ED visits. This project will also increase the need for integrated care. As both medical and behavioral health care are integrated (2.15.1-Integrate Primary and Behavioral Healthcare), more patient satisfaction is expected due to an improved delivery system.

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

Extending clinic hours and providing a transportation service will shorten the wait time for behavioral health services (1.9.2-Expand Specialty Care Capacity) which in turn, will help reduce costs and unnecessary ED visits. This project will also increase the need for integrated care. As both medical and behavioral healthcare are integrated (2.15.1-Integrate Primary and Behavioral Healthcare), more patient satisfaction is expected due to an improved delivery system. This project will participate in the Region's Learning Collaborative. Please refer to Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of all participating provider projects for each collaborative.

Project Valuation:

Pecan Valley developed the valuation of this project based upon both cost savings and impact on quality of life. This project potentially affects individuals from five counties, and more specifically the areas of service determined to most have the need for extended hours. The population will include both adults and youth with severe mental illness and who are currently eligible to receive services from Pecan Valley. According to the study, Impact of Proposed Budget Cuts to Community-Based Mental Health Services,[91] citizens who suffer from behavioral health issues, but do not receive treatment, shift costs from cheaper community-based service delivery methods to more expensive environments, such as state hospitals and jails. According to the study, the average annual cost of providing community-based treatment for an adult is $4,380 per year as opposed to an average cost of $11,629 for a state hospital stay and a $10,960 cost to jails for inmates with mental illnesses. By calculating the cost difference per year of treating a person suffering from mental illness in the community as opposed to a jail setting, Pecan Valley Centers estimates a cost savings of $5,337,696 over the life of the grant. Pecan Valley Centers expects that this will provide a minimum value of $397,488 over the life of the grant. Utilizing the Region 10 pricing model, Pecan Valley Centers assigns the project of enhancing service availability a total value of $5,770,471.

[91] Health Management Associates Services. Impact of proposed budget cuts to community-based mental health. 2011.

130724106.1.2	***1.12.1***	***1.12.1 A-B***	**Extending Services Beyond Normal Business Hours**
Pecan Valley Centers for Behavioral and Developmental Healthcare			130724106
Related Category 3 Outcome Measure(s): *OD.6*	130724106.3.3	3.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]: Identify areas which lack sufficient transportation to appointments and extended operating hours Metric 1 [P-1.1]: Assessment of gaps in accessibility to establish/prioritize geographic areas for intervention Baseline/Goal: Data Source: Survey of outpatient providers; interviews with key stakeholders; Clinic records regarding kept and missed appointments. Milestone 1 Estimated Incentive Payment $1,089,569	**Milestone 2** [P-5]: Establish extended hours option Metric 1 [P-5.1]: Number of areas prioritized for intervention with extended hours in operation Baseline/Goal: 2 clinics with extended hours serving 1,500 patients. Data Source: Encounter data. Metric 2 [P-2.1]: Number of areas prioritized for intervention with transportation services in operation Base/Goal: 2 clinics with transportation services serving 500 patients. Data Source: Encounter data. Milestone 2 Estimated Incentive Payment: $ 1,196,626	**Milestone 3** [I-13]: Adherence to scheduled appointments Metric 1 [I-13.1]: 5% decrease (from 27%) in the number of cancelled or no-show appointments. Numerator: number of cancelled or "no-show" appointments for individuals receiving services through expanded access sites. Denominator: number of individuals receiving services through expanded access sites. Note: This would be measured at specified time intervals throughout the project to determine if there was a decrease. Goal: 5% decrease from 27% Data Source: Encounter data from expanded access sites Milestone 3 Estimated Incentive Payment: $ 1,282,219	**Milestone 4** [I-13]: Adherence to scheduled appointments Metric 1 [I-13.1]: 10% decrease (from 27%) in the number of cancelled or no-show appointments. Numerator: number of cancelled or "no-show" appointments for individuals receiving services through expanded access sites. Denominator: number of individuals receiving services through expanded access sites. Note: This would be measured at specified time intervals throughout the project to determine if there was a decrease. Goal: 10% decrease from 27% Data Source: Encounter data from expanded access sites Milestone 3 Estimated Incentive Payment: $ 1,238,860
Year 2 Estimated Milestone Bundle Amount: $1,089,569	**Year 3 Estimated Milestone Bundle Amount: $ 1,196,626**	**Year 4 Estimated Milestone Bundle Amount: $ 1,282,219**	**Year 5 Estimated Milestone Bundle Amount: $ 1,238,859**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $ 4,807,273			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 1.1.2 – Johnson County Hope APRN Clinic – 1.1.2C Expand Primary Care Capacity (I(D) – Expand Primary Care Clinic Staffing)

Unique Project ID: 131036903.1.1
Performing Provider Name/TPI: Texas Health Harris Methodist Cleburne / 131036903
Provider: Texas Health Harris Methodist Hospital Cleburne is a full-service, 137-bed acute care hospital. Several hospital performing providers in and out of the Texas Health Resources system are developing similar projects that will expand primary care capacity to Medicare, Medicaid/uninsured patients. This project does not directly support, reinforce or enable other projects in the RHP plan due to the remote location of Texas Health Cleburne.
Intervention: To provide supplemental primary care providers and to expand primary care access to patients in the region Primary Care would be provided by APRNs with prescriptive authority under direct physician supervision. This project is a new intervention.
Need of the project: The use of APRNs as intermediate care providers will decrease the admission rates of the described population of patients in the ED and increase the usage of resources within the community for primary care. Expanding primary care capacity is critical to expand the medical home model and redesign primary care.
Target population: The identified target populations of patients the urgent care clinic will service are Non-Funded /self-pay without access to additional resources and high frequency of inpatient admissions and ER visits within the last 6 months. The identified target populations of patients the urgent care clinic will service are:

a) Diagnoses to include COPD, heart failure, diabetes
b) Non-funded/self-pay without access to additional resources
c) High frequency of inpatient admissions and ED visits within the last six months

	DY2013	DY2014	DY2015	DY2016
Average Number of Patients per Month*	60	120	180	180
Number of Patients Annually	720	1440	2160	2160

Expected patient benefits: Within our service area, Medicaid and low-income patients struggle to find access to primary care services, cannot afford the needed labs and/or prescription drug medication in order to continue treatment.
Category 1 or 2 expected patient benefits: This project will establish additional clinics, train additional providers, increase primary care clinic volume of visits and eventually increase the number of the target population reached.
Category 3 outcomes: By the end of the waiver, our goal is to have ≥10% of patients 18 years and older who are uninsured or underfunded seen in a primary care setting (either a THC based urgent care clinic or the JC HOPE Clinic).

Improvement targets for both outcome measures chosen were selected based on populations of patients the project proposes to serve, and align with the goal of decreasing inappropriate utilization of the ED by providing an alternative in an urgent care clinic managed by APRNs, and partnering with the JC HOPE clinic to provide primary care resources for patients who currently do not have access to primary care.

Outcome Measure #1: IT 9.2 Right Care, Right Setting; IT-9.2 ED appropriate utilization Reduce Emergency Department visits for target conditions: Congestive Heart Failure (CHF), diabetes, CV/Hypertension, Chronic Obstructive Pulmonary Disease (COPD), asthma.

Project Option 1.1.2 – Johnson County Hope APRN Clinic **–** 1.1.2C Expand Primary Care Capacity (I(D) – Expand Primary Care Clinic Staffing)

Unique Project ID: 131036903.1.1

Performing Provider Name/TPI: Texas Health Harris Methodist Cleburne / 131036903

Project Description:

The Category 1 project proposed by Texas Health Cleburne (THC) is a collaborative effort with the HOPE clinic in Johnson County as a resource clinic for underinsured, non-funded adult patients. Given the limited resources provided by the Johnson County HOPE clinic, THC will provide supplemental primary care providers to increase the volume of patients who can be seen at HOPE. In addition, overflow patients will be seen in an urgent care clinic based at THC. Primary care will be provided by APRNs with prescriptive authority under direct physician supervision. The patients who are candidates for the urgent care clinic will be referred from the THC inpatient population and the outpatients from the THC Emergency Department only.

Goals and Relationship to Regional Goals:

Project Goals:

Within our service area, Medicaid and low-income patients struggle to find access to primary care services, cannot afford the needed labs and/or prescription drug medication in order to continue treatment. It may be difficult for the patients to get a primary care appointment in a timely manner due to traditional office hours and the practice of medicine structured around the physician, not the patient. Moreover, it is the project's goal of health care improvement to provide more preventive and primary care to keep individuals and families healthy, and avoid more costly ED and inpatient care. RHPs are in real need of expanding primary care capacity in order to implement delivery system reforms needed to provide the right care at the right time in the right setting for all patients.

This project meets the following Regional goals:

i) 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
ii) 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.

Challenges:
Because many of the primary care providers in Johnson County do not accept Medicaid, Medicare, or indigent care patients, a large population of patients frequent the emergency department as their only source of primary care. Of these patients, a large percentage present with chronic conditions that have exacerbated, warranting hospital admissions. The HOPE clinic in Johnson County is the only free clinic that accepts indigent or Medicaid patients. Because the clinic is managed and run by volunteer practitioners, clinic hours are limited, and this patient population is managed on a first-come, first-served basis by telephone appointment only. This project offers additional resources to the HOPE clinic and an alternative when the clinic's limited scheduling capacity is full.

5-Year Expected Outcome for Provider and Patients:
Five-year goals are:

- Increase HOPE clinic resource FTE by 0.5/DY2 until DY5
- Improve access to care for indigent residents in Johnson County
- Augment access for underinsured and underfunded THC patients by opening an urgent care clinic managed by APRNs with prescriptive authority

Starting Point/Baseline:

The baseline for the proposed project is derived from researching the current volume the HOPE clinic can allow, given the current allocation of a 20-hours/week APRN. Our aim is to increase the volume of patients seen by the HOPE clinic, outsourcing current THC APRN staff. In addition, because HOPE clinic management has expressed a limit on the number of patients it's willing to see per day, this project has plans to train additional support staff, allocate real estate on-site at the hospital, hire additional APRNs, and procure a medical director to provide access for THC patients. The identified target populations of patients the urgent care clinic will service are:

d) Diagnoses to include COPD, heart failure, diabetes
e) Non-funded/self-pay without access to additional resources
f) High frequency of inpatient admissions and ED visits within the last six months

	DY2013	DY2014	DY2015	DY2016
Average Number of Patients per Month*	60	120	180	180
APRN Visits per Month	180	360	540	540
Number of Patients Annually	720	1440	2160	2160
Total FTES	**3.57**	**4.16**	**4.16**	**4.16**

Rationale:
According to the Texas Center for Health Disparities, there are striking disparities in health status, access to health care and risk factors between the racial and ethnic minorities and the general population in Texas. The greater Dallas – Fort Worth area is the nation's fifth largest metropolitan area and is home to nearly 6 million residents, and more than 2 million of them are first- and second-generation Americans. Approximately one-sixth of Dallas – Fort Worth residents live under the federal poverty level and one-third live just over the federal poverty level. Health disparities also result from lack of minority health professionals, low health literacy, lack of training of health professionals in addressing these disparities, and unequal exposures to environmental risks. According to the Texas State Data Center, by the year 2040 Texas will need over 350,000 health professionals, of whom nearly 180,000 will be serving the non-white Texas population. In 2000, there were only 41,000 health professionals serving these populations.

Project Components:
The use of APRNs as intermediate care providers will decrease the admission rates of the described population of patients in the ED and increase the usage of resources within the community for primary care. Expanding primary care capacity is critical to expand the medical home model and redesign primary care. Primary care capacity, access, and efficiency attained in primary care clinics along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner are foundational to improving patient outcomes.
We are expanding:

A. Primary care clinic space by utilizing hospital based existing real estate for a proposed urgent care access.
B. Primary clinic hours will be expanded related to the provision of additional APRN resource to manage the increase in volume of patients.
C. Primary clinic staffing will be expanded to include an APRN who will be available at the HOPE clinic and additional staffing for the hospital based urgent care clinic.

Milestones and metrics include:

- Establish additional/expand existing/relocate primary care clinics.
  - Metric: Number of additional clinics or expanded hours or space
- Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.
  - Metric: Documentation of increased number of providers and staff and/or clinic sites
- Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
  - Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting.
- Increase access to primary care capacity using innovative project option.
  - Metric: Increase percentage of target population reached

- Numerator: Number of individuals of target population reached by the innovative project
- Denominator: Number of individuals in the target population

RHPs are in real need of expanding primary care capacity in order to implement delivery system reforms needed to provide the right care at the right time in the right setting for all patients. Additional staff members and providers are necessary to increase capacity to deliver care.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.2 – Shortage of primary care services (e.g., pediatric, prenatal, family care)
- CN.7 – Need to address geographic barriers that impede access to care
- CN.8 – Lack of access to health care due to financial barriers (i.e., lack of affordable care)
- CN.10 – Overuse of emergency department (ED) services
- CN.11 – Need for more care coordination
- CN.12 – Need for more culturally competent care to address unmet needs (e.g., Latino-population need care, translators, translated materials)

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

This project supports the AHRQ Transitional Care Model with the addition of using the APRN prescriptive authority (New Courtland Center for Transitions and Health University of Pennsylvania School of Nursing; NewCourtlandCenter@nursing.upenn.edu).

Related Category 3 Outcome Measures:

Outcome Measures:

IT 9.2 Right Care, Right Setting

IT-9.2 ED appropriate utilization – reduce emergency department visits for target conditions: congestive heart failure (CHF), diabetes, CV/hypertension, chronic obstructive pulmonary disease (COPD), asthma

Reasons/Rationale for Selecting the Outcome Measures:

By the end of the Waiver, our goal is to have $\geq$10% of patients 18 and older who are uninsured or underfunded seen in a primary care setting (either a THC-based urgent care clinic or the JC HOPE Clinic).

In DY2 and DY3, establishing a learning collaborative using process milestones will include (1) Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans, (2) Establish baseline rates, and (3) Disseminate findings, including lessons learned and best practices, to stakeholders. Improvement targets for both outcome measures chosen were selected based on populations of patients the project proposes to serve, and align with the goal of decreasing inappropriate utilization of the

ED by providing an alternative in an urgent care clinic managed by APRNs, and partnering with the JC HOPE clinic to provide primary care resources for patients who currently do not have access to primary care.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**: Several hospital performing providers in and out of the Texas Health Resources system are developing similar projects that will expand primary care capacity to Medicare, Medicaid/uninsured patients. This project does not directly support, reinforce or enable other projects in the RHP plan due to the remote location of Texas Health Cleburne. This project will, however, potentially have a positive impact on the same outcome measures and population-focused improvements as the other proposed RHP projects and interventions and contribute to best practices and lessons learned.

- **Related Category 4 population-focused improvements**: This project's Category 4 Reporting Domain includes RD-1 Potentially preventable admissions (PPAs) in low-income, Medicaid, and uninsured Johnson County adult population with the reporting measures of RD-1.1 CHF, RD-1.2 Diabetes with short-term complications or uncontrolled diabetes, and RD-1.4 COPD or asthma. This project will support, reinforce, and enable other projects through its design and intervention for the above described patient population by adding to best practices and lessons learned.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

- **Approach/Methodology:** For every ED visit avoided, $448 is saved by the health care system. The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing health care costs, individual costs, and community costs.
- **Rationale/Justification:** ED visit outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with more than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already navigate frequent flyers away from the ED.

- Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

131036903.1.1	*1.1.2*	*Project Components 1.1.2 (a-c)*	*Johnson County Hope APRN Clinic – Expand Primary Care Capacity (I(D) – Expand Primary Care Clinic Staffing)*	
Texas Health Harris Methodist Cleburne				*TPI# 1310369-03*
Related Category 3 Outcomes:	*131036903.3.1*	*3.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]: Establish additional primary care clinic Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space, Documentation of detailed expansion plans Baseline/Goal: Implement 1 new clinic Data Source: HR Records, Program Policies Milestone 1 Estimated Incentive Payment: $229,172	**Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: Hire 1.5 additional APRN; 3.0 support staff Data Source: HR Records, Program Policies Milestone 2 Estimated Incentive Payment: $110,944 **Milestone 3** [P-X]: Establish baseline rates for clinic volume of visits Metric 1 [P-X.1]: Determine volume of patient visits to the clinic Goal: Establish baseline Data Source: EHR, registration data Milestone 3 Estimated Incentive Payment: $110,944		**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Goal: 30% improvement over prior reporting period (baseline for DY2). (Total number of visits for reporting period) Data Source: Registry, EHR, claims or other Performing Provider source Incentive Payment: $234,025	**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. Goal: 40% improvement over prior reporting period (baseline for DY2). (Total number of visits for reporting period) Data Source: Registry, EHR, claims or other Performing Provider source Incentive Payment: $188,965
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $229,172	Year 3 Estimated Milestone Bundle Amount: $221,888		Year 4 Estimated Milestone Bundle Amount: $234,025	Year 5 Estimated Milestone Bundle Amount : $188,965

131036903.1.1	*1.1.2*	*Project Components 1.1.2 (a-c)*	*Johnson County Hope APRN Clinic – Expand Primary Care Capacity (I(D) – Expand Primary Care Clinic Staffing)*	
Texas Health Harris Methodist Cleburne				*TPI# 1310369-03*
Related Category 3 Outcomes:	*131036903.3.1*	*3.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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $874,050				

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option – 1.1.2 – Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
Unique Project ID: 135036506.1.1
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Provider: Baylor All Saints Medical Center at Fort Worth, located near downtown Fort Worth, is a full-service hospital dedicated to providing for the health care needs of the community. Baylor Fort Worth is among Tarrant County's oldest not-for-profit hospitals and celebrated 100 years of service in 2006. The medical center has 525 licensed beds and offers a broad range of medical services including programs of excellence in cardiology, transplantation, neurosciences, oncology and women's services. Baylor Fort Worth's service area represents a population of 1.2 million.
Intervention: This project will implement increased access to a Patient-Centered Medical Home (PCMH) clinic designed to provide comprehensive and high-quality primary care services to underserved patients. The project is an expansion of Baylor's Clinic strategy in Fort Worth and Tarrant County. This expansion will focus on the recruitment of more underserved (Medicaid and Uninsured) patients from the community at-large and patients awaiting access to other public resources
Need for the project: Access to quality primary care services has been demonstrated to improve health outcomes and reduce avoidable hospital utilization among underserved patients.
Target population: Uninsured and Medicaid population in Tarrant County. Clinic capacity will allow approximately 600 new patients per year to receive services. Estimated number of patients to be served over course of waiver period: 1850 new patients from DY3-DY5.
Category 1 or 2 expected patient benefits: Establish/expand/relocate primary care clinics; train/hire additional primary care providers and increase number of clinics for existing providers; increase primary care visit volumes; and increase access to primary care capacity. These milestones and metrics tie into the project purpose through increasing visits and opening the PCMH to non-Baylor patients.
Category 3 outcomes: (all baselines will be reevaluated and reestablished in DY2)

- **IT-1.7: Controlling High Blood Pressure**. Our goal is to increase the number of patients with controlled blood pressure (< 140/80 mmHg) from 57.5% currently to 63.6% in DY5.
- **IT-6.1: Percent Improvement over baseline of patient satisfaction scores (clinic wait times)**. Our goal is to increase patient satisfaction from 82.4% currently to 84.9% in DY5.
- **IT-6.1: Percent Improvement over baseline of patient satisfaction scores (timely response to patient phone calls)**. Our goal is to increase patient satisfaction from 94.2% currently to 95.0% in DY5.
- **IT-12.1: Breast Cancer Screening**. Our goal is to increase the number of appropriate women who receive breast cancer screenings from 45.0% currently to 50.4% in DY5.
- **IT-12.5: Other USPSTF screening outcome (Influenza Vaccination).** Our goal is to increase the number of adults 18 and over who receive an influenza vaccination from 62.5% currently to 67.8% in DY5.

Project Option – 1.1.2 – Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion
Unique Project ID: 135036506.1.1
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Project Description:
The Baylor Clinic, on the Baylor All Saints Medical Center at Fort Worth campus, would expand current capacity by opening patient panels to non-Baylor patients (including Medicaid and uninsured patients) and fully utilize the space and providers' capacity. Additional support staff will be hired to better coordinate patient care, ensure transition from the hospital to a Baylor Clinic, and help to facilitate the care of the complex underserved patients. The NCQA-recognized PCMH at Baylor Clinic will open the current panel to the underserved community and provide volume relief for other providers/ health systems in the area, while providing these high-quality primary care services to more people in one location. In addition to receiving primary care, this project also proposes that ancillary services such as labs, imaging (i.e., CT scans, MRI, mammograms, ultrasound, echocardiograms, and interventional radiology) and diagnostics (i.e., colonoscopy, stress tests, esophageal diagnostic, retinal screens) would also be provided upon physician request. This project aims to close the loop of care and increase patient compliance by co-locating/coordinating many of the essential services that the underserved population often has issues accessing and completing.

Goals and Relationship to Regional Goals:
Project Goals:
The five-year goals of this project are: (1) to provide a PCMH and PCP to a greater number of the underserved population, (2) provide continuity and transition to post-acute care services, (3) improve patients' health outcomes and status, (4) create an integrated primary care model for underserved patients in Tarrant County to receive high-quality, complete care keeping these patients from utilizing the emergency department for low acuity needs and preventing readmissions that could have been avoided with proper primary care.

This project meets the following Regional goals:
The Region has a primary care provider and capacity issue for the underserved population. This project aims to address increasing access to primary care and providing high-quality, comprehensive care to patients in a less costly setting. Emergency department utilization is high in RHP 10, and by providing more patients with the primary care they need, the goal is to keep them from using the ED as a means to receive basic care.

Challenges:

Providers and hospitals are reluctant to expand primary care capacity in charity clinics due to the inherent necessity for other downstream services, procedures, and costs associated with adding a patient with multiple, complex needs from the underserved population. Additionally, there is not enough primary and specialty care providers and services supply to meet the demand from this population. Basic primary care needs are unable to be fulfilled because of the lack of funding and capacity to take more patients, thus leading to increased (re)admissions and prevalence of disease complications. Lastly, due to the transient nature of this population, it is difficult to achieve the full extent of quality and clinical outcomes associated with a Patient Centered Medical Home. This project addresses these challenges by creating a low-cost, effective, co-located and comprehensive model specifically for the underserved population. We plan to expand our care teams and services offered to facilitate some of the primary care access issues that exist in Tarrant County.

5-Year Expected Outcome for Provider and Patients:

At the end of five years, 1,850 new, unduplicated patients will have received PCMH/primary care services at the Baylor Clinic on the Baylor All Saints Medical Center Campus. We expect that at least 10-15% of patients who continue to come to the Baylor Clinic will achieve better adult preventive scores (APS) and have overall better clinical outcomes.

Starting Point/Baseline:

In the past year, the Baylor Clinic on the Baylor All Saints Medical Center at Fort Worth served over 600 unduplicated patients. To date, there has not been a formal process to take patients from the community; capacity is typically reserved for those patients who come from a Baylor All Saints Medical Center ED. In addition to patients discharged from Baylor All Saints Medical Center, our target population will focus on 1,850 patients of the more than 443,000[92] patients who are uninsured/underserved in Tarrant County.

Rationale:

We chose this project option because of the demonstrated need in the RHP and to leverage our PCP/PCMH model to patients outside of the Baylor system. According to the Community Health Needs Assessment,[93] 66% of the Region is designated as a medically underserved area and 24.6% of individuals in Tarrant County are uninsured. The combination of these two factors leads to increased ED utilization and clinical complications due to lack of adequate access to coordinated, primary care services. In 2010, there were 1.1 million visits to hospital EDs in 2010, with a rate of 447.5 visits per 1,000 persons in the Region. Additionally, the top outpatient services utilized include internal medicine, labs, psychiatry and pulmonology. These services can be better coordinated and managed in a primary care setting, ensuring patients receive the care they need in a timely fashion with adequate follow-up.

[92] http://quickfacts.census.gov/qfd/states/48/48439.html.
[93] RHP 10 Community Health Needs Assessment.

Baylor clinics have a proven track record for improving patient outcomes and creating primary care capacity in underserved areas. Leveraging this model would improve health outcomes for patients and other performing providers.

Project Components:

a) *Expand primary care clinic space*. We will not physically expand the primary care clinic space, but we will more fully utilize the current space we have and will take advantage of underutilized space in the Baylor Clinic to see more patients. By carving out space to handle non-clinical needs such as finding community resources, education, coordinating care/appointments, etc., this will allow more room for providers to see patients and handle clinical needs.

b) *Expand primary care clinic hours*. We plan to expand our hours through the expansion of care teams. By adding mid-levels and other non-physician support staff, there will be more provider hours available, more appointment availability through expanding our current capacity from two appointment slots an hour to four (for example).

c) *Expand primary care clinic staffing*. We plan on hiring at least 2 FTEs to add to the care team in Fort Worth in order to increase our capacity and services offered. We also plan to make the current staff hours more efficient so that more appointments per hour can be offered to patients.

We also plan to engage regularly in continuous quality improvement activities that focus on: (1) identifying key challenges with the expansion of this project, (2) determine opportunities to scale all or part of the project, depending on available resources and financial constraints, and (3) look for ways to increase efficiency and effectiveness.

The milestones and metrics chosen for this project are more heavily focused on improvements in capacity and patient satisfaction rather than process, because much of the infrastructure and logistics are already in place, as Baylor is already an NCQA-recognized PCMH[94]. The focus of the metrics is on further improving and refining the PCMH baseline that has been established. Improvement metrics that hone in on increasing capacity, patient satisfaction and serving more patients are the impetus of this project. We also plan on engaging in continuous quality improvement activities on a regular basis that focus on: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints and 3) look for ways to increase efficiency and effectiveness.

Unique community need identification numbers the project addresses:

- CN.2 – Shortage of primary care services
- CN.8 – Lack of access due to financial barriers
- CN.10 – Overuse of ED services

[94] NCQA: http://www.ncqa.org/tabid/631/default.aspx.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project has not received funding from any federal source. It enhances current delivery system reform by focusing on providing high-quality, low-cost and comprehensive services to the underserved population, which in turn decrease ED utilization and promotes preventive services.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale For Selecting The Outcome Measures:
Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic. The Category 3 outcomes will be primarily focused on new patients to the Baylor Clinic.
IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018) (Stand-alone measure)
By providing medication management, proper primary care attention and education, patients in our PCMH can achieve better blood pressure control in the outpatient setting and avoid complications In Region 10, hypertension was identified as one of the top five most prevalent diseases in the area, with over 1,000 preventable admissions in 2010.[95]Hypertensive complications can be especially deadly in the African-American population,[96] who make up 12% of the RHP 10 population.
IT-6.1 Percent Improvement over baseline of patient satisfaction scores (Stand-alone measure)
Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust patients have with their clinic and provider, eventually leading to better outcomes and lower costs. Data from Press Ganey Associates in 2007[97] demonstrates that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease. Baylor Clinics have historically had high performance in all measures related to patient satisfaction; however, there is opportunity for improvement. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below:

1) Patients are getting timely care, appointments and information (Stand-alone measure): Wait times

[95] RHP 10 Community Health Needs Assessment.
[96] http://health.nytimes.com/health/guides/disease/hypertension/complications.html.
[97] Drain M & Kaldenberg DO (1999). Building patient loyalty and trust: the role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

2) Patients are getting timely care, appointments and information (Stand-alone measure): Returning patient phone calls

The following two outcome measures focus on adult preventive services recommended by USPSTF as low-cost, highly effective interventions that prevent and maintain patients' health status. Patients who are a part of a Baylor PCMH are routinely screened and monitored to ensure that they are receiving all preventive services that are appropriate for their age and condition.

IT-12.1 Breast Cancer Screening (Non-Stand-alone Measure)

In Tarrant County, only 58% of women over 40 receive breast cancer screenings;[98] we hope to screen more women and utilize early detection methods for breast cancer.

IT-12.5 Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate)

In Tarrant County, only 40% of individuals over 18 received an influenza vaccination in the past 12 months. Less than one out of every three African-American or Hispanic individuals in Tarrant County received an influenza vaccination. There were 290 influenza-related deaths in RHP 10 in 2010.[99] The rate of influenza vaccinations in the Region is quite low, and there is an opportunity to increase the number in the target population who receive this basic vaccination.

Relationship to Other Projects:

135036506.2.1 Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

The Chronic Care Management Model expansion is related to this project because the additional staff that will be hired under this project of primary care capacity expansion will be co-located and provide education and management of CHF, diabetes and asthma/COPD.

135036506.1.2- Improve Access to Specialty Care-Expand Specialty Care Services

Improving access to specialty care is related to this project because patients who require certain specialty care procedures such as outpatient specialty provider visits, wound care, and office-based procedures, catheterizations, surgeries (i.e., gallbladder or hernia), excision of masses (breast, lymphoma), and cataracts, would receive coordinated care/referrals to these services as well as the necessary follow-up required for continuity of care in a primary care clinic setting.

135036506.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

The project relates to this project of expansion of primary capacity because behavioral health would now be a co-located service offered to patients who require this service. This would increase the effectiveness of primary care by addressing behavioral health issues at the same time.

[98] RHP 10 Community Health Needs Assessment.
[99] RHP 10 Community Health Needs Assessment.

This project will help to support, reinforce and enable Category 4 population-focused improvements through project design and appropriate intervention for targeted populations: RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8, RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7, RD-3.1, RD-3.5, RD-3.6, RD-3.10, RD-3.11, RD-3.22, RD-3.26, RD-3.36, RD-4.1, RD-4.2

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

Other projects that focus on expanding primary care are: 216719901.1.1 (Glen Rose–Increase Physician Office Visits), 022817305.X.X (Tarrant County Public Health–Creation of TB Clinics), 138980111.1.1 (University of North Texas Health Science Center–Expand Primary Care Capacity for Medicaid Dual Eligible Elders). The providers of these projects have confirmed that: (1) we each serve distinct geographical areas and/or (2) populations of the underserved. Our projects focus on increasing access to all underserved members of the community and creating a PCMH for these patients. The aforementioned projects serve distinct populations and are focused on carved out services.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Baylor All Saints Medical Center at Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Baylor All Saints Medical Center at Fort Worth defined the population that will be directly impacted by the project as 1,850 underserved patients in the Fort Worth area of the more than 443,000 uninsured in Tarrant County. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4**.** We believe this to be the correct number because this project provides a PCP/PCMH setting for underserved patients who do not have one. This alone has a large impact on individuals being able to meet basic health care needs and receive the medical attention they need to sustain their health. To determine the value to the community of each

individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her dependence on community resources is better utilized and over time, will decrease. When these patients receive health care, they are able to manage their conditions better and in a timely manner, remain productive members of society, stay out of the ED and avoid costly clinical exacerbations. In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and Regional projects. These criteria took factors such as transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability, and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature-based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the Regional cap of funding into consideration.

135036506.1.1	***1.1.2***	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CAPACITY-BAYLOR CLINIC CAPACITY EXPANSION***	
Baylor All Saints Medical Center at Fort Worth				***135036506***
Related Category 3 Outcome Measure(s):	***135036506.3.1*** ***135036506.3.2*** ***135036506.3.3*** ***135036506.3.4*** ***135036506.3.5***	*3.IT-1.7* *3.IT-6.1* *3.IT-6.1* *3.IT-12.1* *3.IT-12.5*	*Controlling high blood pressure (Stand-alone measure)* *Percent improvement over baseline of patient satisfaction scores (Stand-alone)* *Percent improvement over baseline of patient satisfaction scores (Stand-alone)* *Breast Cancer Screening (Non-Stand-alone measure)* *Other USPSTF screening outcome (Influenza Vaccination) (Non-Stand-alone)*	
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]: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline/Goal: Determine optimal usage of clinic space and shift utilization based on clinical need (i.e.: carve out space for consults and non-clinical issues to allow more space for providers to see a greater number of patients) Data Source: Documentation of space reallocation/increased utilization plans Determine provider capacity to hold at least one evening clinic a week Milestone 1 Estimated Incentive Payment: $**344,306** **Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers	**Milestone 3** [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 increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **600** new, unduplicated patients will be seen at the Baylor Clinic over baseline Data Source: E.H.R Milestone 3 Estimated Incentive Payment: $ **375,619** **Milestone 4** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 15% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic Tracking/E.H.R		**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 increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **1200** new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 5 Estimated Incentive Payment: $**376,711** **Milestone 6** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 20% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic Tracking/E.H.R	**Milestone 7** [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 increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: at minimum **1850** new patients will be seen at the Baylor Clinic (cumulative over baseline) Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $**311,196** **Milestone 8** [I-15]: Increase access to primary care capacity. Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: Increase access to 25% of available Baylor Clinic capacity to eligible community patients (non-Baylor patients) Data Source: Electronic Tracking/E.H.R

135036506.1.1	***1.1.2***	***1.1.2 (A-C)***	***EXPAND EXISTING PRIMARY CARE CAPACITY-****BAYLOR CLINIC CAPACITY EXPANSION*	
Baylor All Saints Medical Center at Fort Worth				***135036506***
Related Category 3 Outcome Measure(s):	***135036506.3.1*** ***135036506.3.2*** ***135036506.3.3*** ***135036506.3.4*** ***135036506.3.5***	*3.IT-1.7* *3.IT-6.1* *3.IT-6.1* *3.IT-12.1* *3.IT-12.5*	*Controlling high blood pressure (Stand-alone measure)* *Percent improvement over baseline of patient satisfaction scores (Stand-alone)* *Percent improvement over baseline of patient satisfaction scores (Stand-alone)* *Breast Cancer Screening (Non-Stand-alone measure)* *Other USPSTF screening outcome (Influenza Vaccination) (Non-Stand-alone)*	
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)**
Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: 2.5 new FTEs Data source: Documentation of hired employees Milestone 2 Estimated Incentive Payment *(maximum amount):* **$344,307**	Milestone 4 Estimated Incentive Payment: $**375,620**		Milestone 6 Estimated Incentive Payment: $**376,712**	Milestone 8 Estimated Incentive Payment: $**311,197**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* **$688,613**	Year 3 Estimated Milestone Bundle Amount: $**751,239**		Year 4 Estimated Milestone Bundle Amount: $**753,423**	Year 5 Estimated Milestone Bundle Amount: $**622,393**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ **2,815,668**				

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option – 1.9.2 – Improve Access to Specialty Care-Expand Specialty Care Services

Unique Project ID: 135036506.1.2
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Provider: Baylor All Saints Medical Center at Fort Worth, located near downtown Fort Worth, is a full-service hospital dedicated to providing for the health care needs of the community. Baylor Fort Worth is among Tarrant County's oldest not-for-profit hospitals and celebrated 100 years of service in 2006. The medical center has 525 licensed beds and offers a broad range of medical services including programs of excellence in cardiology, transplantation, neurosciences, oncology and women's services. Baylor Fort Worth's service area represents a population of 1.2 million.
Intervention: This project will increase access to needed specialty care services (i.e. outpatient visits with specialty physicians, hospital-based procedures) for uninsured patients under the care of a Baylor clinics in Fort Worth. This is a new project and will provide access to specialty services previously unattainable for uninsured patients.
Need for the project: Specialty services are a key element to providing a full continuum of care to patients (beyond what can be provided in a primary care clinic) and an important contributor to improved health outcomes. Shortage of specialty care was one of the key needs identified in the region.
Target population: The target population will be a subset of established Baylor clinic patients who require specialty services. While historical data suggests 10-15% of all established patients will develop a need for specialty services, constraints in available specialists and facilities should allow the project to serve approximately 5% of all established patients within a given year. Estimated number of patients to be served over course of waiver period: 209 new patients from DY3-DY5 will receive specialty care services. The Specialty Care program will open up access to specialty services previously not available to uninsured patients, except in emergent situations.
Category 1 or 2 expected patient benefit: Conduct gap assessment of specialty care; collect baseline data for backlog/return appointments; increase number of specialist providers, clinic hours available for high impacted medical specialties; and increase specialty care clinic volumes of visits. These milestones and metrics tie into the project purpose through increasing visits and contracting with more specialty care providers in the community
Category 3 outcomes: (all baselines will be reevaluated and reestablished in DY2)

- IT-11.1: Improvement in Clinical Indicator in identified disparity group: Improvement in Asthma Bundle. Our goal is to improve performance of our Asthma metrics Percent of Opportunities Achieved (POA) from 63.4% completed opportunities currently to 68.6% completed opportunities in DY5.
- IT-12.2: Cervical Cancer Screening. Our goal is to increase the number of appropriate women receive screenings from 72% currently to 75.9% in DY5.
- IT-12.3: Colorectal Cancer Screening. Our goal is to increase the percentage of appropriate patients receive screenings from 23.4% currently to 34.3% in DY5.

Project Option – 1.9.2 – Improve Access to Specialty Care-Expand Specialty Care Services

Unique Project ID: 135036506.1.2
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506
Project Description:
Patients (including Medicaid and uninsured) in an established PCMH can receive specialty care services at Baylor Clinic, including office visits with specialists, wound care, and facility based procedures such as cardiac catheterizations, certain surgeries (i.e., gallbladder/hernia), excision of masses (breast, lymphoma), and cataract removal and excluding transplants, oncology and perinatal services. Specialty care referral and coordination would come from the PCMH clinic per request by the patient's PCP.

Goals and Relationship to Regional Goals:
Project Goals: The goals for this project are to increase/improve access to specialty care services, engage a greater number of providers/facilities to provide these services, increase the number of completed specialty referrals for patients and improve disease-specific clinical outcomes affected by increased access to target specialists.

This project meets the following Regional goals:
This project helps offset some of the demand for specialty care services in a coordinated way that synchronizes with the Regional needs of providing access to more specialty care, and also coordinates the care for the patient to ensure more timely care.

Challenges:
The major challenges with providing increased access to specialty care are multiple: 1) there is a lack of supply of specialty providers in the Region and even smaller supply who are willing to provide specialty care services to the uninsured/Medicaid population, 2) specialty care is expensive to provide for patients who have little or no ability to pay. Major procedures/surgeries can be a financial burden for performing providers and related entities, 3) there is often a long wait list for patients to receive specialty care, leading to clinical exacerbations due to less timely care and 4) there is no coordination or follow-up for patients who do receive specialty care leading to infections, healing issues and lack of wound management which can often lead to a (re)admission to the hospital. We plan to address these challenges through developing community relationships with providers and facilities in the area, find ways to provide more access points for these patients to receive the care they need in a timely manner, monitor utilization and outcomes to be good stewards of the limited specialty care resources available in the Region. Additionally, we plan to engage specialists in the primary care team to ensure continuity of care and through using our E.H.R, we will be able to monitor patients appropriately.

5-Year Expected Outcome for Provider and Patients:

The five-year expected outcomes are to provide specialty care to approximately 209 unduplicated patients over the Waiver period, increase the number of contracted providers/facilities to at least nine; to increase the number of completed referrals for specialty care services by 20% over baseline; and help facilitate the coordination and collaboration of specialists and primary care providers for our patients.

Starting Point/Baseline:

Currently, a small number of specialty referrals is coordinated on a case-by-case basis with a limited network of specialty care providers and Baylor All Saints Medical Center at Fort Worth. This project will begin by more accurately capturing baseline data and formalizing the specialty care referral process. The constraints of limited specialty care providers and facilities willing to care for this population have allowed similar programs in the area to meet demand for approximately 5% of a clinic's patient population.

Rationale:

A key strategy for the Baylor Clinics has been the expansion of primary care access for the underserved population. Increased access to primary care has been strongly correlated with better health outcomes and lower avoidable hospital utilization within this patient population. While primary care providers are able to manage and treat many conditions, historic experience suggests that 10-15% of a clinic's patient population will likely develop a specialty care need at some point. Left untreated, this 10-15% of patients is likely to develop further exacerbation of health problems, experience more complications and increase the likelihood of avoidable hospital utilization. Additionally, as part of an effort to create a complete and robust care team for our patients, making specialty care part of that team is essential. We chose thie project option to supplement our goals of engaging specialty care physicians in providing the more complex and advanced procedures/screenings but also to conduct some basic preventive screenings and education for the patient. We feel that this will make specialists a formal part of the overall care team. Baylor Clinics have established relationships with providers in the community and as we grow, we plan to leverage and expand those relationships in order to serve more of our patients. As Baylor Clinics take on more patients from the community, we anticipate that there will be an increased need for specialty care services in this population. This project proactively creates increased specialty access for these new patients as well established clinic patients who have historically had poor access to specialty care. The Region 10 Community Health Needs Assessment reported a need to increase specialty supply over the next five years, particularly for high-demand specialties.

Project Components:

We plan on completing all required project components for the expansion of specialty care project: a) Increase service availability with extended hours: we will increase service availability by offering more appointments to patients in the outpatient setting and coordinate with surrounding hospitals to provide the inpatient services the patient may need, b) Increase number

of specialty clinic locations: we plan to contract with at least 9 providers/facilities over the course of the waiver, providing more locations for patients to receive the specialty care they need ,c) Implement transparent, standardized referral processes across the system: we already provide a standard referral form and process which is documented in the patient E.H.R and is visible by all staff but will work to improve the tracking, reporting and collection of the referral data and d) Conduct quality improvement for project using methods such as rapid cycle improvement: we will engage in: 1) identifying key challenges with the expansion of this project, 2) determine opportunities to scale all or part of the project- depending on available resources and financial constraints, 3) find ways to integrate the specialist into the care team as much as possible.

Unique community need identification numbers the project addresses:

- CN.3 – Shortage of specialty care
- CN.8 – Lack of access due to financial barriers

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project does not receive any source of federal funding and has been identified as a significant Regional need. It enhances the existing delivery system reform initiative by coordinating specialty care through a primary care setting; thus managing utilization, costs and reducing complications for patients. This project would supply the specialty care needs identified by the Region and individual providers but also ensures that utilization is controlled.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Stand-alone measure)

We will measure improvement in asthma for Baylor Clinic patients who receive specialist care using a standard asthma metrics that consists of: documentation of action/management plan, severity assessment, controller therapy for those who are eligible, and spirometry within last two years. This measurement, which we call the percent of opportunity achieved (POA), is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from bundle performance, which is usually an all-or-none metric calculating the percentage of patients who have achieved all the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their asthma patients than in the prior reporting period. For example: For asthma, there are four opportunities (i.e., metrics) per patient: (1) documentation of action/management plan, 2) severity assessment, 3) controller therapy for those who are eligible, and 4) spirometry within last two years. The denominator would be number of patients times 4. So, for example, if there are 10 patients times 4 opportunities each =

40 opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed, this means that our POA = 30/40, or 75%. To achieve a 10% improvement in POA, we would have to have completed at least 34/40 opportunities to reach 85% achievement.

Asthma affects about 7% of the Tarrant County population and accounted for 1,158 hospitalizations in 2010.[100] Meng, Leung et al. found that patients with asthma who saw a specialist had higher rates of compliance, because specialists were more likely to identify the disease and follow national guidelines and protocols to treat these patients, leading to better quality outcomes and long(er)-term control.[101] Making the pulmonologist a part of our asthma patients' care team will help to avoid exacerbations, prevent complications and reduce hospitalizations. Many underserved patients in the region require specialty care related to chronic diseases. A 2010 study by Bellinger et al. confirmed that minority and underserved populations not only receive less care but access to care is mitigated by physician referral, geographic location and insurance type.[102]

IT-12.2 Cervical Cancer Screening (Non-Stand-alone Measure)

In Tarrant County approximately 77% of women received a Pap smear in the last year; however, this percentage was lower for minorities in the county. According to the National Cancer Institute, African-American women are more likely to be diagnosed with cervical cancer and Hispanic women have the highest cervical cancer incidence rate among all women.[103] There is opportunity to increase the screenings in the minority population through engaging OB/GYNs to provide screenings and education for this population. Additionally, these specialists can provide the advanced screenings and education that would not be available in a PCP/PCMH setting.

IT-12.3 Colorectal cancer screening (Non-Stand-alone Measure)

In Tarrant County, less than 13% of individuals 50 and over obtained a fecal occult blood test within the past two years, and less than 10% of Tarrant county residents 50 and over met colorectal cancer screening guidelines.[104] There is a definite need for these services in Tarrant County, and the Baylor Clinic plans to provide these screenings to a greater number of people. There is greater need for patients to receive (appropriate) sigmoidoscopies/colonoscopies in the region as a preventive measure. According to the CDC, Hispanics and African-Americans are less likely to get screened for colorectal cancer, and it is often found in the latter stages of the disease as compared to their Caucasian counterparts.[105] There is an opportunity to increase the

[100] RHP 10 Community Health Needs Assessment.
[101] Meng YY, Leung KM, Berkbigler D, Halbert RJ. Compliance with US asthma management guidelines and specialty care: a regional variation or national concern? *J Eval Clin Pract.* 1999 May;5(2):213-21.
[102] Bellinger, JD, Hassan, RM et.al. Specialty care use in US patients with chronic diseases. *Int J. Env Res Public Health* 2010, 7, 975-990.
[103] National Cancer Institute: http://www.cancer.gov/.
[104] RHP 10 Community Health Needs Assessment.
[105] Centers for Disease Control and Prevention: http://www.cdc.gov/.

colorectal cancer screening rates by engaging specialists in the Tarrant County area to provide these basic and advanced screenings along with education focused on this topic.

Relationship to Other Projects:

This project is related to 135036506.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion. Increasing access to specialty care is related to the aforementioned project of expanding primary care capacity for two reasons: (1) as more patients enter the PCMH, there will be a linear increase in the need for specialty care services, and (2) primary care is essential to coordinate the specialty care and to allow for adequate follow-up for the patient, in order to avoid complications or issues that may arise after specialty care is received

Some of the inpatient specialty care proposed to be provided under this project would directly be tied to some of the Category 4 metrics. RD-1.1, RD-1.4; RD-2.1, RD-2.4, RD-2.5, RD.2.7; RD-3.1, RD-3.3, RD-3.4, RD-3.5, RD-3.7, RD-3.8, RD-3.10, RD-3.11, RD-3.13, RD-3.14, RD-3.15, RD-3.16, RD-3.20, RD-3.21, RD-3.22, RD-3.27, RD-3.37, RD-3.38, RD-3.40, RD-3.41 RD-3.44, RD-3.45, RD-3.36, RD-3.48, RD-3.51, RD-3.52, RD-3.53; RD-4.1, RD-4.2

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

Related projects in RHP 10 are: Helen Farabee Centers' project focused on psychiatric services (Project 127373205.1.2); John Peter Smith Hospital's project focused on incorporating ophthalmology into PCP setting (126675104.1.3) and, Pecan Valley's project focused on psychiatric services (130724106.1.1). Our project aims to open access to patients who could not otherwise receive the specialty care they need and will require coordination and collaboration with other performing providers in the region. Our project does not (1) serve the same specialty care population as the aforementioned projects, and (2) we plan to have a broader scope of specialty care services offered through our PCMH.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Baylor All Saints Medical Center at Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the

health care system, the individual and the community. (*See Section V.B. for a full explanation of the model.)*

Baylor All Saints Medical Center at Fort Worth defined the population that will be directly impacted by the project as underserved individuals in the Fort Worth and Tarrant County area who access to specialty care services. People who receive these services must be a patient of the Baylor Clinic prior to being referred to specialty care. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when people are positively impacted, their ability to maintain their health and address their complex health needs will be addressed. People will receive the procedures, diagnostics, etc. that they previously were unable to afford or could not have access to.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a *3* .We believe this to be the correct number because when people are positively impacted, their clinical exacerbations are lessened and they incur less costly procedures and surgeries versus waiting for specialty care and having a more serious condition occur.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and Regional projects. These criteria took factors such as transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability, and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature-based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the Regional cap of funding into consideration.

135036506.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE***-EXPAND SPECIALTY CARE SERVICES
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 3 Outcome Measure(s):	*135036506.3.6* *135036506.3.7* *135036506.3.8*	*3.IT-11.1* *3.IT-12.2* *3.IT-12.3*	*Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Stand-alone measure)* *Cervical Cancer Screening (Non-Stand-alone Measure)* *Colorectal cancer screening (Non-Stand-alone 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]: Conduct specialty care gap assessment based on community need Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline/Goal: Documentation of gap assessment based on Baylor Clinic patient need and how this coincides with Regional needs Data Source: E.H.R Milestone 1 Estimated Incentive Payment *(maximum amount):* $**282,508** **Milestone 2** [P-3]: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1 [P-3.1]: Establish baseline for performance indicators Baseline/Goal: Determine current wait time for specialty care services by specialty Data Source: E.H.R (chart review) Milestone 2 Estimated Incentive Payment *(maximum amount):* $ **282,508**	**Milestone 3** [P-5]: Provide reports on the number of days to process referrals and/or wait time from receipt of referral to actual referral appointment Metric 1 [P-5.1]: Generate and provide reports on average referral process time and/or time to appointment (to providers, staff, and referring physicians. Baseline/Goal: Determine average referral time for patients that were seen in DY3. This metric is the subsequent step to **P-3.1**. Data Source: E.H.R Milestone 3 Estimated Incentive Payment: $**205,467** **Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 3 providers or facilities to provide	**Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 6 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 6 Estimated Incentive Payment: $**309,097** **Milestone 7** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least 127 unduplicated patients with specialty	**Milestone 8** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Goal: Contract with at least 9 providers or facilities to provide specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 8 Estimated Incentive Payment: $**255,341** **Milestone 9** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least 209 unduplicated patients with specialty

135036506.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE***-EXPAND SPECIALTY CARE SERVICES
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 3 Outcome Measure(s):	*135036506.3.6* *135036506.3.7* *135036506.3.8*	*3.IT-11.1* *3.IT-12.2* *3.IT-12.3*	*Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Stand-alone measure)* *Cervical Cancer Screening (Non-Stand-alone Measure)* *Colorectal cancer screening (Non-Stand-alone 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)**
	specialty care services (over DY2) Data Source: Documentation of implemented contracts Milestone 4 Estimated Incentive Payment: $ **205,467** **Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients, or size of patient panels. Demonstrate improvement over prior reporting period (baseline for DY2). Goal: Provide at least 57 unduplicated patients with specialty care services over DY2 Data Source: E.H.R Milestone 5 Estimated Incentive Payment: $ **205,468**	care services over DY2 Data Source: E.H.R Milestone 7 Estimated Incentive Payment: $**309,097**	care services over DY2 Data Source: E.H.R Milestone 9 Estimated Incentive Payment: $**255,341**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* **$565,016**	Year 3 Estimated Milestone Bundle Amount: **$616,402**	Year 4 Estimated Milestone Bundle Amount: **$618,194**	Year 5 Estimated Milestone Bundle Amount: **510,682**

135036506.1.2	***1.9.2***	***1.9.2 (A-D)***	***IMPROVE ACCESS TO SPECIALTY CARE***-EXPAND SPECIALTY CARE SERVICES
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 3 Outcome Measure(s):	*135036506.3.6* *135036506.3.7* *135036506.3.8*	*3.IT-11.1* *3.IT-12.2* *3.IT-12.3*	*Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Stand-alone measure)* *Cervical Cancer Screening (Non-Stand-alone Measure)* *Colorectal cancer screening (Non-Stand-alone 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***: $2,310,294**			

Project Option 1.1.2 – Expand Pediatric Primary Care
Unique Project ID: 138910807.1.1 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine (Region 10). Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. There is one MyChildren's office in Grapevine (Region 10). Annually, Children's has approximately 600,000 patient contacts. Children's has the largest market share for pediatrics in the DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured).
Intervention: The purpose of this project is to expand the hours of operation to include nights and weekends at the MyChildren's location in Grapevine and to establish a 24 hour RN triage telephone service. It is an expansion of an existing initiative.
Need for the project: The need for this project is documented in the community needs assessment, specifically: CN. 1 Lack of provider capacity, CN. 2 Shortage of primary care services and CN. 10 Overuse of emergency department (ED) services.
Target population: Children in RHP 10 covered by Medicaid and CHIP. Estimated number of patients to be served over course of waiver period: 6,770 patients annually on panel at MyChildren's Grapevine and 3,500 patient contacts for the specific services offered in this project. Provide access to primary care in the appropriate setting on nights and weekends and use an RN after-hours triage telephone system to determine need for appropriate urgent care or emergency care use. MyChildren's Grapevine payor mix is 75% Medicaid, 5% Self-pay (uninsured), 15% CHIP and 5% Commercial Insurance.

Patient contacts	DY3	DY4	DY5	Total
RN triage line	730	900	1,100	2,730
After hours care	200	250	320	770
Total	930	1,120	1,420	3,500

Category 1 and 2 expected patient benefit: Process and improvement milestones were selected to support the successful implementation of the project. Expected benefits include increased patient satisfaction, improved health and reduced overall costs.
Category 3 outcomes: OD-9 Preventive and Primary Care. IT.9.2 ED appropriate utilization. This measure was selected because the project is designed to support appropriate utilization of ED services and reduce the inappropriate use of ED services. By expanding the hours for pediatric primary care and by providing a 24 hour nurse triage phone line, patients and families will have access to care outside of the ED during evenings, nights and weekends. Literature suggests that families using a nurse triage line report up to an 86% reduction in seeking ED care after using a nurse triage telephone line. Anecdotally, parents of younger children and new parents tend to seek more medical care for their infants and young children. MyChildren's patient panels tend to be younger children so there is a potential for even greater impact in reduction of inappropriate use of ED services.

Project Option 1.1.2 – Expand Pediatric Primary Care
Unique Project ID: 138910807.1.1 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807

Project Description:
Expand the capacity of pediatric primary care in Tarrant County through: (B) expanding primary clinic hours and (C) expanding primary care clinic staffing to better accommodate the needs of the pediatric population (Medicaid and CHIP), so that children receive the right care at the right time; have access to same-day appointments thereby reducing the unnecessary use of emergency department services. No additional primary care clinic space (component A) is anticipated, as additional capacity can be achieved in the current space by increasing hours open and adding staff. This project will also establish a 24/7 pediatric nurse/physician advice line and outreach call capability. The additional capacity will be integrated with all other community-based providers across a continuum of care to establish a virtual safety net for children's health care.

Goals and Relationship to Regional Goals:
Project Goals:
The goals of the project are to increase the availability of pediatric primary care services in Tarrant County and ensure the appropriate use of such services by the population through support systems and electronic technology. Incremental increase in the local pediatric primary care through after-hours availability, coupled with a 24/7 pediatric nurse/physician advice line and outreach call capability will ensure both the availability and use of cost-effective, high-quality pediatric care and health advice and reduce unnecessary use of emergency department services.

Patient contacts	DY3	DY4	DY5	Total
RN triage line	730	900	1,100	2,730
After hours care	200	250	320	770
Total	930	1,120	1,420	3,500

This project meets the following Regional goals:
This project is related to the Regional goals of improving access to primary and preventive care, decreasing potentially avoidable admissions, decreasing potentially avoidable readmissions, decreasing potentially avoidable complications, increasing self-management skills and increasing adherence to self-care plans.

Challenges:

A major challenge will be changing the behaviors of families who have used emergency services for low-complexity care. This challenge will be addressed through the use of health literacy principles, language and culturally appropriate approaches through the use of community health workers who reside in the community and understand the customs and speak the language. A second challenge will be recruiting sufficient numbers of staff who are bilingual and multicultural. Children's is the pediatric training site for many student health care training programs. Bilingual and culturally diverse students will be identified through the relationships developed during the training at Children's and then recruited after the student training is completed.

5-Year Expected Outcome for Provider and Patients:
The five-year expected outcomes of the project include: increase in the number of children with all recommended well-child visits, increase in children receiving immunizations on schedule, increase in availability of same-day or next-day sick visits, reduction in the inappropriate emergency department use and reduction in overall cost of health care for children in Tarrant County.

Starting Point/Baseline:
The baseline for this project is the hours of operations of MyChildren's locations in Tarrant County at the beginning of DY1.

Rationale:
The project is data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance (lack of after-hours access).

The demand for pediatric primary care services for children on Medicaid and CHIP, which are both accessible and convenient for patient families, exceeds the available capacity, thus limiting health care access for many low-level acute care management or chronic conditions. Emergency departments are treating high volumes of pediatric patients with preventable conditions or conditions that are suitable to be addressed in a primary care setting. Additionally, many pediatric primary care physicians accept a limited number of the Medicaid/CHIP/uninsured population and may have limited or no extended hours, ultimately even further restraining the capacity of many families to access important primary care services. Between 2000 and 2010, the percentage of Texas doctors accepting Medicaid patients decreased from 67% to 31%. In the North Texas Corridor, almost 40% of children either have no health insurance or insurance with limited access (Medicaid and CHIP).

Project Components:

Project 1.1 Establish more primary care clinics contains core project components. As noted above, we will not be using component (A), expand clinic space but will increase capacity through components (B) expand clinic hours and (C) expand primary care staffing.

Milestones and metrics are based on relevancy to the RHP 10's pediatric population, the community needs for additional pediatric primary care and the baseline data of non-emergent emergency department use by children.

Unique community need identification numbers the project addresses:

- CN. 1 Lack of provider capacity.
- CN. 2 Shortage of primary care services.
- CN. 10 Overuse of emergency department (ED) services.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The project will significantly enhance the current supply of pediatric primary care and lessen the burden of care in current Federally Qualified Health care Centers and other centers which serve children covered by Medicaid and CHIP.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

OD-9 Preventive and Primary Care. IT-.9.2 ED appropriate utilization. (Stand-alone measure)

This measure was selected because the project is designed to support appropriate utilization of ED services and improve the health of low-income children. By expanding the hours for pediatric primary care and by providing a 24 hour nurse triage phone line, patients and families will have access to care outside of the ED during evenings, nights and weekends. Literature suggests that families using a nurse triage line report up to an 86% reduction in seeking ED care after using a nurse triage telephone line. Anecdotally, parents of younger children and new parents tend to seek more medical care for their infants and young children. MyChildren's patient panels tend to be younger children so there is a potential for even greater impact in reduction of inappropriate use of ED services.

Relationship to Other Projects:
This project is related to the other projects submitted by Children's Medical Center in Pass 2 for RHP 10:

1.2 Implement Disease Management

1.3 Expand Pediatric Behavioral Health

2.1 Expand/Enhance Medical Homes

These projects all enhance the services provided in a community-based pediatric medical home dedicated to providing primary and secondary medical services to children in RHP 10 covered by Medicaid and CHIP.

Related Category 4 population-focused improvements

RD-1 Potentially Preventable Admissions

RD-2 30-day readmissions

RD-3 Potentially Preventable Complications

RD-4 Patient-centered Health care

-RD-6 Initial Core Set of Health Care Quality Measures

By providing additional access to primary care through extended hours and use of a 24/7 RN triage phone line, potentially preventable admissions, 30-day readmissions and potentially preventable complications can all be reduced. Patient-centered health care measures should improve by increasing customer satisfaction. Emergency department efficiency should improve with less low-complexity illness in emergency departments. The core set of health care measures should improve for the children covered by Medicaid and CHIP who access care through improvements made with this project.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

This project was valued using a Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals 4
- Addresses Community Needs 2
- Project Investment 1
- Project Scope 1
- Value Weight of the Project 8

Each point of the scale was given a value of $187,500 based on expected savings, improved outcomes and improved satisfaction with the health care system over the life of the project and beyond the life of the project as all patients are pediatric with expected savings to continue into adulthood. The overall project value was then divided between Category 1 and 3 based on HHSC-provided guidelines with Category 4 being allotted the maximum 15% in later years by reporting on Optional Domain 6.

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138910807.1.1	1.1.2	COMPONENTS B AND C	EXPAND PEDIATRIC PRIMARY CARE
Children's Medical Center of Dallas			138910807
Related Category 3 Outcome Measure(s):	**138910807.3.1**	**IT--9.2**	**ED appropriate utilization (Stand-alone 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]**:** 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 Rationale/Evidence: Expanded hours not only allow for more patients to be seen, but also provide more choice for patients. Goal: Expanded hours offered by 9/30/13. Data Source: Clinic documentation **Milestone 1 Estimated Incentive Payment *(maximum amount):* $159,375** **Milestone 2** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites.	**Milestone 3** [P-7]: Establish a nurse advice line and/or primary care patient appointment unit. Metric 1 [P-7.1]: Documentation of nurse advice line and/or primary care patient appointment unit. Rationale: In many cases patients are unaware of the appropriate location and timing to seek care for urgent and chronic conditions. Implementation of a nurse advice line allows for primary care to be the first point of contact and offer clinical guidance around how to mitigate symptoms, enhance patient knowledge about certain conditions and seek timely care services. Goal: RN advice line implemented by 9/30/14 Data Source: Documentation of advice line and appointment unit implementation, operating hours and triage policies. Advise line system logs, triage algorithms and appointment unit operations/ policies. Estimated patient served: approximately 730	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Total number of visits for reporting period Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care. Goal: 200 total additional visits from baseline Data Source: Registry, EHR, claims or other Performing Provider source **Milestone 4 Estimated Incentive Payment *(maximum amount):* $262,500**	**Milestone 5** [I-13]**:** Enhanced capacity to provide urgent care services in the primary care setting. Metric 1 [I-13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or an urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rates Numerator: number of patients receiving urgent care appointment within 2 days of request Denominator: number of patients requesting urgent care appointment. Rationale: Identifying patient flow as it relates to urgent care needs allow Performing Providers to tailor staffing, triage protocols and service hours to best address patient needs and increase capacity to accommodate both urgent and non-urgent appointments. Goal: 300 urgent care after hours additional visits from baseline Data source: Registry, EHR,

138910807.1.1	1.1.2	COMPONENTS B AND C	EXPAND PEDIATRIC PRIMARY CARE
Children's Medical Center of Dallas			138910807
Related Category 3 Outcome Measure(s):	138910807.3.1	IT--9.2	ED appropriate utilization (Stand-alone 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)
Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. Goal: 2 new staff trained by 9/30/13 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 2 Estimated Incentive Payment *(maximum amount):* $159,375**	**Milestone 3: P-7. Estimated Incentive Payment *(maximum amount):* $281,250**		claims or other Performing Provider scheduling source **Milestone 5 Estimated Incentive Payment *(maximum amount):* $97,500** **Milestone 6** [I-14]: Increase the number of patients served and questions addressed on the nurse advice line. Demonstrate improvement over prior reporting period. Metric 1 [I-14.1]: Number of patients served by the nurse advice line. Demonstrate improvement over baseline rates. Numerator: number of unique records created from calls received to the nurse advice line. Denominator: total number of calls placed to the nurse advice line (distinct from number of calls answered). Rationale/Evidence: This measure will indicate how many calls are addressed successfully as well as an

138910807.1.1	1.1.2	COMPONENTS B AND C	EXPAND PEDIATRIC PRIMARY CARE
Children's Medical Center of Dallas			138910807
Related Category 3 Outcome Measure(s):	138910807.3.1	IT--9.2	ED appropriate utilization (Stand-alone 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)**
			overall call abandonment rate. Abandonment rate is the percentage of calls coming into a telephone system that are terminated by the person originating the call before being answered by a staff person. It is related to the management of emergency calls. This metric speaks to the capacity of the nurse advice line. Goal: Average 3 calls per night Data Source: Automated data from call center **Milestone 6 Estimated Incentive Payment *(maximum amount):* $97,500**
Year 2 Estimated Milestone Bundle Amount: $318,750	**Year 3 Estimated Milestone Bundle Amount: $281,250**	**Year 4 Estimated Milestone Bundle Amount: $262,500**	**Year 5 Estimated Milestone Bundle Amount: $195,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,057,500			

Project Option 1.3.1 – Implement and Utilize Pediatric-Specific Disease Management System Functionality

Unique Project ID: 138910807.1.2 (Pass 2)

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine (Region 10). Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. There is one MyChildren's office in Grapevine (Region 10). Annually, Children's has approximately 600,000 patient contacts. Children's has the largest market share for pediatrics in the DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured). The payor mix for MyChildren's Grapevine is 75% Medicaid, 15% CHIP, 5% Self-pay (uninsured) and 5% commercially insured. Combined percentage of children in the schools with school-based clinics who are eligible for free or reduced price lunches (similar income guidelines as for Medicaid and CHIP eligibility) is 55%.

Intervention: The purpose of this project is to implement a disease management program at the MyChildren's location and in school-based primary care settings in RHP 10. It is a new initiative.

Need for the project: The need for this project is documented in the community needs assessment, specifically: CN. 1 Lack of provider capacity, CN. 2 Shortage of primary care services, CN. 3 Shortage of specialty care, CN. 8 Lack of access to healthcare due to financial barriers, CN. 10 Overuse of emergency department (ED) services, CN. 11 Need for more care coordination, CN. 12 Need for more culturally competent care to address unmet needs. CN. 13 Necessity of patient education programs and CN. 15 Need for more education, resources and promotion of healthy lifestyles.

Target population: Children in RHP 10 covered by Medicaid and CHIP who have chronic diseases. Estimated number of patients to be served over course of waiver period: 13,200 patient contacts. Provide disease management to children with chronic diseases resulting in the best management of chronic disease with the least cost and minimal disruption of daily life for these children and their families.

Estimated patients by year:	DY3: 540	DY4: 1,050	DY5: 1,320	
Estimated contact per patient year:	DY3: 3	DY4: 4	DY5: 5.6	
Estimated patient contacts per year:	DY3: 1600	DY4: 4,200	DY5: 7,400	total 13,200

Category 1 and 2: Process and improvement milestones were selected to support the successful implementation of the project.

Category 3: OD-9 Preventive and Primary Care. IT-3.9.3 Pediatric/Young Adult Asthma Emergency Department Visits. (Stand alone measure) This measure was selected because the project is designed to support appropriate management of asthma and reduce the use of ED services for asthma management. Studies have shown a more than 50% reduction in future ED use for asthma management by patients enrolled in an asthma management program. While other chronic diseases such as obesity and diabetes will also be targeted by this project, asthma

accounts for the highest volume and greatest percentage of ED visits at Children's emergency rooms for any chronic illness.

Project Option 1.3.1 – Implement and Utilize Pediatric-Specific Disease Management System Functionality

Unique Project ID: 138910807.1.2 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807

Project Description:
Expand the implementation of Children's Medical Center's (CMC's) disease management programs into CMC's primary care setting in Tarrant County and in other selected primary care settings such as school-based settings.

Goals and Relationship to Regional Goals:
Children's Medical Center (CMC) has seven Joint Commission Disease-Specific Certified disease management programs; however, resources, infrastructure and technology have been severely limited, and therefore, CMC is able to care for only a very small percentage (<1%) of chronic disease management patients in Tarrant County. The goal of this project is to expand the CMC-certified disease management programs capacity to treat more patients, to provide the infrastructure and support needed to accomplish standardized, evidence-based chronic illness management in the primary care setting including school-based health clinics, and implement the infrastructure that supports the Regional goals of patient population health, panel management and coordination of care.

Project Goals:

- Expand the CMC-certified disease management programs in the community ambulatory settings
- Design care coordination strategies that are designed to optimize care across a continuum, including home, school and community settings
- Design culturally appropriate patient/family self-management programs for chronic illness management
- Incorporate electronic registries, predictive modeling, decision support and social awareness systems that are pediatric-specific and family-focused into team-based practice settings
- Incorporate and maintain evidence-based standards in the pediatric disease management programs

Estimated patients by year:	DY3: 540	DY4: 1,050	DY5: 1,320	
Estimated contact per patient year:	DY3: 3	DY4: 4	DY5: 5.6	
Estimated patient contacts per year:	DY3: 1600	DY4: 4,200	DY5: 7,400	total 13,200

This project meets the following Regional goals:
This project is related to the Regional goals of improving access to primary and preventive care, decreasing potentially avoidable admissions, decreasing potentially avoidable readmissions,

decreasing potentially avoidable complication, increasing self-management skills, increasing adherence to self-care plans and increasing the availability of primary and preventive services.

Challenges:
A major challenge will be changing patient/family behaviors to improve and maintain the health of children with chronic illnesses. Training patients/families in self-management of their own health is a challenge for any population of chronically ill patients. Another challenge will be the ability to risk-adjust the population and tailor the interventions to achieve the best outcomes with limited resources. These challenges will be addressed by using behavior change science, health literacy principles, language and culturally appropriate approaches and the use of community health workers who reside in the community, understand the customs and speak the language. State-of-the-art, evidence-based software will be used for risk-adjusting the population and identifying the children who are appropriate for enrollment in disease management programs and identifying the children who are at highest risk.

5-Year Expected Outcome for Provider and Patients:
Implementing and utilizing pediatric-specific disease management system functionality is a prerequisite for many of the improvements targeted by pediatric medical home initiatives to prevent disease, minimize unnecessary exacerbation of chronic illness, train patients/families in effective behavior change and self-management techniques and maintain a higher state of well-being across the family. Additionally, pediatric-specific disease management programs that are electronically supported and integrated consistently across the continuum of care can keep children out of the emergency department, specialist clinics and inpatient beds. The expected result will be decreased ED visits, decreased specialty clinic visits and decreased preventable admissions/readmissions/complications (PPAs, PPRs and PPCs).

Starting Point/Baseline:
Baseline will be number of patients from Tarrant County enrolled in program during DY1.

Rationale:
The project is data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance (lack of coordination of care for chronic disease management).

Effective and accessible pediatric-specific chronic disease management programs have been shown to have a measurable impact on quality of life, reducing the risk and consequences of worsening health conditions and reducing the need for unnecessary ED visits, specialist visits and inpatient admissions/length of stay (LOS).

In 2006, at the Public Health Forum, held in Austin, it was reported that one in three children in Texas can be considered overweight or obese. Additionally, the racial disparity of higher diabetic-related deaths in African-Americans demonstrated in the adult population is also present among children. According to the Dallas Morning News, "those of Mexican ancestry, for example, are nearly twice as likely to have diabetes as non-Hispanic whites." With the association of diabetes and obesity there is also concern of the future trajectory as low-income preschool obesity within the Dallas/Fort Worth Metropolitan Statistical Area was 17.2% in 2009, placing many young children at higher risk of developing diabetes in later years. Finally, the Community Needs Assessment Report documented increasing rates of many chronic diseases, including but not limited to asthma and diabetes.

According to Children's Medical Center data, between 2000 and 2010, the number of Children's Medical Center admissions of youth with a primary or secondary diagnosis of asthma increased by 15%.

Project Components:
The project components will include:

a. Enter patient data into unique chronic disease registry
b. Use registry data to proactively identify, contact, educate and track patients by disease status, risk status, self-management status, self-management status, community and family need
c. Use registry to develop and implement targeted QI plan
d. Conduct quality improvement or 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 the expansion of the project, including special considerations for safety net populations.

These components were selected because they provide a logical framework for successful completion of the project.

Milestones and metrics are based on relevancy to the RHP 10's pediatric population, the community needs for disease management and the capabilities to develop a community-based disease management program.

Unique community need identification numbers the project addresses:

- CN. 1 Lack of provider capacity
- CN. 2 Shortage of primary care services
- CN. 3 Shortage of specialty care
- CN. 8 Lack of access to health care due to financial barriers

- CN. 10 Overuse of emergency department (ED) services
- CN. 11 Need for more care coordination
- CN. 12 Need for more culturally competent care to address unmet needs
- CN. 13 Necessity of patient education programs
- CN. 15 Need for more education, resources and promotion of healthy lifestyles

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will significantly increase the number of pediatric patients enrolled in disease management programs in RHP 10.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
OD-9 Preventive and Primary Care. IT-9.3 Pediatric and Young Adult Asthma Emergency Department Visits. (Stand-alone measure)

This measure was selected because the project is designed to enable effective management of pediatric asthma, which will support appropriate utilization of ED services for pediatric and young adult asthma. Studies have shown a more than 50% reduction in future ED use for asthma management by patients enrolled in an asthma management program. While other chronic diseases such as obesity and diabetes will also be targeted by this project, asthma accounts for the highest volume and greatest percentage of ED visits at Children's emergency rooms for any chronic illness.

Relationship to Other Projects:
1.1 Expand Access to Pediatric Care

1.3 Expand Pediatric Behavioral Health

2.1 Expand/Enhance Medical Homes

This project supports and reinforces the other projects that Children's is proposing in RHP 10 by providing the infrastructure to manage the difficult and challenging patients with chronic diseases.

Related Category 4 population-focused improvements
RD-1 Potentially Preventable Admissions

RD-2 30-day readmissions

RD-3 Potentially Preventable Complications

RD-4 Patient-centered Health care

-RD-6 Initial Core Set of Health Care Quality Measures

By providing increased disease management services to children in Tarrant County, potentially preventable admissions, 30-day readmissions and potentially preventable complications can all be reduced. Patient-centered health care measures should improve by increasing customer satisfaction. Emergency department efficiency should improve with fewer poorly managed pediatric patients with chronic disease. The core set of health care measures should improve for the children covered by Medicaid and CHIP whose chronic diseases are better managed through improvements made with this project.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

This project was valued using a Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals 5
- Addresses Community Needs 5
- Project Scope 4
- Project Investment 2
- Value Weight of the Project 16

Each point of the scale was given a value of $187,500 based on expected savings, improved outcomes and improved satisfaction with the health care system over the life of the project and beyond the life of the project as all patients are pediatric with expected savings to continue into adulthood. The overall project value was then divided between Category 1 and 3 based on HHSC-provided guidelines with Category 4 being allotted the maximum 15% in later years by reporting on Optional Domain 6.

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Lieu TA, Quesenberry CO, Sorel ME, Mendoza GR & Leong AB. Prediction models to support cost-effective disease management of pediatric asthma. *Pediatric Research* (1997) 41, 78–78; doi:10.1203/00006450-199704001-00471.

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138910807.1.2	*1.3.1*	*1.3.1 A, B, C, D*	**Implement and Utilize Pediatric-Specific Disease Management System Functionality**
Children's Medical Center			138910807
Related Category 3 Outcome Measure(s):	***138910807.3.2***	*IT-9.3*	*Pediatric and Young Adult Asthma Emergency Department Visits*

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]: Review current registry capability and assess future needs. Metric 1 [P-2.1]: Documentation of review of current registry capability and assessment of future registry needs. a. Numerator: number entered into the registry;0 if documentation is not provided, 1 if it is provided; b. Denominator: total patients with the target condition; Rationale/Evidence: Used to determine if the necessary elements for a chronic disease registry are in place for optimal care management. Necessary elements may include inpatient admissions, emergency department visits, test results, medications, weight, activity level changes and/or diet changes. Goal: Review complete by 9/30/13 Data source: EHR systems and/or other performing provider documentation.	**Milestone 3** [P-4]: Implement/expand a functional disease management registry. Metric 1 [P-4.1]: Registry functionality is available in X% of the Performing Provider's sites and includes an expanded number of targeted diseases or clinical conditions. a. Numerator: Number of sites with registry functionality b. Denominator: Total number of sites Rationale/Evidence: Utilization of registry functionalities helps care teams to actively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which should improve rates of preventive care. Having the functionality in as many sites as possible will enable care coordination for patients as they access various services throughout a Performing Provider's facilities. Registry use can be targeted to clinical conditions/diseases most pertinent to	**Milestone 5** [I-16]: Increase the number of patient contacts recorded in the registry relative to baseline rate. Metric 1 [I-16.1]: Total number of in-person and virtual (including email, phone and web based) visits, either absolute or divided by denominator. a. Numerator: Number of patient contacts recorded in the registry b. Denominator: Number of targeted patients in the registry ("targeted" as defined by Performing Provider) Rationale/evidence: help physicians and other members of a patient's care team identify and reach out to patients who may have gaps in their care. Goal: - 4 patient contacts per year by 9/30/15 Data source: Internal clinic or hospital records/documentation **Milestone 5 Estimated Incentive Payment *(maximum amount):*** $262,500 **Milestone 6** [I-17]: Use the registry to	**Milestone 7** [I-18]: Perform routine follow-up monitoring to ensure adherence to the disease management program Metric 1 [I-18.1]: As measured by the # of patients adhering to the recommended program regimen compared to the total number of patients following a program regimen – using the patient registry a. Numerator: Number of patients of a certain target group involved in disease management programs. b. Denominator: Total number of patients in the target group or the clinic. Rationale/Evidence: Improve effective management of chronic conditions and ultimately improve patient clinical indicators, health outcomes and quality, and reduce unnecessary acute and emergency care utilization. Goal: 25% of eligible patients participating in program by 9/30/16 Data Source: Internal clinic or hospital records/documentation, 330 patients

138910807.1.2	*1.3.1*	*1.3.1 A, B, C, D*	**Implement and Utilize Pediatric-Specific Disease Management System Functionality**
Children's Medical Center			138910807
Related Category 3 Outcome Measure(s):	***138910807.3.2***	*IT-9.3*	*Pediatric and Young Adult Asthma Emergency Department Visits*

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 2: P-2. Estimated Incentive Payment *(maximum amount):* -$637,500	the patient population (e.g., diabetes, hypertension, chronic heart failure). Goal: -25% of sites with functionality by 9/30/14, 1 site Data Source: Documentation of adoption, installation, upgrade, interface or similar documentation **Milestone 3 Estimated Incentive Payment *(maximum amount):*** $281,250 **Milestone 4** [P-5]: Demonstrate registry automated reporting ability to track and report on patient demographics, diagnoses, patients in need of services or not at goal, and preventive care status Metric 1 [P-5.1]: Documentation of registry automated report a. Numerator: number of patients with required information entered in the registry b. Denominator: total number of patients with target condition	identify patients and families that would benefit from targeted patient education services. Develop and implement patient and family training programs, education, and/or teaching tools related to the target patient group using evidence-based strategies such as: teach-back, to reinforce and assess if patient or learner is understanding, patient self-management coaching, medication management, nurse and/or therapist-based education in primary care sites, group classes or patients' homes and standardized teaching materials available across the care continuum. Metric 1 [I-17.2]: Development of tool for documenting the existence of patient's self-management goals in patient record for patients with chronic disease(s) at defined pilot sites(s). Goal: Tool developed by 9/30/15 Data source: administrative data **Milestone 6 Estimated Incentive Payment *(maximum amount):*** $262,500	**Milestone 7 Estimated Incentive Payment *(maximum amount):*** $390,000

138910807.1.2	*1.3.1*	*1.3.1 A, B, C, D*	**Implement and Utilize Pediatric-Specific Disease Management System Functionality**
Children's Medical Center			138910807
Related Category 3 Outcome Measure(s):	***138910807.3.2***	*IT-9.3*	*Pediatric and Young Adult Asthma Emergency Department Visits*

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)**
	Rationale/Evidence: To be meaningful for panel management and potentially for population health purposes, registry functionality should be able to produce reports for groups or populations of patients that identify clinical indicators. Goal:- 40% of patients with target condition entered by 9/30/14 Data Source: Registry, 216 patients **Milestone 4 Estimated Incentive Payment *(maximum amount):*** $281,250		
Year 2 Estimated Milestone Bundle Amount: $637,500	**Year 3 Estimated Milestone Bundle Amount: $562,500**	**Year 4 Estimated Milestone Bundle Amount: $525,000**	**Year 5 Estimated Milestone Bundle Amount: $390,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,115,000			

Project Option 1.12.2 – Enhance Community-Based Settings Where Behavioral Health Services May Be Delivered in Underserved Areas

Unique Project ID: 138910807.1.3 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine (Region 10). Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. There is one MyChildren's office in Grapevine (Region 10). Annually, Children's has approximately 600,000 patient contacts. Children's has the largest market share for pediatrics in the DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured). The payor mix for MyChildren's is 75% Medicaid, 15% CHIP, 5% self-pay (uninsured) and 5% Commercially insured.
Intervention: The purpose of this project is to bring behavioral health services into the primary care setting through the MyChildren's office in Region 10. It is a new initiative.
Need for the project: The need for this project is documented in the community needs assessment, specifically: CN. 1 Lack of provider capacity, CN. 3 Shortage of specialty care, CN. 4 Lack of access to mental health services, CN. 5 Insufficient integration of mental health care in the primary care medical system, CN. 10 Overuse of emergency department (ED) services, CN. 11 Need for more care coordination and CN. 12 Need for more culturally competent care to address unmet needs.
Target population: Children in RHP 10 covered by Medicaid and CHIP who have behavioral health needs. Estimated number of patients to be served over course of waiver period: –1700 patient contacts and 330 patients. (3% of patient panel. Studies suggest a higher incidence, however that is for older pediatric patient populations Since MyChildren's tends to see younger patients, a lower percentage was used.) Provide behavioral health services to children in the medical home setting to allow for more rapid access to behavioral health services and better coordination of behavioral and medical services for children and their families.

Year	Patients	Total Patient Contacts
DY3	280	400
DY4	300	620
DY5	330	680
Total		1700

Category 1 or 2: Process and improvement milestones were selected to support the successful implementation of the project.
Category 3 outcomes: OD-1 Primary Care and Chronic Disease Management IT-1.18 Follow-up after Hospitalization for Mental Illness. (Stand alone measure) This measure was selected based on its relevance to the project and its goals. Providing outpatient follow-up after an inpatient hospitalization for mental illness will be a vital step in the developing and maintaining the continuum of care for behavioral health and avoiding additional high-cost inpatient stays.

Project Option 1.12.2 – Enhance Community-Based Settings Where Behavioral Health Services May Be Delivered in Underserved Areas

Unique Project ID: 138910807.1.3 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807

Project Description:
Expand pediatric behavioral health capacity in the Children's primary care setting, MyChildren's, in Tarrant County to align and coordinate care for behavioral and medical illnesses to improve patient/family self-management and reduce unnecessary exacerbation of chronic illnesses. Collaborate with Timberlawn Services and other behavioral health care providers for coordination of care between medical services and behavioral health services.

Goals and Relationship to Regional Goals:
Project Goals:
The following goals address Regional needs of better coordination of care between behavioral health and medical providers and increasing access to behavioral health services.

1. Build clinical protocols with primary care physicians and psychiatrists
2. Place pediatric behavioral health capacity (social workers and psychologists) in primary care settings
3. Integrate behavioral health and medical health treatment plans into a family-focused, comprehensive and culturally appropriate approach, using a care team approach
4. Improve coordination of care between behavioral health and medical providers

1700 patient contacts and 330 patients are estimated.
This project meets the following Regional goals:
This project is related to the Regional goal of increasing access to behavioral health services and integrating mental health care into the primary care system.

Challenges:

A major challenge will be to identify, recruit and retain pediatric behavior health staff. Children's and its academic partner, UT Southwestern, have one of the country's largest pediatric psychiatry and psychology training programs in the country. Staff will be recruited from the training program. Another challenge will be the development of processes and protocols to integrate behavioral health services into the primary care setting and align/integrate behavioral health and medical services. We will work with Timberlawn Psychiatric Services, which currently provides inpatient and outpatient behavioral health services to children and adolescents in RHP 10, to assist us in overcoming the challenges noted. We will also collaborate with other behavioral health care providers in RHP 10.

5-Year Expected Outcome for Provider and Patients:

- Increase behavioral health visits in primary care center
- Transition appropriate patients from specialty mental health care to primary care
- Implement primary care-initiated behavioral health visits in primary care clinic

Starting Point/Baseline:

In 2011, there were no behavioral health services available in the MyChildren's locations. As a result, medical professionals and behavioral health professionals were treating the same children without common evidence-based protocols and without an integrated family-focused, comprehensive and culturally appropriate care team approach.

Rationale:

The project is data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance (lack of coordination of care for behavioral and medical care).

Texas ranks 50th nationally in mental health funding. Despite the strong relationship between behavioral health and medical illness related outcomes and costs, the percentage of the 200% FPL population receiving behavioral health care to primary care settings is below the national average in Texas. Children's Medical Center is not a NorthSTAR provider, and consequently, children who may be successfully served in primary care settings are referred to NorthSTAR. This results in dilution of limited NorthSTAR funds, inadequate services available to children, and coordination of care issues.

According to Beyond ABC, Growing Up in the North Texas Corridor, the number of children in the North Texas Corridor identified with a diagnosable emotional disturbance or addictive disorder has increased to approximately 9,304 in 2010. According to 2005 research conducted by the National Institute of Mental Health, half of all lifetime cases of mental illness begin by age 14. Services in the health care community frequently do not include the family-focused and comprehensive approach needed to adequately address these mental health issues. Rather, nearly

all the intensive service availability, including evidence-based programs such as multisystemic therapy, is provided through the juvenile justice system. Furthermore, the number of youth served in the juvenile justice system is increasing, as evidenced by a 17% increase in the number of children receiving psychotropic medications in juvenile detention from 2010 to 2011.

Expanded pediatric behavioral health capacity and integration with medical care in the primary care setting in a family-focused, comprehensive and culturally appropriate manner will improve access for children to behavioral health services, prevent unnecessary exacerbation of chronic illnesses, improve patient/family self-management and improve cost and quality outcomes. The result will be reduced ED visits, specialty care visits and preventable admissions/readmissions for the identified population.

Project Components:
There are no project components for this project.

The milestones and metrics for this project are based on the relevancy to RHP 10 population, the community need, RHP priority and the starting point.

Unique community need identification numbers the project addresses:

- CN. 1 Lack of provider capacity
- CN. 3 Shortage of specialty care
- CN. 4 Lack of access to mental health services
- CN. 5 Insufficient integration of mental health care in the primary care medical system
- CN. 10 Overuse of emergency department (ED) services
- CN. 11 Need for more care coordination
- CN. 12 Need for more culturally competent care to address unmet needs

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents a new initiative to bring behavioral health services into MyChildren's Medical Home Practice.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
OD-1 Primary Care and Chronic Disease Management

IT-1.18 Follow-up after Hospitalization for Mental Illness. (Stand-alone measure)

This measure was selected based on its relevance to the project and its goals. Providing outpatient follow-up after an inpatient hospitalization for mental illness will be a vital step in developing and maintaining the continuum of care for behavioral health and avoiding additional

high-cost inpatient stays. By specifically targeting timely outpatient follow-up after an inpatient stay for mental illness, additional processes and resources will be dedicated to provide timely outpatient follow-up.

Relationship to O - ther Projects:
1.1 Expand Access to Pediatric Care

1.2 Expand Disease Management Services

2.1 Expand/Enhance Medical Homes

Related Category 4 population-focused improvements:
RD-1 Potentially Preventable Admissions

RD-2 30-day readmissions

RD-3 Potentially Preventable Complications

RD-4 Patient-centered Health care

RD-5 Emergency Department

RD-6 Initial Core Set of Health Care Quality Measures

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

This project will participate in the Region's Learning Collaborative activities. Please refer to Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of all participating provider projects for each collaborative.

Project Valuation:
This project was valued using a Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals 2
- Addresses Community Needs 4
- Project Scope 1
- Project Investment 1
- Value Weight of the Project 8

Each point of the scale was given a value of $187,500 based on expected savings, improved outcomes and improved satisfaction with the health care system over the life of the project and beyond the life of the project as all patients are pediatric with expected savings to continue into

adulthood. The overall project value was then divided between Category 1 and 3 based on HHSC-provided guidelines with Category 4 being allotted the maximum 15% in later years by reporting on Optional Domain 6.

References

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Smith JP, Smith GC. Long-term economic costs of psychological problems during childhood. *Social Science & Medicine*, v. 71, no. 1, July 2010, p. 110-115.

138910807.1.3	*1.12.2*	*NO COMPONENTS*	**Expand Behavioral Health care Capacity**
Children's Medical Center			**138910807**
Related Category 3 Outcome Measure(s):	***138910807.3.3***	***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-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. Goal: Project plan completed by 9/30/13 Data Source: Project Plan **Milestone 1Estimated Incentive Payment *(maximum amount):*** $159,375 **Milestone 2** [P-4]: Hire and train staff to operate and manage projects selected.	**Milestone 3** [P-3]: Develop administrative protocols and clinical guidelines for projects selected. Metric 1 [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines Goal: Protocols and Guidelines developed by 9/30/13 Data Source: Administrative protocols; Clinical guidelines **Milestone 3 Estimated Incentive Payment *(maximum amount)*:** $140,625 **Milestone 4** [P-6]: Establish behavioral health services in new community-based settings in underserved (targeted) areas. Metric 1 [P-6.1]: Number of new community-based settings where behavioral health services are delivered Goal: 1 new setting Data Source: Number of patients served at these new community-based sites	**Milestone 5** [I-11]: Increase utilization of community behavioral health care Metric 1 [I-11.1] Percent utilization of community behavioral health care services. Numerator: Number receiving community behavioral health care after access expansion. Denominator: Number of people eligible for receiving community behavioral health services after access expansion. Goal: 25% patients referred receive the service., 75 patients Data source: Claims data and encounter data **Milestone 5 Estimated Incentive Payment *(maximum amount):*** $262,500	**Milestone 6** [I-12]: Use of Emergency Department Care by individuals with mental illness or substance use disorders. Metric 1 [I-12.1]: X% decrease in inappropriate utilization of Emergency Department. Numerator: total number of individuals receiving services through expanded access sites who inappropriately use emergency department. Denominator: total number of individuals receiving services through expanded access sites Rationale: see project description. Goal: Percentage decrease to be determined in DY2 Data Source; Claims data and encounter data from ED and expanded access sites Requires additional definition of patient cohort before establishing percentage decrease. **Milestone 6: I.12. Estimated Incentive Payment *(maximum amount):*** $195,000

138910807.1.3	*1.12.2*	*NO COMPONENTS*	**Expand Behavioral Health care Capacity**
Children's Medical Center			**138910807**
Related Category 3 Outcome Measure(s):	***138910807.3.3***	***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)**
Metric 1 [P-4.1]: Number of staff secured and trained Goal: 3 staff hired and trained for the MyChildren's System by 9/30/13 Data Source: Project records; Training curricula as develop in P-2 **Milestone 2 Estimated Incentive Payment *(maximum amount):*** $159,375	**Milestone 4 Estimated Incentive Payment *(maximum amount):*** $140,625		
Year 2 Estimated Milestone Bundle Amount: $318,750	**Year 3 Estimated Milestone Bundle Amount:** $281,250	**Year 4 Estimated Milestone Bundle Amount:** $262,500	**Year 5 Estimated Milestone Bundle Amount:** $195,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,057,500			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 1.7.1 – Telemedicine for Children Recovering From Severe Burns

Unique Project ID: 138980111.1.1

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.

Intervention: The project establishes a Telemedicine (Telehealth) Clinic based at the UNTHSC Department of Pediatrics to provide follow-up services to children from North and West Texas who are recovering from burns and who require the expertise available at the Shriners Burn Hospital in Galveston. This project is a new initiative for UNTHSC.

Need for the project: The project goals include: improving the overall health of the population being served, improving the health care experience (quality of care), and providing the best care possible while reducing health care costs over time. The UNTHSC campus with consultation and care directed by the Shriners Burn Team in Galveston, offers a unique opportunity for patients to receive their care much closer to home, will reduce transportation and care costs, emergency room utilization and re-hospitalizations.

Target population: Children from North and West Texas who are recovering from burns and who require the expertise available at the Shriners Burn Hospital in Galveston. It is estimated that more than 100 patients will be served over the course of the waiver period. Eighty-four percent of the target population receives Medicaid or lacks health insurance coverage.

Expected patient benefits: The project will provide a unique children's patient population with a greater opportunity at health, student, and family success. It will ensure the availability of treatment before illnesses become more expensive to treat for both Medicaid and those needing health care services without insurance.

Category 1 or 2 expected patient benefits: Category 1 or 2 milestones selected for project? How do they tie into project's purpose? This project will implement a telemedicine program, increase number of telemedicine visits by 25 by DY4 and - 100 by DY5 over baseline and achieve improvements in access to care of patients receiving telemedicine/ telehealth services by reducing wait times to 12 days by DY4 and 10 days by DY5 -.

Category 3 outcomes:

i. IT 6.1 Our goal is to improve patient satisfaction with getting timely care, appointments and information by 10% by - 5% over the baseline in DY 4 and 10% by DY 5.
ii. IT 9.2 Our goal is to decrease inappropriate ED utilization for target population by -. 5% over the baseline in DY4 and 10% by DY 5.
iii. IT 1.1 Our goal is to improve time to third next available appointment by -. 5% over the baseline in DY4 and 10% by DY 5.

iv. IT 10.1 Our goal is to improve Quality of Life scores by - 2.5% over the baseline by DY4 and 5% by DY5.

Project Option 1.7.1 – Telemedicine for Children Recovering From Severe Burns

Unique Project ID: 138980111.1.1

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:

The intent of this project is to establish a Telemedicine (Telehealth) Clinic based at the UNTHSC Department of Pediatrics in order to provide follow-up services to children from North and West Texas who are recovering from burns and who require the expertise available at the Shriners Burn Hospital in Galveston. The patients will have been cared for initially in Galveston and then released home, anticipating frequent follow-up visits at Galveston.

Goals and Relationship to Regional Goals:

Project Goals:

The immediate purpose is to provide follow-up burn care, facilitated by Telemedicine services, so that these children may remain closer to home, have fewer absences from school and their parents from work, and to be able to utilize resources at UNTHSC to enhance opportunities for recovery and rehabilitation from disabilities induced by severe burns. The patient visits will occur in UNTHSC clinic(s) equipped to interact with the Burn Team at Shriners Children's Hospital, Galveston.

Many of these children and families may also lack a primary care medical home for delivery of other preventive health care services. The program will reduce avoidable emergency department visits. A medical home for the patient and the entire family can assist with recovery and provide the necessary coping skills.

This project meets the following Regional goals:

The UNTHSC campus, with consultation and care directed by the Shriners Burn Team in Galveston, offers a unique opportunity for patients to receive their care much closer to home. The development of such a capability will fulfill an unmet community need in the care of patients surviving severe burns. Transportation and care, emergency department utilization, and rehospitalization may all be reduced by this proposed partnership between UNTHSC and the Shriners Burn Hospital. The project will accomplish assessment of identified needs, including outpatient follow-on care needs of severely burned children, other pediatric children specialty care needs currently unmet in the Region, provision of care coordination and transition, and emergency department care reduction.

Challenges:

Providing specialty and follow-up medical care to severely burned children, improving the lives of the children as they recover, assisting the family with care coordination, and at the same time reducing costs associated with their care are critical to the success of this project. Currently the North Texas area does not offer children who suffer severe burns follow-up care.

According to Marcin et al., a pre-telemedicine medical needs survey demonstrated several barriers in access to subspecialty care (traveling, missing work, relying on the ED and medication regulation).[106] Overall satisfaction with the telemedicine program was very high in the study.[107] Other studies demonstrate that care is easier to obtain, there was a lower incidence of missed appointments, and satisfaction with reduced travel time. As a result, patients were willing to return to future telemedicine clinic sessions.[108, 109, 110]

According to Nguyen et al., total cost for 1,000 telemedicine follow-up visits for burn care were $145,522, averaging $146 per visit.[111] In 2002, Redlick et al. reported patients' telemedicine consultations were completed in only 2.7 hours (including travel time to site, waiting in the clinic, seeing the specialist, and returning home). The average expense per patient including meals, transportation, parking, hotel and child care was $16.66 for a telemedicine consult, which was considerably less than patient's estimated average cost of $615.74 for an out-of-town consultation.[112] Additionally, Mertens et al. reported in a study of patient satisfaction and cost effectiveness that families of burned children reported an average savings of $16. per visit in child care and transportation savings of $145. Furthermore, in a series of burned children, Resendez et al. reported the average travel time for a hospital visit was 9.75 hours versus 1.64 hours for the telemedicine clinic, which resulted in a decrease in cost to the caregiver.[113]

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[106] Marcin JP, Ellis J, Mawis R, Nagrampa E, Nesbit TS, Dimand RJ. Using telemedicine to provide pediatric subspecialty care to children with special health care needs in a underserved rural community. *Pediatrics* 113: (1) January 2004.

[107] Ibid.

[108] Gustke S.S., Balch DC, West V, Rogers LO. Patient satisfaction with telemedicine. *Telemedicine Journal* 6:(1) July 2004.

[109] Mertens DM, Kagan RJ, Warner P. Telemedicine: patient satisfaction and cost-effectiveness. *Journal Burn Care and Research* 27:(2): S142, March 2006.

[110] Resendez D, Serghiou M, McCauley R. Improving patient satisfaction through the delivery of burn telemedicine clinics. *Journal Burn Care and Research* 33:(2): S138, April 2012.

[111] Nguyen LT, Massman NJ, Franzen BJ, Ahrenholz DJ, Sorensen NW, Mohr WJ, Solem LD. Telemedicine follow up of burns: Lessons learned from the first thousand visits. *Journal Burn Care and Research* 25:(6), 2004.

[112] Redlick F, Roston B, Gomez M, Fish J.S. An initial experience with telemedicine in follow up burn care. *Journal of Burn Care and Research* 23:(2), 2002.

[113] Op. cit. Mertens.

5-Year Expected Outcome for Provider and Patients:

- Provide telemedicine services for children recovering from severe burns, to allow them to be evaluated long distance by the Burn Team at Shriners Children's Hospital, Galveston by increasing visits 10% each year.
- Reduce travel costs and inconvenience of frequent follow-up trips from North Texas to Shriners Burn Hospital by attaining a 10% or higher increase in patient satisfaction scores over baseline.
- Reduce unnecessary emergency department and hospital visits for burn patients by at least 10% from DY3 levels.
- Determine other possible pediatric telemedicine needs for North Texas with an additional specialty service for children established in addition to outpatient telemedicine burn care.
- Provide pediatric telemedicine specialty care to children in the Region by linking with an additional clinic location.
- Provide third next available appointment within 10 days of request.
- Improve patient satisfaction scores in getting timely care, appointment and information by 10% over baseline.

Starting Point/Baseline:

Based upon information provided by the Shriners Burn Hospital, we anticipate that the majority of these patients will be eligible for Medicaid. There are over 100 patients currently active who have been treated recently in Galveston, but reside in the North Texas area. Currently patients are followed up for care at quarterly visits for one year after discharge. This would equate to approximately 300 to 400 encounters for this initial active patient population based upon their time after discharge. We anticipate that the success of this initiative could lead to expansion of telemedicine services to involve other children with special needs as well as the establishment of a network involving smaller communities in rural Texas with limited resources. Baseline data will be collected in DY3.

The project will also increase the number of telemedicine and telehealth clinics in North Texas by at least one site. This will require identification of children's specialty medical needs in the urban and rural areas of North Texas, identifying physician and staff, and linking of additional locations. Patient and Parent satisfaction improvements can be based on CGCAHPS pre-and post-survey results. Other value based cost savings will also be determined using pre- and- post baseline data.

Rationale:

This project was selected based on the evidence base described in 3.c above as well as the following factors:

- American Family Physician, (62:(9)v. 2000) "Ambulatory Management of Burns" states burns can cause death, disfigurement, and lifelong dysfunction. Postambulatory burn care follow-up can lessen impacts.
- National Institutes of Health supports research in burn care follow-up that prevents complications and improves the recovery process.
- Trends in medical home show that centered and coordinated care may improve health outcomes once patients select a single source of management for their health care and rehabilitation needs. UNTHSC Department of Pediatrics can provide these services for our North Texas pediatric burn patients.
- Improving Patient Satisfaction Through the Delivery of Burn Telemedicine Clinics (Resendez et al.) Proceedings of the American Burn Association 44th Annual Meeting, April, 2012) shows high patient satisfaction with this innovative model of treatment.

Project Components:

The core project components include:

a) provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications; and

b) conduct quality improvement 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.

The milestones and metrics contained in the plan allow us to meet the goal of providing these services within RHP 10 while ensuring access to the highest level of specialty care. Quality Milestone P-3 was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.2 – Shortage of primary care services
- CN.3 – Shortage of specialty care
- CN.7 – Need to address geographic barriers that impede access to care

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

This project is a new initiative and has not been funded by any other federal funds.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
Outcome Measure 1: IT-6.1 (1) Patient Satisfaction percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information
Improvement Target: 10% increase over baseline in patient satisfaction as measured by CGCAHPS survey on patient's overall health status/functional status.
Rationale: Children's burns account for many hours of care and follow-up visits lasting months to years (children under 5 account for almost 20% of all burn cases in the U.S.). Successful treatment outcomes and patient satisfaction are correlated. When the patient and parents are satisfied with the medical care and service they receive, they are more likely to follow treatment plans, complete treatments and not drop out of care.
Outcome Measure 2: IT-9.2 ED Appropriate Utilization
Decrease inappropriate use of emergency departments by target population.
Improvement Target: 10% decrease in inappropriate emergency department visits over baseline.
Rationale: This measure was selected because partnerships; a regular source of care; assistance in navigating the health care system; education on illnesses; and continuity of care offer the potential to encourage appropriate use of care and improve the health of project patients while lowering costs.

Outcome Measure 3: IT-1.1 Third next available appointment
Improvement target is to decrease time to third next available appointment by 10% over baseline
Rationale: Improvement efforts are focused on developing the most efficient scheduling systems that can meet the needs of children with severe burns and their families. The third next available appointment is the industry standard for measuring appointment access. Reducing how long a patient waits to be seen is a key to improved health care.

Outcome Measure 4: IT-10.1 Quality of Life
Demonstrate improvement in quality of life (QOL) scores.
Improvement Target: 5% improvement over baseline for patients receiving intervention.
Rationale: If patients and parents participate in a coordinated multidisciplinary burn care program, the patient has the greatest chance of a satisfying long-term outcome. Improved quality of life improves the patients' ability to integrate back into a social and school environment, which is very difficult after a severe burn. Improving quality of life scores allow burn survivors and their caregivers to become integrated back into their community and assures a high quality of life and life success.

Relationship to Other Projects:

N/A

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value was calculated on four outcomes, which included (1) Third next available appointment, (2) Patient satisfaction percent improvement over baseline of patient satisfaction scores, (3) ED appropriate utilization, and (4) quality of life.

a. For third next available appointment, UNT Health Science Center defined the population that will be directly impacted by the project as severely burned patients in North Texas requiring burn follow-up care services, which would be approximately 100 patients. We anticipate that all of the population will be positively impacted by a 10% decrease in time to third next available appointment, -.

   Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,183 (Baylor Health Care System data)-.

   For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which was valued at $237 for each positive outcome realized.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect",

due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For patient satisfaction percent improvement over baseline of patient satisfaction scores, UNT Health Science Center defined the population that will be directly impacted by the project as severely burned patients in North Texas requiring burn follow-up care services, which would be approximately 100 patients. We anticipate that we will test the entire population, and expect to increase the patient satisfaction scores for the project by 10%,

Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $13 (per General Services Administration's federal per diem rates, as well as information provided by UNT Health Science Center's Department of Pediatrics), which was based on two percent of the expected reduced cost of each estimated travel occurrence, in addition to the reduced cost of lost productivity for both school and work-.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which was valued at $11 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

c. For ED appropriate utilization, UNT Health Science Center defined the population that will be directly impacted by the project as severely burned patients in North Texas requiring burn follow-up care services, which would be approximately 100 patients. The percentage of improvement expected by the project is 10%, equating to 10 lives positively impacted by this outcome

Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,500 due to the patient population mix -.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $1,200 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved with the project.

d. For quality of life, UNT Health Science Center defined the population that will be directly impacted by the project as severely burned patients in North Texas requiring burn follow-up care services, which would be approximately 100 patients. We anticipate testing the entire population and expect to increase the quality of life scores by 5%, -.

Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,510 (as cited in the articles, "Relationships between Quality of Life Questionnaire (QLQ) and the SF-36 among young adults burned as children" in the journal, *ScienceDirect* and "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention -. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all

projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.1.1	***1.7.1***	***1.7.1.(A-B)***	*Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region -Telemedicine for Children Recovering From Severe Burns*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.2* *138980111.3.3* *138980111.3.4* *138980111.3.1*	*3.IT- 6.1(1)* *3.IT- 9.2* *3.IT 10.1* *3.IT 1.1*	*Patient Satisfaction percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information.* *ED appropriate utilization* *Quality of Life* *Third next available appointment*

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 needed specialties that can be provided via telemedicine Metric 1 [P-1.1]: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel Baseline/Goal: Completed needs assessment Data Source: Program records Milestone 1 Estimated Incentive Payment *(maximum amount):* $85,996 **Milestone 2** [P-2]: Conduct needs assessment to identify needed services that could be delivered via telehealth Metric 1 [P-2.1]: Needs assessment Baseline/Goal: Completed needs assessment	**Milestone 4** [P-3]: Implement or expand telemedicine program for selected medical specialties based upon Regional and community need Metric 1 [P-3.1]: Documentation of program materials including implementation plan, vendor agreements, contracts, staff training and HR documents Baseline/Goal: Program materials documented Data Source: Program records Milestone 4 Estimated Incentive Payment *(maximum amount):* $89,713 **Milestone 5** [P-8]: Create plan to monitor and enhance Internet use for telemedicine/ telehealth program Metric 1 [P-8.1]: Documentation of expansion of services utilizing the	**Milestone 7** [I-12]: Increase number of telemedicine visits for each specialty identified as high need Metric 1 [I-12.1]: Number of telemedicine visits Goal: -Increase telemedicine visits by 25 over baseline by DY4. Data Source: Program records Milestone 7 Estimated Incentive Payment: $95,972 **Milestone 8** [-**Milestone 8** [I-18] Implement interventions to achieve improvements in access to care of patients receiving telemedicine/ telehealth services using innovative project option.-Goal: 12 days to appointment Data Source: Documentation of target	**Milestone 10** [I-12]: Increase number of telemedicine visits for each specialty identified as high need Metric 1 [I-12.1]: Number of telemedicine visits Goal: -Increase telemedicine visits by 100 over baseline by DY5. Data Source: Program records Milestone 10 Estimated Incentive Payment: $92,726 **Milestone 11** -**Milestone 11** [I-18] Implement interventions to achieve improvements in access to care of patients receiving telemedicine/ telehealth services using innovative project option.-Goal:10 days to appointment -Data Source: Program Records

138980111.1.1	***1.7.1***	***1.7.1.(A-B)***	*Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region -Telemedicine for Children Recovering From Severe Burns*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.2* *138980111.3.3* *138980111.3.4* *138980111.3.1*	*3.IT- 6.1(1)* *3.IT- 9.2* *3.IT 10.1* *3.IT 1.1*	*Patient Satisfaction percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information.* *ED appropriate utilization* *Quality of Life* *Third next available appointment*

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)
Data Source: Program records Milestone 2 Estimated Incentive Payment *(maximum amount):* $85,996 **Quality Milestone 3** [P-11-]: 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. Metric 3 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 3 Estimated Incentive	Internet as a medium Baseline/Goal: Documented plan Data Source: Program records Milestone 5 Estimated Incentive Payment *(maximum amount):* $89,713 **Quality Milestone 6** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes	population reached Milestone 8 Estimated Incentive Payment: $95,972 **Quality Milestone 9** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 9 Estimated Incentive	Milestone 11 Estimated Incentive Payment: $92,726 **Quality Milestone 12** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 12 Estimated Incentive Payment: $92,726

138980111.1.1	***1.7.1***	***1.7.1.(A-B)***	*Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region -Telemedicine for Children Recovering From Severe Burns*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.2* *138980111.3.3* *138980111.3.4* *138980111.3.1*	*3.IT- 6.1(1)* *3.IT- 9.2* *3.IT 10.1* *3.IT 1.1*	*Patient Satisfaction percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information.* *ED appropriate utilization* *Quality of Life* *Third next available appointment*

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)**
Payment *(maximum amount):* $85,996	Milestone 6 Estimated Incentive Payment *(maximum amount):* $89,713	Payment: $95,972	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $257,988	Year 3 Estimated Milestone Bundle Amount: $269,138	Year 4 Estimated Milestone Bundle Amount: $287,915	Year 5 Estimated Milestone Bundle Amount: $278,179

138980111.1.1	***1.7.1***	***1.7.1.(A-B)***	*Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region -Telemedicine for Children Recovering From Severe Burns*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.2* *138980111.3.3* *138980111.3.4* *138980111.3.1*	*3.IT- 6.1(1)* *3.IT- 9.2* *3.IT 10.1* *3.IT 1.1*	*Patient Satisfaction percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information.* *ED appropriate utilization* *Quality of Life* *Third next available appointment*

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)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,093,219			

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 1.1.3 – Community-Based Primary Care for the Elderly
Unique Project ID: 138980111.1.2
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.

Intervention: This project is a community-based geriatric primary care model to reach Medicaid eligible elders as well as childless adult "near elders" (ages 50-64), who are not receiving medical care through project 138980111.1.3 by development and implementation of mobile teams and clinics in order to reduce hospitalizations, increase access to care and improve patient quality of life. This is a new initiative for UNTHSC that utilizes mobile teams and clinics to increase access to care. Patients requiring intensive geriatrician management will be referred to project 138980111.13 and those suffering from depression will be referred to project 138980111.1.6 for treatment. The outcomes of this project will be measured independently of other geriatric-related projects.

Need of the project: This project will improve access to ongoing preventive, primary and chronic care which is a major Region 10 goal by focusing on a key population, low-income seniors, which the community health needs assessment has found to be the population experiencing the highest growth rate, as well as the costliest.

Target population: Medicaid eligible elders and near elders residing in RHP 10. Estimated 20,476- Medicaid eligible elders and near elders who are residing in RHP 10.

Expected patient benefits: This project will have tremendous benefit to the Medicaid and Uninsured of RHP 10 by providing appropriate levels of care within the community where the patients live. By providing regular medical contact to older adults with multiple chronic conditions, we will increase access to care, improved health, and reduce cost burden to CMS.

Category 1 or 2 expected patient benefits:
This project will increase access to care by generating four mobile teams and opening two community-based clinics.

Category 3 outcomes:

v. IT 2.12- Our goal is to reduce all cause admission rates for target population by 3% in DY4 (15 admission prevented) and 5% by DY5 (25 admissions prevented) as measured by Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions.
vi. IT 3.1 Our goal is to reduce all cause 30 day readmission rates by 5% (5 re-admissions prevented) in DY4 and 10% (10 re-admissions prevented) in DY5 for target population -.
vii. IT 6.1 Our goal is to improve patient satisfaction scores for patient's involvement with shared decision making by 10% by DY4 and 15% by DY5 among all 3,071 patients.

viii. IT 10.1 Our goal is to improve Quality of Life scores for target population by 5% over baseline by DY4 and 10% over baseline by DY5 among all 3,071 patients.

Project Option 1.1.3 – Community-Based Primary Care for the Elderly

Unique Project ID: 138980111.1.2

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:

Project Area: Expand Primary Care Capacity

Project Intervention: Expand Mobile Clinics

We propose a community-based geriatric primary care model to reach Medicaid-eligible elders as well as childless adult near elders (ages 50-64) through development and implementation of mobile clinics. Medical teams, led by physician assistants (PAs) or nurse practitioners (NPs) that incorporate community health workers (CHWs) and others (pharmacy, physical therapy, social work), will provide appropriate levels of care to patients within community settings and clinics who are not currently receiving services based on their individual needs. Appropriate referrals to the UNTHSC Division of Geriatrics will be provided (project 138980111.1.3). This enhancement of geriatric primary care services will expand encounters to a significant portion of Medicaid-eligible elders within Tarrant County and RHP 10.

Goals and Relationship to Regional Goals:

Project Goals:

The project goal is to implement community-based medical models for Medicaid-eligible elders in RHP 10 using mobile clinics, community-based clinics, nurse advice line, and urgent-based primary care appointments to (1) increase access to care, (2) increase access to urgent care, (3) reduce all-cause hospital admissions, (4) reduce 30-day hospital readmissions, (4) improve overall patient satisfaction, (5) improve patient satisfaction with involvement in medical decision making, and (6) improve patient quality of life.

This project meets the following Regional goals:

A major goal of the Region is to improve access to ongoing preventive, primary and chronic care. This project will contribute to achieving that goal by focusing on a key population, low-income seniors, which the Community Health Needs Assessment has found to be the population experiencing the highest growth rate, as well as the costliest.

Challenges:

A 2009 report titled "Addressing the Needs of Older Adults in Tarrant County" identified access to providers as a key barrier for elders in the community, which is consistent with many other areas of Texas and the U.S. Low-income and underserved adults and elders rarely have access to geriatric primary care services, and suffer from higher rates of chronic medical conditions (e.g., diabetes, hypertension) that, without regular care, can escalate to acute episodes, poorer health status and lower quality of life. Additionally, Medicaid-eligible elders suffer from increased health burden, are less educated, and have lower access to care. As of June 2012, there were

20,476 Medicaid-eligible patients in RHP 10. The goal of this project is to establish mobile clinics consisting of NPs and CHWs along with PT, social work and pharmacy, to provide appropriate levels of care for a minimum of 15% (3,071 patients) of all Medicaid-eligible elders in Tarrant County and RHP 10 -. By overcoming the access to care barrier, we expected to significantly impact the health of Medicaid elders and near elders of RHP 10.

5-Year Expected Outcome for Provider and Patients:
The five-year expected outcomes are to (1) provide geriatric primary care services to 15% (3,071) of Medicaid-eligible elders in RHP 10, (2) reduce all-cause hospital admissions by 5% (25 admissions), (3) reduce all-cause 30-day readmission rates by 10% over baseline (10 readmission), - (4-) increase patient satisfaction with involvement in medical decision making 15% and (5-) increase quality of life (QOL) by 10%.

Starting Point/Baseline:
As of June 2012, there were 20,476 senior and near senior patients in RHP 10, which is a sizable number of elders, with the aging segment of the community continuing to grow. This project will target a minimum of 15%, or 3,071 patients, of the Region's senior and near senior population by DY5. The Division of Geriatrics currently serves approximately 2.5% of this population, and these patients are not necessarily receiving ongoing care. We currently have some providers trained in the team-based, chronic care and medical home models, but we will also hire over 20 FTEs as part of this project's goal to greatly enhance services. The baseline time period is DY2.

Rationale: The U.S. population is aging at a rapid rate; however, the availability of geriatric primary care services is not expanding at the same rate. UNTHSC has a unique ability to meet the aging needs of Tarrant County with aging being a particular strength of UNTHSC. This project builds on existing strengths to enhance access to geriatric primary care services in order to meet the emerging medical needs of our community. Provision of such services at the community level will afford optimal management of chronic medical conditions and improve quality of life through a more cost-effective system. The milestones and metrics were specifically chosen for monitoring and ensuring program effectiveness.

Project Components:
No core project components are required for this project area. Core activities include: (1) expand primary care community-based clinic space for elders for RHP 10, (2) identify and address language access needs and/or gaps in language access, (3) increase self-management training to patients, (4) hire and train staff to use the UNTHSC registry reports to develop and implement targeted QI plan.

Our milestones were chosen to measure primary care expansion for this population. Specifically: (1) we are adding over 20 FTEs to staff and support four newly established mobile teams and (2) the two new community-based clinics. As a result of these capacity expansions, we will be able to demonstrate improved access to primary care for this population, measured by the number of unique patient encounters above baseline. Quality Milestone P--10 was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.1 Lack of provider capacity
- CN.2 Shortage of primary care services
- CN.7 Need to address geographic barriers that impede access to care
- CN.8 Lack of access to health care due to financial barriers
- CN.9 Need for increased geriatric, long-term, and home care resources
- CN.10 Overuse of emergency department (ED) services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

Outcome Measure 1: IT 2.12- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions.
Improvement goal is 10% reduction (25 admissions prevented) in hospital admissions due to PQI composite measure by the end of the Waiver period.

-Numerator: All unplanned hospital admissions from PQI composite measure among patients receiving services from the project entitled Community-Based Primary Care for the Elderly in DY4/DY5.
Denominator: All hospitalized Medicaid eligible elders and near elders receiving services from the project entitled Community-Based Primary Care for the Elderly in DY4/DY5
Data Source: program records/EMR/Claims records
Rationale: According to the CDC 2010 estimates, approximately 16% of those 65 and above will experience a hospital stay within a 12 month timeframe and the percentage increases to 21% for those ages 85 and over. Medicaid eligible elders are more likely to experience hospital admission owing to chronic illnesses and comorbidities. Additionally, it has been proposed that upwards of 40% of hospital admissions are avoidable. Our mobile clinics will address this need.

Outcome Measure 2: IT 3.1 All-cause 30-day readmission rate – NQF 1789: 1 All-cause 30-day readmission rate for Medicaid-eligible elders 65 and near elders receiving services from the

project titled Community-Based Primary Care for the Elderly. Improvement goal is 10% reduction (10 readmissions prevented) in all-cause 30-day readmission rate by the end of the Waiver period.

Numerator: All unplanned all-cause 30-day readmission of Medicaid eligible elders and near elders receiving services from the project entitled Community-Based Primary Care for the Elderly in DY4/DY5.
Denominator: All hospitalized Medicaid eligible elders and near elders receiving services from the project entitled Community-Based Primary Care for the Elderly in DY4/DY5
Data Source: program records/EMR/Claims records
Rationale: Approximately 20% of Medicaid eligible elders are readmitted to hospitals within 30-days of discharge, which is a significant financial drain that also reduces overall quality of life. By providing care to 15% of the Region's senior and near senior population through implementation of our mobile teams and community-based clinics, we propose to reduce 30-day readmissions, thereby providing a substantial cost savings.

Outcome Measure 3: IT 6.1 Percent improvement over baseline of patient satisfaction scores: Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Improvement goal is 5%.

(1) Are getting timely care, appointments, and information; (**Stand-alone measure**)
(2) How well their doctors communicate; (**Stand-alone measure**)
(3) Patient's rating of doctor access to specialist; (**Stand-alone measure**)
(4) Patient's involvement in shared decision making, and (Stand-alone measure)
(5) Patient's overall health status/functional status. (**Stand-alone measure**)

Rationale: Prior work has shown that patient perception of involvement in medical decision making and medical care is directly related to outcomes (Brody et al 1989). The Consumer Assessment of Health Plans Survey (CAHPS) module on Patient/Caregiver Experience – Shared Decision Making will be administered prior to receiving a clinic visit by the community-based mobile clinics for baseline perception based on prior medical experiences. The questionnaire will be administered again after clinic visit and again at follow-up visits to determine the improvement in patient perception of involvement in shared decision making experienced from receiving care through the community-based medical model. This Category 3 improvement target complements and expands on our Category 1 milestones significantly.

Outcome Measure 4: IT 10.1 Quality of Life – Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool (SF-36), for the target population.

Rationale: Prior work shows how quality of life and health status have reciprocal relationships. In fact, the Oregon Health Insurance Experiment (Finkelstein 2011) demonstrated that enrollment in Medicaid had a significant beneficial impact on quality of life, health care utilization (including preventive care measures and hospitalizations),

and overall medical expenditures and debt when compared to the control group with no insurance. By implementing this community-based medical model, we propose to improve quality of life by 10% over baseline. We will achieve this improvement by providing medical services through mobile teams and community clinics, nurse advice lines, and acute care along with continuity of care processes utilizing community health workers. Improved QOL will translate to significant improvement in a broad range of health outcome measures as outlined above and result in a significant cost savings over the course of the project.

Relationship to Other Projects:

138-980111.1.3 Expand Primary Care Capacity – Expand Existing Primary Care Capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid-eligible Elders. The project titled Community-Based Primary Care for the Elderly will support this effort by referring patients with complex needs requiring regular direct care from geriatricians, and will enable the Geriatric Clinic to refer less complex cases to the community-based model for maintenance and follow-up. These projects will work in tandem to provide appropriate level of care targeted to the specific patient's needs.

138-980111.2.5 Implement/Expand Care Transitions Program – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid-eligible elders. The project titled Community-Based Primary Care for the Elderly will reinforce this project by providing a referral mechanism for patients without regular primary care providers. Upon discharge, patients who do not receive regular follow-up from a primary care provider can be referred to the community-based program for regular care and follow-up, utilizing the evidence-based care transitions implemented. 138980111.1.6 – The current project does not provide behavioral treatment for mental health disorders, therefore patients suffering from depression will be referred to project 138980111.1.6 for depression treatment and management. The goals of this project will be measured independently of all other geriatric-related projects.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at

the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value was calculated on four outcomes, which included (1) All-Cause 30-day Readmission Rate, (2) Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions, (3) Improving Patient Satisfaction Scores and (4) Quality of Life.

a. For All Cause 30 day Readmission Rate, UNT Health Science Center defined the population that will be directly impacted as Patients receiving services from the project titled Community-Based Primary Care for the Elderly who have been admitted to a hospital. It is anticipated that approximately 500 patients will be hospitalized annually. Based on various literature, it is estimated that 20% (or 100) of the target population will be readmitted within 30 days. The percentage of improvement - expected by the project is 10%, equating to 10 lives positively impacted by this outcome.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,491 (TX Dept. of State Health Services data).-The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions, UNT Health Science Center defined the population that will be directly impacted as approximately 3,071 patients receiving services from the project titled "Community-Based Primary Care for the Elderly." Based on various literature, it is anticipated that approximately 500 of those patients will be admitted to a hospital. The percentage of improvement expected by the project - is 5%, equating to 25 lives positively impacted by this outcome.

   Utilizing - the pricing matrix developed by Region-10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,100.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an

additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

c. For Patient Satisfaction Percent Improvement Over Baseline of Patient Satisfaction scores, UNT Health Science Center defined the population that will be directly impacted by the project as 3,071 individuals who will receive services through this project. We are anticipating that we will - test the entire population and are expecting to increase the patient satisfaction scores of patient's involvement in shared decision making by 15%.

   Utilizing, - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $16 (per article "BMC Medicine Research" in the journal BioMed Central), which is based on two percent of the expected reduced cost of mobile healthcare.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

d. For Quality of Life, UNT Health Science Center defined the population as the 3,071 individuals who will receive services through the project titled Community-Based Primary Care for the Elderly. We anticipate that we will survey the entire population and expect to increase quality of life scores by 10% for patients receiving services through this project.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,755(as cited in the article "Cost –effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial", in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained to the intervention. -This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an

additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.1.2	*1.1.3*	*N/A*	*Expand Primary Care Capacity – Expand Mobile Clinics – 1.1.3 – Community-Based Primary Care for the Elderly*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*138980111.3.40* *138980111.3.6* *138980111.3.7* *138980111.3.8*	*3.IT 2.12* *3.IT 3.1* *3.IT 6.1* *3 IT 10.1*	*PREVENTION QUALITY INDICATORS (PQI) COMPOSITE MEASURES POTENTIALLY PREVENTABLE HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS* *ALL-CAUSE 30-DAY READMISSION RATE* *PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES* *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-5]: Train/hire additional primary care providers and staff for mobile teams Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline/Goal: Documentation completed hiring of personnel (n=20) Data Source: Program Records Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,572,710 **Milestone 2** [P-7]: Establish a nurse advice line and primary care patient appointment unit for mobile clinics providing services to Medicaid-eligible elders of Tarrant County and RHP 10 Metric 1 [P-7.1]: Documentation of	**Milestone 4** [P-3]: Implement a mobile health clinic program for Medicaid-eligible elders and childless near elders of RHP 10 Metric 1 [P-3.1]: Number of additional clinics. Baseline/Goal: Establish four mobile clinic teams for Medicaid eligible elders of RHP 10 Data Source: Program Records Milestone 4 Estimated Incentive Payment: $1,640,678 **Milestone 5** [P-2]: Implement a community-based clinics program for Medicai- eligible and childless near-elders of RHP 10 Metric 1 [P-2.1]: Number of additional clinics. Baseline/Goal: Establish two community-based clinics for	**Milestone 7**- [I-15]: Increase access to primary care capacity (using innovative project option for Medicaid-eligible elders of RHP 10) Metric 1 [I-15.1]: Increase percentage of target population reached. Goal: 10% of RHP 10 Medicaid-eligible elders will receive encounters Data Source: Program Records Milestone **7**- Estimated Incentive Payment: -$1,755,144 **Milestone 8**- [I-13]: Enhanced capacity to provide urgent care services in the primary care setting (for Medicaid-eligible elders and childless adult near elders of RHP 10 through mobile and community-based clinics)	**Milestone 10**- [I-13]: Enhanced capacity to provide urgent care services in the primary care setting (for Medicaid-eligible elders and childless adult near elders of RHP 10 through mobile and community-based clinics) Metric 1 [13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rates to be collected in DY3 as well as urgent care visits provided by mobile and community-based clinics in DY4. Goal: 50% patients requesting urgent care visits be seen within 2 calendar days by mobile clinics or

138980111.1.2	*1.1.3*	*N/A*	*Expand Primary Care Capacity – Expand Mobile Clinics – 1.1.3 – Community-Based Primary Care for the Elderly*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*138980111.3.40* *138980111.3.6* *138980111.3.7* *138980111.3.8*	*3.IT 2.12* *3.IT 3.1* *3.IT 6.1* *3 IT 10.1*	*PREVENTION QUALITY INDICATORS (PQI) COMPOSITE MEASURES POTENTIALLY PREVENTABLE HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS* *ALL-CAUSE 30-DAY READMISSION RATE* *PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES* *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)**
nurse advice line and primary care patient appointment unit for mobile and community-based clinics. Baseline/Goal: Documentation completed Data Source: Program Records Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,572,710 **Quality Milestone 3** [P-10-]: 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. Metric 1 [P-10-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings	Medicaid- eligible elders in Tarrant County and RHP 10 Data Source: Program Records Milestone 5 Estimated Incentive Payment: $1,640,678 **Quality Milestone 6** [P-10-]: 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. Metric 1 [P-10-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes	Metric 1 [13.1]: Percent patients receiving urgent care appointment in the primary care clinic (instead of having to go to the ED or urgent care clinic) within 2 calendar days of request. Demonstrate improvement over baseline rates to be collected in DY3 as well as urgent care visits provided by mobile and community-based clinics in DY4. Goal: 30% patients requesting urgent care visits be seen within 2 calendar days by mobile clinics or teams Data Source: Program Records Milestone **8**- Estimated Incentive Payment: -$1,755,144 **Quality Milestone 9**- [P-10-]: Participate in face-to-face learning at	teams Data Source: Program Records Milestone 10- Estimated Incentive Payment: -$2,542,688 **Quality Milestone 11**- [P-10-]: 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. Metric 1 [P-10-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 11-Estimated Incentive

138980111.1.2	*1.1.3*	*N/A*	*Expand Primary Care Capacity – Expand Mobile Clinics – 1.1.3 – Community-Based Primary Care for the Elderly*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*138980111.3.40* *138980111.3.6* *138980111.3.7* *138980111.3.8*	*3.IT 2.12* *3.IT 3.1* *3.IT 6.1* *3 IT 10.1*	*PREVENTION QUALITY INDICATORS (PQI) COMPOSITE MEASURES POTENTIALLY PREVENTABLE HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS* *ALL-CAUSE 30-DAY READMISSION RATE* *PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES* *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)**
Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,572,710	Milestone 6 Estimated Incentive Payment *(maximum amount):* $1,640,678	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 Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone **9**-Estimated Incentive Payment *(maximum amount)* : $1,755,145	Payment *(maximum amount):* $2,542,687
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,718,130	Year 3 Estimated Milestone Bundle Amount: $4,922,035	Year 4 Estimated Milestone Bundle Amount: $5,265,433	Year 5 Estimated Milestone Bundle Amount: $5,087,375

138980111.1.2	*1.1.3*	*N/A*	*Expand Primary Care Capacity – Expand Mobile Clinics – 1.1.3 – Community-Based Primary Care for the Elderly*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*138980111.3.40*	*3.IT 2.12*	*PREVENTION QUALITY INDICATORS (PQI) COMPOSITE MEASURES POTENTIALLY PREVENTABLE HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS*
	138980111.3.6	*3.IT 3.1*	*ALL-CAUSE 30-DAY READMISSION RATE*
	138980111.3.7	*3.IT 6.1*	*PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES*
	138980111.3.8	*3 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $19,992,974			

Attachment 1
Project Option 1.1.2 – Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elders
Unique Project ID: 138980111.1.3
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: This project will provide an enhanced medical home model and expand access to primary care and consultative services to Medicaid eligible-elders -. This project is an expansion of existing services and patients served will not overlap with those from projects 138980111.1.2 and 138980111.1.6 though it will serve as a referral source for medically complex patient seen by those programs as well as a referral source to those programs for medically stable and depressed patients.
Need of the project: A major goal of the region is to provide improved access to ongoing preventive, primary and chronic care. This project fits this goal by focusing on a key population, low-income seniors, which the community needs assessment has found to be the population experiencing the highest growth rate, as well as the costliest.
Target population: Estimated 1,013 Medicaid eligible elders of Tarrant County age 65 and above who receive services from the UNTHSC Department of Internal Medicine.
Expected patient benefits: This project is important in that Medicaid elders suffer multiple chronic conditions that effect function and quality of life and are costly to CMS when these conditions are not managed appropriately. Enhanced access to geriatric primary and services to this population will afford optimal management of co-morbid and chronic medical conditions thereby lowering costs to CMS.
Category 1 or 2 expected patient benefits: The project seeks to expand access to geriatric primary care services within the UNTHSC Department of Internal Medicine by 35% through hiring new providers and staff, adding 3 half-day clinics and expanding hours by 25% and to develop automated tracking system for measuring time to next available appointment.
Category 3 outcomes:

- IT 2.12- Our goal is to reduce all cause hospital admission rates by 5% (estimated 8 hospitalizations prevented) over baseline by DY5 as measured by Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions for those receiving intervention
- IT 6.1 Our goal is to improve patient satisfaction with getting timely care, appointments and information by 5% over baseline by DY5
- IT 3.1 Our goal is to reduce all cause 30 day readmission rates by 10% (3 re-admissions prevented) for population receiving intervention by DY5
- IT 12.4 Our goal is to improve pneumonia vaccination status for those receiving intervention by 15% (51 new vaccinations) by DY5.

Project Option 1.1.2 – Expanding Geriatric Primary Care and Consultative Services to Medicaid-Eligible Elders

Unique Project ID: 138980111.1.3
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:
Project Area: Expand Primary Care Capacity
Project Intervention: Expand existing primary care capacity
The proposal is to provide primary care and geriatric consultative services in the Geriatrics Assessment Program developed by the University of North Texas Health Science Center's Department of Medicine/Division of Geriatrics and that has operated for over 20 years. This model of assessment and care provides an enhanced medical home model for older adults and their caregivers. Social service coordinators provide the initial intake process for all new geriatrics patients, and an interprofessional team consisting of a geriatrician, physician assistant and/or nurse practitioner, nurses, medical assistants and social workers provide a comprehensive geriatrics assessment that consists of medical, psychosocial, functional, and cognitive evaluations. A patient and family conference occurs where a plan of care is developed and options for care and care coordination are discussed. Patients are then followed at least every three to four months for chronic disease management and continued care coordination. This approach has been shown to decrease hospitalizations, nursing facility admissions and improve the quality of life of older adults and their caregivers.

Goals and Relationship to Regional Goals:

Project Goals:
Access to Geriatrics Assessment Programs have shown improvement in older adults' chronic medical conditions, improved diagnosis of cognitive and functional conditions, decreased hospitalizations and improved caregiver stress and satisfaction. The five-year goals of this project are: (1) to expand access to geriatric primary care services for Medicaid-eligible elders within the UNTHSC Department of Internal Medicine by 35% through hiring new providers and staff, adding clinics and expanding hours, and (2) to facilitate access to UNTHSC Division of Geriatrics clinic through establishment of an automated tracking system measuring next available offered appointment, thereby reducing days to third next available appointment.

This project meets the following Regional goals:
A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project will contribute to achieving that goal by focusing on a key population,

low-income seniors, which the Community Needs Assessment has found to be the population experiencing the highest growth rate, as well as the costliest.

Challenges:
Recent data from the Texas Medical Association revealed that only 31% of Texas physicians will accept new Medicaid patients in 2012. These numbers are at an all-time low and this trend will greatly affect access to ambulatory clinical care for Medicaid-eligible older adults who currently number 14,791 in Tarrant County, based on data from the Texas Department of Health and Human Services. Most older adults have at least three or more chronic conditions, and vulnerable elders will have not only medical problems, but also cognitive, functional, and psychosocial issues that affect their ability to remain independent. These older adults, and in particular the Medicaid-eligible, require more frequent access to medical care and services and utilize emergency department and hospital services more often.

5-Year Expected Outcome for Provider and Patients:
By expanding UNTHSC Division of Geriatrics clinic capacity, this project will: (1) increase access to geriatric primary care services for Medicaid-eligible elders within the UNTHSC Department of Internal Medicine by 35% through hiring new providers and staff, adding clinics and expanding hours, and (2) facilitate access to UNTHSC Department of Internal Medicine/Division of Geriatrics Clinic through establishment of automated tracking system measuring next available appointment, thereby reducing days to third next available appointment, (3) reduce all-cause hospital admission rates for patients receiving intervention by 5% over baseline, (4) reduce all-cause 30-day readmission rates by 10% over baseline, (5) increase patient satisfaction scores in getting timely care, appointments and information by 5% over baseline, and (6) improve pneumonia vaccination status for older adults receiving intervention by 15% over baseline.

Starting Point/Baseline:
This project is designed to increase access to geriatric primary care services for Medicaid-eligible elders through expanding capacity of the UNTHSC Department of Internal Medicine/Division of Geriatrics. Baseline data on the number of patients meeting eligibility criteria will be collected in DY3.

Rationale:
The UNTHSC Geriatric Assessment Program (GAP) Program has been a very successful model of ambulatory geriatrics care that is ripe to be expanded to the Medicaid-eligible geriatrics patients in Tarrant County who are having difficulty accessing medical care, let alone the necessary specialty of geriatrics comprehensive assessment and care.

Project Components:

To achieve the goals of this project, which involve expanding primary care capacity, the following core components are necessary. This project contains all the core components (expand staff, hours and space).

By achieving our milestones of adding staff, we will establish additional primary care clinics and expand hours of existing clinics to enhance access to primary care services to Medicaid-eligible seniors of Tarrant County, improve pneumonia vaccination status, reduce all-cause 30-day admissions and all-cause 30-day readmission rates, and increase patient satisfaction for Medicaid-eligible seniors in Tarrant county receiving the intervention. Quality milestone P-10 was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.9 – Need for increased geriatric, long-term, and home care resources
- CN.10 – Overuse of emergency department (ED) services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome measures:

Outcome Measure 1: IT 2.12- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions - Goal is reduction in all-cause readmission rates of 3% (estimated 5 hospitalizations prevented) over baseline in DY4 and 5% (estimated 8 hospitalizations prevented)over baseline in DY5 (total reduction goal of 5% over course of project) in Medicaid-eligible elders.
Rationale: According to the CDC 2010 estimates, approximately 16% of those 65 and above will experience a hospital stay within a 12-month time frame and the percentage increases to 21% for those ages 85 and over. Medicaid-eligible elders are more likely to experience hospital admission owing to chronic illnesses and comorbidities. Additionally, it has been proposed that upwards of 40% of hospital admissions are avoidable. By enhancing access to geriatric primary care to those patients seen by the UNTHSC Department of Internal Medicine, we seek to reduce admissions among this population.

Outcome Measure 2: IT 6.1 Percent improvement over baseline of patient satisfaction scores: Percent improvement over baseline of patient satisfaction scores for one or more of the patient

satisfaction domains that the provider targets for improvement in a specific tool (for this project, we are measuring patient satisfaction with getting timely care, appointments and information. Goal is 5% improvement for all 1,013 patients.
Rationale: A sizable literature supports the notion that patient satisfaction with medical care has direct impact on patient outcomes as well as clinical quality and operation performance. In fact, these are related to commonly implemented quality metrics utilized by clinics throughout the U.S. We seek to improve patient satisfaction with getting timely care, appointments and information by 5% over the Waiver period. We will collect baseline data prior to and after clinic appointments. In DY4 we seek to improve patient satisfaction scores by 3% over baseline and we seek to improve satisfaction scores by 5% over baseline in DY5.
Outcome Measure 3: IT 3.1 All-cause 30-day readmission rate – NQF 1789 for Medicaid-eligible elders 65 and above who receive care from the UNTHSC Department of Internal Medicine. Improvement goal is 5% reduction (2 re-admissions prevented) in all-cause hospital readmission rate over baseline in DY4 and a 10% reduction (3 re-admissions prevented) in all-cause readmission rate over baseline in DY5 in Medicaid-eligible elders.
Rationale: Approximately 20% of Medicaid-eligible elders are readmitted to hospitals within 30 days of discharge, which drastically increases medical costs. By enhancing access to geriatric primary care for Medicaid-eligible elders receiving services within the UNTHSC Department of Internal Medicine, we propose to reduce 30-day readmissions by 10% by the end of the Waiver period for the target population. This reduction in readmissions will result in a significant cost savings.

Outcome Measure 4: IT 12.4 Pneumonia vaccination status for older adults (HEDIS 2012) for Medicaid-eligible elders 65 and above who receive care from UNTHSC Department of Internal Medicine. Improvement goal is 15% increase (51 new vaccinations) in adults ages 65 and above from target population who ever received a pneumonia vaccine.
Numerator: Number of adults ages 65 and above from the target population that have ever received a pneumonia vaccine.
Denominator: Number of adults ages 65 and above in the target population.
Data source: Program records, EHR, claims
Rationale: The risk for developing pneumonia is higher among the elderly owing to chronic (often comorbid) illnesses; however, approximately 33% of elders have not received vaccination (Jackson & Janoff 2008). Pneumonia is often cited as the fifth leading cause of death among the elderly. Given the increased medical illnesses and comorbidities among our target population, they are at increased risk for pneumonia. The current project seeks to increase the percentage of elders ever receiving a pneumonia vaccine by 15% over the Waiver period (10% over baseline in DY4 [33 new vaccinations] and 15% over baseline in DY5 [51 new vaccinations]).

Relationship to Other Projects:

138-980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics -1.1.3: Community-Based Primary Care for the Elderly. The current project will support and reinforce the Community-Based Primary Care for the Elderly project by providing a referral source for complex cases requiring intensive geriatrician input and management. Such patients identified within the community will be referred to and treated by the current project. Therefore, these two projects will work in tandem to provide appropriate level of care within the most appropriate setting based on the individual patient's needs.
138-980111.2.5 Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid Eligible elders. It is anticipated that several of the patients receiving this evidence-based transitions care program will be patients of the UNTHSC Geriatric Clinic and, therefore, these projects will support one another by providing a seamless transition from acute care settings back to the primary care provider.
138980111.1.6 – the current project will not provide behavioral treatment and management for mental health conditions and, therefore, will refer all identified depressed patients to project 138980111.1.6 for treatment and management.
The goals of this project will be measured independently of all other projects.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value was calculated on four outcomes, which include (1) Prevention Quality Indicators (PQI) composite measures potentially preventable hospitalizations for Ambulatory Care Sensitive Conditions -, (2) Improving the percentage of patient satisfaction

scores over the baseline, (3) All-cause readmission rates; and (4) pneumonia vaccination status for older adults.

- For Prevention Quality Indicators (PQI) composite measures potentially preventable hospitalizations for Ambulatory Care Sensitive Conditions -, the UNT Health Science Center defined the population that will be directly impacted by - the project - as Medicaid-eligible elders of Tarrant County ages 65 and above, who receive services from the UNTHSC Department of Internal Medicine, - which would be approximately- 162 individuals. - The percentage of improvement - expected - by the project is 5%, equating to 8 lives positively impacted by this outcome

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,100 due to the patient population mix -.

  For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $4,260 for each positive outcome realized. Another additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $2,840 for each positive outcome realized.

  The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

- For all cause 30 day readmission rate, the UNT Health Science Center defined the population that will be directly impacted by the project as the number of hospitalized Medicaid-eligible elders of Tarrant Count ages 65 and above, who receive services from the UNTHSC Department of Internal Medicine, which would - be 33 - individuals. - The percentage of improvement - expected - by the project is 10%, equating to 3 lives positively impacted by this outcome -.

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,491 (Texas Department of State Health Services data) -.

  For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $4,495 for each

positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $2,996 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

- For patient satisfaction percent improvement over baseline of patient satisfaction scores, UNT Health Science Center defined the population that will be directly impacted by the project as Medicaid-eligible elders of Tarrant County ages 65 and above, who receive services from the UNTHSC Department of Internal Medicine, - which would be approximately 1,013 individuals. We are anticipating that we will test the entire population, and - are expecting to increase - the patient satisfaction scores for the project by 5%-.

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $15 (per information provided by the UNT Health Science Center's Division of Geriatrics) -.

  For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $9 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $6 for each positive outcome realized.

  The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

- For pneumonia vaccination status for older adults, UNT Health Science Center defined the population that will be directly impacted by the project as Medicaid-eligible elders of Tarrant County ages 65 and above, who receive services from the UNTHSC Department of Internal Medicine is estimated to be 1013 individuals, of which 674 have received the

vaccination. It is anticipated that approximately 15 -% or 51 - additional patients will receive the vaccination-.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $15,682 (as cited in the article "Incidence and Cost of Pneumonia in Medicare Beneficiaries" in *Chest* Journal) -.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $6,273 for each positive outcome realized. Also, additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $6,273 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.1.3	***1.1.2***	***1.1.2.A*** ***1.1.2.B*** ***1.1.2.C***	*Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elders*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	138980111.3.41 138980111.3.11 138980111.3.10 138980111.3.12	*3.IT 2.12* *3.IT 6.1* *3.IT 3.1* *3.IT12.4*	*PREVENTION QUALITY INDICATORS (PQI) COMPOSITE MEASURES POTENTIALLY PREVENTABLE HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS* *PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES* *ALL-CAUSE 30-DAY READMISSION RATE – NQF 1789* *PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS*

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-5]: Train/hire additional primary care providers and staff and/or increase the number of primary clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites Baseline/Goal: Documentation Completed Data Source: Program Records Milestone 1 Estimated Incentive Payment *(maximum amount):* $501,962 **Milestone 2** [P-8]: Develop automated tracking system for measuring time to next available offered appointment at Performing	**Milestone 4** [P-1]: Establish additional/expand existing/relocate primary care clinics for Medicaid-eligible elders. Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space for Medicaid eligible elders. Baseline/Goal: Establish 3 additional half-day provider clinics in UNTHSC Division of Geriatrics for Medicaid-eligible elders Data Source: Program Records Milestone 4 Estimated Incentive Payment: $523,656 **Milestone 5** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours Metric 1 [P-4.1]: Increased number of	**Milestone 7** [I-10]: Enhance patient access to primary care by reducing days to third next-available appointment (for Medicaid-eligible elders). Demonstrate improvement over prior reporting period (baseline for DY2) Metric 1 [I-10.1]: Third Next-Available Appointment: The length of time in calendar days between the days a patient makes a request for an appointment with a provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as reported for the most recent month. The ultimate improvement target over time would be seven calendar days (lower is better), but depending on the	**Milestone 10** [I I-10]: Enhance patient access to primary care by reducing days to third next-available appointment (for Medicaid- eligible elders). Demonstrate improvement over prior reporting period (baseline for DY2) Metric 1 [I-10.1]: Third Next-Available Appointment: The length of time in calendar days between the days a patient makes a request for an appointment with a provider/care team, and the third available appointment with that provider/care team. Typically, the rate is an average, measured periodically (weekly or monthly) as reported for the most recent month. The ultimate improvement target over time would be seven calendar days (lower is better), but depending on the

138980111.1.3	***1.1.2***	***1.1.2.A*** ***1.1.2.B*** ***1.1.2.C***	*Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elders*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	138980111.3.41 138980111.3.11 138980111.3.10 138980111.3.12	*3.IT 2.12* *3.IT 6.1* *3.IT 3.1* *3.IT12.4*	*PREVENTION QUALITY INDICATORS (PQI) COMPOSITE MEASURES POTENTIALLY PREVENTABLE HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS* *PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES* *ALL-CAUSE 30-DAY READMISSION RATE – NQF 1789* *PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS*

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)**
Provider primary care medical homes for non-urgent needs Metric 1 [P-8.1]: Documentation that providers and staff are aware of next available appointment time using real time scheduling data to ensure that patients can receive primary care services according to acuity and need Baseline/Goal: Documentation Completed Data Source: Program Records Milestone 2 Estimated Incentive Payment *(maximum amount):* $501,962 **Quality Milestone 3** [P-10-]: 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.	hours at primary care clinic over baseline for Medicaid-eligible elders. Baseline/Goal: Target is 25% increase in hours from existing clinics. Data Source: Program Records Milestone 5 Estimated Incentive Payment: $523,656 **Quality Milestone 6** [P-10-]: 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. Metric 1 [P-10-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings	Performing Provider's starting point, that may not be possible within four years. Goal: Improve days to next third available appointment by 2% over baseline Data Source: Program Records Milestone 7 Estimated Incentive Payment: $560,190 **Milestone 8** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services (for Medicaid-eligible elders) Metric 1 [I-12.2]: Documentation of increased number of visits. Demonstrate improvement over prior period Goal: 20% over baseline for DY2	Performing Provider's starting point, that may not be possible within four years. Goal: Improve days to next third available appointment by 3% over baseline Data Source: Program Records Milestone 10 Estimated Incentive Payment: $541,246 **Milestone 11** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services (for Medicaid eligible elders) Metric 1 [I-12.2]: Documentation of increased number of visits. Demonstrate improvement over prior period Goal: 35% over baseline for DY2

138980111.1.3	***1.1.2***	***1.1.2.A*** ***1.1.2.B*** ***1.1.2.C***	*Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elders*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	138980111.3.41 138980111.3.11 138980111.3.10 138980111.3.12	*3.IT 2.12* *3.IT 6.1* *3.IT 3.1* *3.IT12.4*	*PREVENTION QUALITY INDICATORS (PQI) COMPOSITE MEASURES POTENTIALLY PREVENTABLE HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS* *PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES* *ALL-CAUSE 30-DAY READMISSION RATE – NQF 1789* *PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS*

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)**
Metric 1 [P-10-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 3 Estimated Incentive Payment *(maximum amount):* $501,962	Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 6 Estimated Incentive Payment *(maximum amount):* $523,656	for Medicaid eligible elders through UNTHSC Department of Internal Medicine Clinics (FY11 baseline is approx. 750 patients; estimated 900 patients will be provided medical services) Data Source: Program Records, UNTHealth EMR Milestone 8 Estimated Incentive Payment: $560,190 **Quality Milestone 9** [P-10-]: 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. Metric 1 [P-10-.1]: Participate in semi-annual face-to-face meetings or	for Medicaid eligible elders through UNTHSC Department of Internal Medicine (FY11 baseline was approx. 750 patients; estimated 1013 patients will be provided medical services) Data Source: Program Records, UNTHealth EMR Milestone 11 Estimated Incentive Payment: $541,246 **Quality Milestone 12** [P-10-]: 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. Metric 1 [P-10-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP

138980111.1.3	***1.1.2***	***1.1.2.A*** ***1.1.2.B*** ***1.1.2.C***	*Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elders*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)				138980111
Related Category 3 Outcome Measure(s):	138980111.3.41 138980111.3.11 138980111.3.10 138980111.3.12	*3.IT 2.12* *3.IT 6.1* *3.IT 3.1* *3.IT12.4*	*PREVENTION QUALITY INDICATORS (PQI) COMPOSITE MEASURES POTENTIALLY PREVENTABLE HOSPITALIZATIONS FOR AMBULATORY CARE SENSITIVE CONDITIONS* *PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES* *ALL-CAUSE 30-DAY READMISSION RATE – NQF 1789* *PNEUMONIA VACCINATION STATUS FOR OLDER ADULTS*	
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)**
			seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 9 Estimated Incentive Payment *(maximum amount):* $560,190	Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 12 Estimated Incentive Payment *(maximum amount):* $541,246
Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,505,887	Year 3 Estimated Year 2 EstimMilestone Bundle Amount: $1,570,968		Year 4 Estimated Milestone Bundle Amount: $1,680,570	Year 5 Estimated Milestone Bundle Amount: $1,623,738
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $6,381,163				

Project Option 1.2.1 – Training Primary Care Workforce in Evolving Health Care Delivery Models

Unique Project ID: 138980111.1.4
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) /138980111

Providers: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: This project will support development of current and future primary care workforce through providing updated primary care training programs including training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement. This is a new initiative.
Need for the project: This project supports the regional goals of improved care coordination and more patient education programs by providing primary care continuing medical education to physicians, resulting in improved patient care.
Target population: Patients of the primary care workforce receiving training. Based on 10% of PCP workforce (physicians, nurses, clinical staff, etc) in RHP 10 receiving the intervention (training), it is estimated that 171 physicians will receive training and an estimated 29,534 patients enrolled in Medicaid will be impacted.
Expected patient benefits: The project is important because the Medicaid population we are targeting (those at high risk for pneumococcal infection) can result in costly admissions and readmissions if they are not appropriately assessed for immunization status or immunized.
Category 1 or 2 expected patient benefit: This project seeks to increase training to 10% (1,279) of RHP 10 PCP workforce and increase knowledge assessment scores for trainees by at least 2% over baseline by DY4 and 3% over baseline by DY5.
Category 3 outcomes:

ix. IT 11.3- Our goal is 1% improvement over baseline by DY4 and 2% improvement over baseline by DY5 in pneumococcal vaccine status for targeted population- (baseline established at beginning of project from data sources).
x. IT 9.2 Our goal is to reduce inappropriate ED usage of targeted patients by 1% over baseline by DY4 and 2% over baseline by DY5
xi. IT 12.4 Our goal is to improve pneumonia vaccination status for targeted older adults by 2% over baseline by DY4 and 3% over baseline by DY5.

Project Option 1.2.1 – Training Primary Care Workforce in Evolving Health Care Delivery Models

Unique Project ID: 138980111.1.4
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) /138980111

Project Description:
Project Area: Training of Primary Care Workforce
Project Intervention: Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement.

UNTHSC Professional and Continuing Education (PACE) will employ a series of educational activities, develop community partnerships with advocacy groups, health care service providers and area health education centers to train RHP 10's primary care workforce on emerging and evolving health care delivery models, including strategies to deploy newer effective models for improved patient outcomes, such as medical home model, chronic care model, interprofessional and team-based care, cultural competency and improved use of palliative care. This project will support the educational and skill development of the current and future primary care workforce in newer organized and effective models of health care delivery. This project will support other Medicaid Waiver projects of implementation of medical homes, chronic care models, interdisciplinary and team-based care to better manage high-risk patients with chronic disease. This project will also promote disease registries, patient panel management and QI/PI. It will establish and expand a faculty development program, increase staff and faculty participation and increase primary care training in traditional and alternative modalities, including in continuity clinics (multiple sessions). A gap analysis of the primary care workforce will be conducted. A complex, multifaceted continuing education model of continuing education, including varying types of live, online and QI/PI activities will be utilized. Multiple clinical teaching tools will be developed and disseminated for primary care and interprofessional clinics/sites.

Goals and Relationship to Regional Goals:

Project Goals:
The overall goal of this project is to increase the training of the primary care workforce in RHP 10 on evolving health care delivery models. Specific goals include:

- Conduct an assessment of 5% (639) of the primary care workforce in RHP 10.

- Enroll 5% (11) of faculty/staff into faculty development program.
- Develop and disseminate at least one clinical tool.
- Educate 10% of the PCP workforce (1,279 providers) in RHP 10 with expanded training programs.
- Improve trainee knowledge assessment scores by 2% in DY4 and 3% over DY4 in DY5.
- Improve number of staff completing courses by 2% in DY4 and 3% over DY4 in DY5.

This project meets the following Regional goals:
This project supports the Regional goals of improved care coordination and more patient education programs by providing primary care continuing medical education to physicians. Primary care training on medical home and chronic care models, and the use of disease registries will result in increased rates of pneumococcal vaccinations and reduce inappropriate ED use.

Challenges:
Changes in the health care system occur rapidly. Advances in therapies and diagnostics, clinical guidelines, data transmission and interpretation, and the understanding of efficacy and effectiveness by comparative analyses are slow to be incorporated into primary care practice, which negatively impact patient care and lead to increased costs and decreased outcomes.

5-Year Expected Outcome for Provider and Patients:
The five-year expected outcome is to update and expand primary care training programs to include training on medical home and chronic care models, disease registry use for population health management, increase enrollment of health care providers in these programs and as a result, improve the percentage of high-risk populations receiving preventive measures such as the pneumococcal vaccination, and increase patient self-management. This project will improve pneumococcal vaccinations in minority populations receiving the intervention by 2% over baseline, improve pneumonia vaccination status for older adults receiving the intervention by 3% over baseline, and reduce ED visits for target conditions by 2% over baseline.

Starting Point/Baseline:
Development, distribution and collection of Regional assessment of attitudes, beliefs and knowledge of primary care workforce in RHP 10 to determine where current gaps exist. Activities will be designed based on this collection of information, which will improve the knowledge, attitudes, competence and performance of RHP 10's primary care workforce with regard to medical home model, chronic care model, interprofessional and team-based care, cultural competency and improved use of palliative care. Impact will be assessed using a mixed-methods approach, which considers qualitative and quantitative data and information to fully realize the outcomes of the project. Outcomes will be demonstrated through better management of high-risk patients with chronic disease, particularly those with diabetes, hypertension,

congestive heart failure and asthma. According to the Texas Public Use Data File, all of these conditions are potentially preventable conditions tracked by the State. For example, according to hospitalcompare.gov, in Tarrant County, there were 2,951 hospitalizations for bacterial pneumonia in 2010, resulting in an estimated $602 million in hospital charges. On average only 76% of inpatients were assessed for or given pneumococcal vaccinations. Between October 2010 and October 2011, the three largest hospitals in the county had a combined 1,493 readmissions for pneumonia estimated to result in charges of $44.7 million. Baseline data for this project will be collected in DY3.

Rationale:
Initial hospitalizations for pneumonia will be reduced through use of newer delivery models such as the medical home. In addition, coordination of care upon hospital discharge will be improved through the use of these models. Quality, cost-effective patient care is negatively impacted by individual, clinical and systemic barriers. Often, these barriers are due to deficiencies in knowledge and competence, appropriate examples, or attitudinal predispositions. UNTHSC PACE has demonstrated its ability to use certified interdisciplinary continuing education and community partnerships to change health care provider behavior, promote the adoption of best practices and improve performance through enhanced knowledge and competence. Ultimately, patient care is improved.

Project Components:
No core project components required for this project area. Core activities include:

- Utilize a gap analysis to asses and/or measure PCP's NCQA PCMH readiness.
- Conduct educational sessions
- Implement a comprehensive, multidisciplinary intervention to address the needs of the shared, high-risk patients
- Evaluate effectiveness of PCP training

The milestones selected for this project will allow us to reach and/or measure the accomplishment of our five-year expected outcome to improve coordination of care which will positively impact patient self-management, interprofessional management and use of preventive measures such as the pneumococcal vaccination.

Unique community need identification numbers the project addresses:

- CN.11 – Need for more care coordination
- CN.13 – Necessity of patient education programs

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome measures:

Outcome Measure 1: IT-11.3- Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.
Measure: Percentage of people at high risk for infection receiving pneumococcal vaccination
Numerator: Number of people ages 18 and older at high risk for infection who have received a pneumococcal vaccination
Denominator: Number of people ages 18 and older at high risk for pneumococcal infection
Data Source: Meaningful Use Data
Rationale: The outcomes measure selected – IT-11.3-, specifically addresses gaps in care provided to the targeted population. Minority populations, especially African-Americans and Hispanics, are disproportionately underimmunized for invasive pneumococcal bacteria. Training includes modules in pneumonia prevention, including immunization. Medical home and chronic care models have been shown to improve immunizations.

Outcome Measure 2: IT-9.2 ED appropriate utilization
Reduce emergency department visits for target conditions

- Congestive heart failure
- Diabetes
- End-stage renal disease
- Cardiovascular disease/hypertension
- Chronic obstructive pulmonary disease
- Asthma

Data Source: North Texas Regional Extension Center and/or North Texas Accountable Healthcare Partnership
Rationale: The outcomes measure selected – IT-9.2 ED appropriate utilization
Reduce emergency department visits for target conditions

- Congestive heart failure
- Diabetes
- End-stage renal disease
- Cardiovascular disease/hypertension
- Chronic obstructive pulmonary disease
- Asthma

Specifically address desired results of training components, that patients receive care in the appropriate setting. Each cause of ED visits listed above is potentially preventable with

appropriate management and self-management. Appropriate training of the PC workforce can improve these aspects leading to fewer ED visits.

Outcome Measure 3: IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)

Numerator: Number of adults ages 65 and older who have ever received a pneumonia vaccine.

Denominator: Number of adults ages 64 and older in the patient or target population

Data Source: EMR, claims

Rationale: The outcomes measure selected – IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012) specifically addresses gaps in primary care, where suboptimal rates of pneumonia immunizations are administered to older patients. Training includes modules in pneumonia prevention, including immunization. Medical home and chronic care models have been shown to improve immunizations.

Relationship to Other Projects:

This project supports 138980111.2.2 – Apply Process Improvement Methodology to Improve Quality/Efficiency – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency – 2.8.1- Improving Primary Care Clinical Processes to Reduce Hospitalization Risk. Many of the providers targeted in 138980111.2.2 will also receive targeted information during this project, reinforcing the intervention and supporting the outcomes measures.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)* Specifically, this project's value was calculated on three outcomes, which include (1) improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity - (percentage of people at high risk for infection receiving

pneumococcal vaccination), (2) pneumonia vaccination status for older adults and (3) ED appropriate utilization.

a. For - Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity, UNT Health Science Center defined the - population - that will be directly impacted by the project as patients in RHP 10 who are considered high risk for infection and receive services from PCPs receiving intervention, which would be approximately 38,185. The percentage of improvement in pneumonia vaccinations for this population is expected to be 2%, equating to 764 lives positively impacted by this outcome.
   -Utilizing, - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $417 (as cited in the article, "Pneumococcal Vaccination Reduces Mortality and Costs in Elderly" in the internet journal at www.respiratoryreviews.com), -which was based on the average savings per person vaccinated.

   For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $167 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $167 for each positive outcome realized.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For pneumonia vaccination status for older adults, UNT Health Science Center defined the - population - that will be directly impacted by the project as patients in RHP 10 who are 65 and older-and receive services from PCPs receiving - intervention**,** which would be approximately 14,167. The percentage of improvement in pneumonia vaccinations for this population is expected to be 3%, equating to 425 lives positively impacted.

   Utilizing, - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $417 (as cited in the article, "Pneumococcal Vaccination Reduces Mortality and Costs in Elderly" in the internet journal at www.respiratoryreviews.com), -which was based on the average savings per person vaccinated.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $167 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $167 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

c. For ED appropriate utilization, UNT Health Science Center defined the - population - that will be directly impacted by the project as patients in RHP 10 who visit the ED and receive services from PCPs receiving - intervention-, which would be approximately 23,612 patients. The percentage of improvement by the project - is -2%-, equating to 472 lives positively impacted by this outcome.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,200 due to the patient population mix. -For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $480 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $480 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health

Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.1.4	***1.2.1***	***N/A***	*INCREASE TRAINING OF PRIMARY CARE WORKFORCE – "OTHER" PROJECT OPTION: UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT – 1.2.1:TRAINING PRIMARY CARE WORKFORCE IN EVOLVING HEALTH CARE DELIVERY MODELS*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*-138980111.3.13* *138980111.3.15* *138980111.3.42*	*-3.IT 9.2* *3.IT 12.4* *3.IT 11.3*	*-ED appropriate utilization* *Pneumonia vaccination status for older adults (HEDIS 2012)* *Improve utilization rates of clinical preventive services (testing, preventive services, treatment) 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-1]: Conduct a primary care gap analysis to determine workforce needs Metric 1 [P-1.1]: Gap assessment of workforce shortages. Baseline/Goal: Assess need of 5% (639) of PC workforce in RHP 10 Data Source: Program Records Milestone 1 Estimated Incentive Payment *(maximum amount):* $475,999 **Milestone 2** [P-8]: Establish/expand a faculty development program Metric 1 [P-8.1]: Enrollment of faculty staff into primary care education and training program	**Milestone 4** [P-2]: Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists Metric 1 [P-2.1]: Expand the primary care mid-level provider and/or other clinician/staff training programs. Baseline/Goal: Educate 10% (1279) of the PCP workforce in RHP 10 Data Source: Program Records Metric 2 [P-2.3]: Develop alternative primary care training modalities, including but not	**Milestone 7** [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.6]: Improvement in trainee knowledge assessment scores. Goal: 2% increase from baseline. Data Source: Pre and Post-Assessment Tests Milestone 7 Estimated Incentive Payment: $531,215 **Milestone 8** [I-14]: Increase the number of faculty staff completing educational courses Metric 1 [I-14.1]: Number of staff completing courses. Goal: 2% increase from baseline. Data Source: Program Records	**Milestone 10** [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.6]: Improvement in trainee knowledge assessment scores. Goal: 3% increase over DY4. Data Source: Pre -and Post-Assessment Tests Milestone 10 Estimated Incentive Payment: $513,251 **Milestone 11** [I-14]: Increase the number of faculty staff completing educational courses Metric 1 [I-14.1]: Number of staff completing courses. Goal: 3% increase over DY4. Data Source: Program Records

138980111.1.4	***1.2.1***	***N/A***	*INCREASE TRAINING OF PRIMARY CARE WORKFORCE – "OTHER" PROJECT OPTION: UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT – 1.2.1:TRAINING PRIMARY CARE WORKFORCE IN EVOLVING HEALTH CARE DELIVERY MODELS*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*-138980111.3.13* *138980111.3.15* *138980111.3.42*	*-3.IT 9.2* *3.IT 12.4* *3.IT 11.3*	*-ED appropriate utilization* *Pneumonia vaccination status for older adults (HEDIS 2012)* *Improve utilization rates of clinical preventive services (testing, preventive services, treatment) 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)**
Baseline/Goal: 5% (11) of faculty staff enrolled Data Source: Program Records Milestone 2 Estimated Incentive Payment *(maximum amount):* $475,999 **Quality Milestone 3** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas,	limited to distance/online training, alternative scheduling and education in nontraditional training settings. Baseline/Goal: Establish 4 alternative teaching methodologies Data Source: Program Records Milestone 4 Estimated Incentive Payment: $496,570 **Milestone 5** [P-9]: Develop/disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites Metric 1 [P-9.1]: Clinical teaching tool. Baseline/Goal: One tool developed and disseminated Data Source: Program Records	Milestone 8 Estimated Incentive Payment: $531,215 **Quality Milestone 9** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 9 Estimated Incentive Payment *(maximum amount):*	Milestone 11 Estimated Incentive Payment: $513,251 **Quality Milestone 12** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 12 Estimated Incentive Payment *(maximum amount):*

138980111.1.4	***1.2.1***	***N/A***	*INCREASE TRAINING OF PRIMARY CARE WORKFORCE – "OTHER" PROJECT OPTION: UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT – 1.2.1:TRAINING PRIMARY CARE WORKFORCE IN EVOLVING HEALTH CARE DELIVERY MODELS*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*-138980111.3.13* *138980111.3.15* *138980111.3.42*	*-3.IT 9.2* *3.IT 12.4* *3.IT 11.3*	*-ED appropriate utilization* *Pneumonia vaccination status for older adults (HEDIS 2012)* *Improve utilization rates of clinical preventive services (testing, preventive services, treatment) 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)**
slides from presentations, meeting notes Milestone 3 Estimated Incentive Payment *(maximum amount):* $475,999	Milestone 5 Estimated Incentive Payment: $496,570 **Quality Milestone 6** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes	$531,215	$513,251

138980111.1.4	***1.2.1***	***N/A***	*INCREASE TRAINING OF PRIMARY CARE WORKFORCE – "OTHER" PROJECT OPTION: UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT – 1.2.1:TRAINING PRIMARY CARE WORKFORCE IN EVOLVING HEALTH CARE DELIVERY MODELS*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*-138980111.3.13* *138980111.3.15* *138980111.3.42*	*-3.IT 9.2* *3.IT 12.4* *3.IT 11.3*	*-ED appropriate utilization* *Pneumonia vaccination status for older adults (HEDIS 2012)* *Improve utilization rates of clinical preventive services (testing, preventive services, treatment) 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 6 Estimated Incentive Payment *(maximum amount):* $496,570		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,427,996	Year 3 Estimated Milestone Bundle Amount: $1,489,710	Year 4 Estimated Milestone Bundle Amount: $1,593,644	Year 5 Estimated Milestone Bundle Amount: $1,539,752

138980111.1.4	***1.2.1***	***N/A***	*INCREASE TRAINING OF PRIMARY CARE WORKFORCE – "OTHER" PROJECT OPTION: UPDATE PRIMARY CARE TRAINING PROGRAMS TO INCLUDE TRAINING ON THE MEDICAL HOME AND CHRONIC CARE MODELS, DISEASE REGISTRY USE FOR POPULATION HEALTH MANAGEMENT, PATIENT PANEL MANAGEMENT, ORAL HEALTH, AND OTHER IDENTIFIED TRAINING NEEDS AND/OR QUALITY/PERFORMANCE IMPROVEMENT – 1.2.1:TRAINING PRIMARY CARE WORKFORCE IN EVOLVING HEALTH CARE DELIVERY MODELS*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*-138980111.3.13* *138980111.3.15* *138980111.3.42*	*-3.IT 9.2* *3.IT 12.4* *3.IT 11.3*	*-ED appropriate utilization* *Pneumonia vaccination status for older adults (HEDIS 2012)* *Improve utilization rates of clinical preventive services (testing, preventive services, treatment) 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $6,051,102			

Project Option 1.2.2 – Community Health Worker Network

Unique Project ID: 138980111.1.5
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: The existing CHW training offered by the UNTHSC TPHTC will be expanded to offer cross-training for CHW with basic - - case management skills as well as much needed placement assistance for CHWs who have traditionally struggled with finding employment in RHP 10. Internships with RHP 10 providers will be added to the training program. Additionally, existing partnerships with RHP 10 providers will be leveraged to facilitate job placement for newly trained CHWs. CHWs will be trained to work as part of multidisciplinary health care teams, and will be specifically well-suited to serve as frontline paraprofessionals who can spend more time with patients than physicians and nurses. CHWs most often spend their time making sure patients understand their treatment plans, scheduling needed follow-up appointments and coordinating services that may be available to patients, all with an emphasis on providing culturally competent care. Since CHWs extend the reach of typical primary care providers, they have been shown to improve patient satisfaction and quality of life, as well as patient health outcomes.
Need of the project: Given that four out of the nine counties in RHP 10 are designated Health Professional Shortage Areas and five out of the nine counties in RHP 10 are designated Medically Underserved Areas, the importance of this project cannot be overemphasized. Expanding the primary care workforce to include culturally competent community health workers will add resources to the region's health care infrastructure at relatively low cost and address the needs of provider capacity and shortage of primary care services. The addition of CHWs to the region's primary care workforce will increase the ability of RHP 10 providers to address patient's concerns and ensure appropriate and timely follow-up care, all of which will result in improved patient satisfaction and quality of life.
Target population: Low income, racial or ethnic minority or uninsured patients seen by RHP 10 providers where newly trained CHWs are placed. Estimated 2,500 patients will be served over course of waiver.
Expected patient benefits: It is expected that patient satisfaction and quality of life will improve after a CHW becomes part of the patient's health care team. CHWs will engage in personalized, culturally competent interactions with patients to communicate necessary information patients regarding their care. The addition of the CHW will provide patients with the opportunity to better understand their care and add a member to the health care team who is more accessible than physicians and nurses.
Category 1 or 2 expected patient benefits:

xii. 25% increase (8) in number of CHW rotations over baseline by DY4

xiii. 50% increase (10) in number of CHW rotations over baseline by DY5
xiv. 25% increase (4) in number of CHWs accepting positions over baseline by DY4
xv. 50% increase (8) in number of CHWs accepting positions over baseline by DY5

Category 3 outcomes:

i. IT-6.1 – 5% increase by DY4 and 10% increase by DY5 in patient satisfaction over baseline measured by CG-CAHPS survey
ii. IT-10.1 – 5% increase by DY4 and 10% increase by DY5 in quality of life measured by the SF-36

Project Option 1.2.2 – Community Health Worker Network

Unique Project ID: 138980111.1.5

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:
Project Area: Increase Training of Primary Care Workforce
Project Intervention: Increase the number of primary care providers
The existing CHW training offered by the UNTHSC TPHTC will be expanded to offer cross-training for CHW with basic - case management skills, as well as much-needed placement assistance for CHWs who have traditionally struggled with finding employment in RHP 10. Internships with RHP 10 providers will be added to the training program. Additionally, existing partnerships with RHP 10 providers will be leveraged to facilitate job placement for newly trained CHWs. CHWs will be trained to work as part of multidisciplinary health care teams, and will be specifically well-suited to serve as frontline paraprofessionals who can spend more time with patients than physicians and nurses. CHWs most often spend their time making sure patients understand their treatment plans, scheduling needed follow-up appointments and coordinating services that may be available to patients, all with an emphasis on providing culturally competent care. Since CHWs extend the reach of typical primary care providers, they have been shown to improve patient satisfaction and quality of life, as well as patient health outcomes. The service area of current UNTHSC CHW training efforts will be greatly expanded to include the entire RHP 10.

Goals and Relationship to Regional Goals:

Project Goals:
Utilizing CHWs will increase the capacity of RHP 10 providers to deliver services that are community-based, culturally competent and - designed to specifically - address the needs of vulnerable patients, and will ultimately result in improvements in - - - - patient satisfaction and quality of life. -. Evidence suggests that CHWs are particularly effective in assisting patients in accessing appropriate care and services in a timely manner, improving patient outcomes, and also, - reducing the occurrence of unnecessary complications. Our CHWs will teach their clients to maximize their use of the health care system based on training in the areas of health advocacy, service coordination, and capacity building, to name a few. Additionally, CHWs will ensure that their patients leave their appointments with a clear understanding of treatment plans and follow up care. Specifically, the result of these efforts will be more efficient use of health care services among patients working with CHWs. -Since our trainees may work with patients in a variety of health care settings and with diverse health needs, we choose to measure improvements in quality of life and patient satisfaction, rather than focusing on any particular clinical outcome.

This project meets the following Regional goals:

Given that four out of the nine counties in RHP 10 are designated Health Professional Shortage Areas and five out of the nine counties in RHP 10 are designated Medically Underserved Areas, the importance of this project cannot be overemphasized. Expanding the primary care workforce to include culturally competent community health workers will add resources to the Region's health care infrastructure at relatively low cost, and address the needs of provider capacity and shortage of primary care services. The addition of CHWs to the region's primary care workforce will increase the ability of RHP 10 providers to address patient's concerns and ensure appropriate and timely follow-up care, all of which will result in improved patient satisfaction and quality of life.

Challenges:

Community health workers (CHWs) are lay members of communities who work in association with local health care systems, academic institutions, health departments and community-based organizations. They typically share the ethnicity, language, socioeconomic status and life experiences of the community members they serve. Their primary function is to serve as liaisons between the community and the health care system and/or resources within the community. National sociodemographic changes in the past decade have resulted in a greater reliance on CHWs across many communities in the U.S. Population changes, increasing numbers of younger low-income families, provider shortages, and an increased need for language interpretation and cultural understanding in health care delivery have placed increasing demands on the health care system, and many of these demands can be efficiently met by CHWs. CHWs are considered an effective means to delivering health care and education to underserved and isolated communities.[114]

Studies using CHWs in community interventions report improved patient outcomes,[115,116,117] greater patient satisfaction,[130] and the ability to successfully explore and understand patient and family needs beyond traditional approaches.[118]

While most health care providers agree that using community health workers enhances patient care, they would also agree that hiring CHWs to become part of a multidisciplinary health care

[114] Bureau of Health Professions. Community Health Workers National Workforce Study. Available at: http://bhpr.hrsa.gov/healthworkforce/chw.
[115] Balcazar HG, Byrd TL, Ortiz M, Tondapu SR, Chavez M. A randomized community intervention to improve hypertension control among Mexican Americans: using the promotoras de salud community outreach model. J Health Care Poor Underserved. 2009;20(4):1079-94.
[116] Faucher MA, Mobley J. A community intervention on portion control aimed at weight loss in low-income Mexican American women. J Midwifery Women's Health. 2010 Jan-Feb;55(1):60-4.
[117] Balcázar H, Alvarado M, Cantu F, Pedregon V, Fulwood R. A promotora de salud model for addressing cardiovascular disease risk factors in the US-Mexico border Region. Prev Chronic Dis. 2009 Jan;6(1):A02.
[118] Berg J, Anderson NL, Tichacek MJ, Tomizh AC, Rachelefsky G. One gets so afraid: Latino families and asthma management – an exploratory study. J Pediatric Health Care. 2007 Nov-Dec;21(6):361-71.

team is not feasible because CHW services are not currently reimbursed in Texas. Blue Cross Blue Shield of Minnesota has already begun reimbursing for CHW services as part of a demonstration project and has documented marked cost-savings.[119]

The two most effective ways to build the evidence needed to convince policymakers that CHW services improve patient outcomes and are cost effective, and therefore, should be reimbursed, is to (1) create opportunities for CHWs to work within the current health care infrastructure so RHP 10 providers can see firsthand how beneficial their services can be to improving patient outcomes and reducing costs; and (2) expand CHW training beyond traditional health education to include skills that are more useful in a clinical setting (e.g., - case management).

The Texas Public Health Training Center at UNTHSC has offered CHW training for the past five years. In that time, we have trained over 50 CHWs with the 160-hour state-certified curriculum and delivered almost 2,000 hours of continuing education to CHWs on topics ranging from diabetes management to bullying to advanced care planning for older adults. We are well-positioned to expand beyond traditional CHW training because of our unique placement within a health science center. Moreover, finding placements for CHW trainees with health care providers within RHP 10 will also be facilitated by leveraging existing relationships UNTHSC and the TPHTC maintains with RHP 10 providers. Based on the existing evidence demonstrating improved health outcomes among patients participating in interventions using CHWs, our goal is to increase patient satisfaction and quality of life among patients receiving care from RHP 10 providers that incorporate CHWs into their multidisciplinary health care teams.

5-Year Expected outcome for Provider and Patients:
The five-year goals of this project are to expand the utilization of CHWs providing primary care services in RHP 10 performing providers. Specifically, this will be accomplished by expanding CHW training - to - areas that will make CHWs more useful to RHP 10 performing providers, developing mentoring programs for newly trained CHWs, increasing the number of CHW trainees to 25 per year in DY4 and DY5, and increasing the number of CHWs employed by RHP 10 performing providers to 10 in DY4 and DY5. This project will also improve patient satisfaction scores of patients' overall health status/functional status by 10% over baseline and improve quality of life scores (SF-36) by 10% over baseline.

Starting Point/Baseline:
Currently, the UNTHSC TPHTC serves as a Texas DSHS-certified CHW training site with resources allocated to handle organization, marketing, tracking, recruitment, retention, certification and compliance with DSHS - and provides training to CHWs in Tarrant County. However, access to CHW training and the services we propose are extremely limited in the

[119] Community health workers in Minnesota: Bridging barriers, expanding access, improving health. Blue Cross and Blue Shield of Minnesota. 2010.

counties beyond Tarrant in RHP 10. The proposed project will expand - the scope and volume of services provided by trained CHWs working with RHP 10 providers.

Rationale:
Several studies from the states of Massachusetts, Minnesota, Florida and Arizona have demonstrated that CHWs are effective in improving patient outcomes and reducing health care expenditures. However, data in Texas are limited since CHW services are not yet reimbursed by third party payors. Anecdotal reports of grant-funded interventions using CHWs in Texas have also shown similar results. The rationale for the enhancement of our CHW training program with case management skills and internship experiences with RHP 10 providers and the facilitation of job placement for newly trained CHWs with RHP 10 providers lies in the difficulty CHWs face when trying to secure employment with health care providers when their services are unable to be billed to third party payors. We expect that RHP 10 providers will take notice of the improvements in patient satisfaction and quality of life, as well as other clinical benefits not measured by this study, and deem the investment in CHWs worthwhile. It is also our expectation that the results of this project will contribute to the existing evidence in support of third party reimbursement of CHW services in Texas.

Project Components:
Training CHWs and equipping them with skills to be members of inter-professional teams - can not only reduce health care costs, but - can also result in improved patient outcomes, such as improved patient satisfaction and quality of life. CHWs can spend more time with patients at less cost to health care providers to ensure that patients understand their care, manage their chronic conditions and utilize the health care system effectively. The individual role of a CHW trainee placed with an RHP 10 provider will depend on the position the RHP 10 provider gives the CHW trainee. However, regardless of the specifics of the position, every CHW will enhance the health care encounter of every patient served by implementing the competencies taught in the CHW training, including health advocacy, capacity building and service coordination, to name a few.

Our milestones measure expansion of the primary care workforce. We are training new CHWs and seeking to place them in performing providers' facilities throughout RHP 10. In doing this, we will increase patient satisfaction and quality of life for the targeted population. Quality milestone P-3 was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.2 – Shortage of primary care services (e.g., pediatric, prenatal, family care)
- CN.12 – Need for more culturally competent care to address unmet needs (e.g., Latino-population need care, translators, translated materials)

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
We propose to organize and formalize CHWs in RHP 10 with the establishment of the UNTHSC Community Health Worker Academy in order to achieve the ultimate goal of improving health outcomes among RHP 10 Medicaid beneficiaries. In order to achieve these goals, the CHW Academy will provide: (1) Organization that will result in greater visibility and marketability in the Regional health care market, because the capabilities of CHWs are not well understood; (2) Training that will build on existing state-certified training, but will expand to include specialty areas of focus to make CHWs more marketable to RHP 10 providers; (3) Development, referring to cross-training with basic skills from other areas to increase CHW utility in clinical settings; (4) Facilitation of placement that is critical in this Region as most RHP 10 providers have limited experience in utilizing CHWs. A positive primary care exposure will be provided through mentorship of CHWs in training and newly trained CHWs by CHW instructors. This mentorship will include the necessary coaching to enable CHWs to perform in primary care settings. Existing models within the School of Public Health will be used to create internship/job opportunities and will be leveraged to rapidly integrate CHWs into various health care settings (e.g., hospitals, community-based clinics). This project builds upon the HRSA-funded Texas Public Health Training Center (TPHTC) and leverages existing CHW infrastructure in Tarrant County.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

b. **Outcome Measure 1:** IT-6.1(1) Patient Satisfaction
   Percent improvement over baseline of patient satisfaction scores for patients getting timely care appointments, and information.
   Improvement Target: 10% increase over baseline in patient satisfaction as measured by CGCAHPS survey on patients getting timely care appointments and information.
   Rationale: The project will add 40 CHWs and place them in performing providers' facilities throughout RHP 10. This improvement target measures the expected outcome of improved patient satisfaction.
c. **Outcome Measure 2:** IT-10.1 Quality of life
   Demonstrate improvement in quality of life scores, as measured by evidence-based and validated assessment tool (SF-36), for the target population.
   Improvement Target: 10% increase in the SF-36 score by the end of the Waiver
   Rationale: This outcome improvement target measures quality of life scores of the patients served by community health workers assigned to providers' facilities. Quality of life is a critical part of a person's health. Appraisals of quality of life may be an early indicator of changes in health, as they are often more malleable than traditional

health indicators such as cholesterol levels or hemoglobin A1c. Further, assessments of quality of life provide great insight into how a patient perceives the effect of his or her own health and its subsequent effect on overall life.

Relationship to Other Projects:

This project is related to one other project from UNTHSC. It is related to 13898011.1.2 Expand Primary Care Capacity – Expand Mobile Clinics –1.1.3: Community-Based Primary Care for the Elderly – Community-Based Primary Care for the Elderly in that this project will train the CHWs needed for the multidisciplinary teams. This project may support other projects in RHP 10 in that the following projects may utilize the training supported by this project to train patient navigators:

- Establish/Expand a Patient Care Navigation Program
- Implement Evidence-based Health Promotion Programs – Establish self-management programs and wellness using evidence-based designs

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value was calculated on two outcomes, which included (1) improving patient satisfaction scores, and (2) quality of life.

- For Patient Satisfaction Percent Improvement over Baseline of Patient Satisfaction Scores, UNT Health Science Center defined the population that will be directly impacted by the project as patients seen by providers where newly trained CHWs/promotoras are placed, which would be approximately 2,500 individuals. We are anticipating that we

will test the entire population, and are expecting to increase the patient satisfaction scores for the project by 10%.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $32 (as cited in the article, "Medicaid Savings Resulted When Community Health Workers Matched Thoses With Needs To Home and Community Care" in the journal, *Health Affairs*), which was based on two percent of the expected reduced annual Medicaid spending per participant

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

- For Quality of Life, UNT Health Science Center defined the population that will be directly impacted by the project as Patients seen by providers where newly trained CHWs/promotoras are placed, which would be approximately 2,500 individuals. We anticipate that we will test the entire population and are expecting to increase the quality of life scores by 10%,

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome would be $3,755 (as cited in the article, "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Control Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention. - This threshold has been a standard way of valuing life-terms of whether the cost of the intervention exceeds this standard.

  The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

  Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's

project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.1.5	*1.2.2*	*N/A*	*Increase Training of Primary Care Workforce – Increase the Number of Primary Care Providers – 1.2.2: Community Health Worker Network*	
University of North Texas Health Science Center (UNTHSC)				*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.16* *138980111.3.17*	*3.IT-6.1* *3.IT-10.1*	*Percent improvement over baseline of patient satisfaction scores* *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-2] : Expand primary care training for CHWs Metric 1 [P-2.1]: Expand the primary care community health workers/ promotoras training programs and/or rotations Baseline/Goal: Training program expanded to accommodate 20 additional CHWs per year Data Source: Program Records Metric 1 [P-2.2]: Hire one additional precepting primary care faculty members (CHW instructors) Baseline/Goal: TBD Data Source: Program records Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,558,618 **Milestone 2** [P-3]: Expand positive primary care exposure for residents/trainees (CHWs) Metric 1 [P-3.1]: Develop mentoring program with primary care faculty and new CHW trainees	**Milestone 4** [P-2]: Expand primary care training for CHWs Metric 1 [P-2.1]: Expand the primary care community health workers/promotoras training programs and/or rotations Baseline/Goal: Training program expanded to accommodate 20 additional CHWs per year Data Source: Program Records Metric 2 [P-2.2]: Hire additional precepting primary care faculty members (CHW instructors) as needed Baseline/Goal: TBD Data Source: Program records Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,625,977 **Milestone 5** [P-3]: Expand positive primary care exposure for residents/trainees (CHWs) Metric 1 [P-3.1]: Develop mentoring program with primary care faculty		**Milestone 7** [I-11]: Increase primary care training and/or rotations for CHWs Metric 1 [I-11.1]: Increase the number of primary care residents and/or trainees, as measured by percent change of class size over baseline or by absolute number Goal: 25% increase in the number of CHWs over baseline Data Source: Program records Metric 2 [I-11.2]: Increase the number or primary care trainees rotating at the Performing Provider's facilities Goal: 25% increase (8) in the number of CHWs over baseline Data Source: Program records Milestone 7 Estimated Incentive Payment: $1,739,417 **Milestone 8** [I-12]: Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities	**Milestone 10** [I-11]: Increase primary care training and/or rotations for CHWs Metric 1 [I-11.1]: Increase the number of primary care residents and/or trainees, as measured by percent change of class size over baseline or by absolute number Goal: 50% increase in the number of CHWs over baseline Data Source: Program records Metric 2 [I-11.2]: Increase the number or primary care trainees rotating at the Performing Provider's facilities Goal: 50% increase (10) in the number of CHWs over baseline Data Source: Program records Milestone 10 Estimated Incentive Payment: $1,680,596 **Milestone 11** [I-12]: Recruit/hire more trainees/graduates to primary care positions in Performing Provider

138980111.1.5	*1.2.2*	*N/A*	*Increase Training of Primary Care Workforce – Increase the Number of Primary Care Providers – 1.2.2: Community Health Worker Network*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.16* *138980111.3.17*	*3.IT-6.1* *3.IT-10.1*	*Percent improvement over baseline of patient satisfaction scores* *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)
Baseline/Goal: 20 CHWs trained in DY2 Data Source: Program records Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,558,618 **Quality Milestone 3** [P-11-]: 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. Metric1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,558,618	and new CHW trainees Baseline/Goal: 40 - CHWs trained in DY3 Data Source: Program records Milestone 5 Estimated Incentive Payment *(maximum amount):* $1,625,977 **Quality Milestone 6** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 6 Estimated Incentive Payment *(maximum amount):* $1,625,977	Metric 1 [I-12.1]: Percent change in the number of graduates/trainees accepting positions in the Performing Provider's facilities over baseline Goal: 25% increase (4) in the number of CHWs accepting positions over baseline Data Source: Program records Milestone 8 Estimated Incentive Payment: $1,739,417 **Quality Milestone 9** [P-11-]: Participate in face-to-face learning (i.e., meetings or seminars) at least twice per year with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Meeting participation Data Source: Documentation of semi-annual meetings including meeting agendas, presentations,	facilities Metric 1 [I-12.1]: Percent change in the number of graduates/trainees accepting positions in the Performing Provider's facilities over baseline Goal: 50% increase (8) in the number of CHWs accepting positions over baseline Data Source: Program records Milestone 11 Estimated Incentive Payment: $1,680,596 **Quality Milestone 12** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes

138980111.1.5	*1.2.2*	*N/A*	*Increase Training of Primary Care Workforce – Increase the Number of Primary Care Providers – 1.2.2: Community Health Worker Network*	
University of North Texas Health Science Center (UNTHSC)				*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.16* *138980111.3.17*	*3.IT-6.1* *3.IT-10.1*	*Percent improvement over baseline of patient satisfaction scores* *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)**
			and/or notes Milestone 9 Estimated Incentive Payment: $1,739,417	Milestone 12 Estimated Incentive Payment *(maximum amount):* $1,680,596
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,675,853	Year 3 Estimated Milestone Bundle Amount: $4,877,931		Year 4 Estimated Milestone Bundle Amount: $5,218,252	Year 5 Estimated Milestone Bundle Amount: $5,041,789
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $19,813,826				

"Other" project option: Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above –1.12.4: Community-Based Behavioral Health care for Depressed Medicaid Elders and Near Elders

Unique Project ID: 138980111.1.6 (Pass 2)

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other health care professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.

Intervention: The project will create a mobile mental health team consisting of community health workers (CHWs) and licensed mental health providers (social workers and psychologists) that will provide behavioral health services for depression to Medicaid eligible elders (65 and above) and near elders (50-64) of Tarrant County. This project is a new initiative and will provide depression treatment and management to those not receiving services. Projects 13898011.1.2, 138980111.1.3 and 138980111.2.5 do not provide mental health services and, therefore, will serve as a referral source to the current program. The goals of the current program will be evaluated independently of all other programs.

Need of the project: This project would contribute to increasing access to care by focusing on low-income seniors suffering from symptoms of depression. It is anticipated that over 5,000 Medicaid eligible elders in Tarrant County suffer from symptoms of depression at any given time.

Target population: At least 5,000 of the approximately 18,000 elders and near elders residing in Tarrant County experience depression at any given time. Estimated 1,500 patients will be served over course of waiver period.

Expected patient benefits: Depression is a major health problem for the elderly as it exacerbates medical illness and substantially increases medical cost. By providing behavioral health services (i.e. screens, therapy, referrals, case management), this project will reduce depression symptoms, improve patient quality of life and patient satisfaction with involvement in decision-making among Medicaid eligible elders and near elders suffering from symptoms of depression in Tarrant County.

Category 1 or 2 expected patient benefits:

1. 15% (750 patients) of Medicaid-eligible elders suffering from symptoms of depression utilize behavioral health service by DY4 and 30% (1,500 patients) by DY5
2. 5% decrease from baseline by DY4 and 7% decrease from baseline by DY5 in number of cancelled or no-show appointments

Category 3 outcomes:

i. IT-1.8 – Conduct depression screening and treatment planning protocols for 750 patients by DY4 and 1,500 patients by DY5

ii. IT-1.9 – 5% (75 patients) in remission at 12 months by DY4 and 10% (150 patients) in remission at 12 months by DY5

iii. IT-6.1 – 3% improvement from baseline by DY4 and 5% improvement from baseline by DY5 in patient satisfaction scores for involvement in medical decision-making for all 1,500 patients
iv. IT-10.1 – 5% increase from baseline by DY4 and 10% increase from baseline by DY5 in quality of life as measured by SF-36, for all 1,500 patients

Project Option 1.12.4 – Enhance service availability of appropriate levels of behavioral health care – "Other" project option: Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above –1.12.4: Community-Based Behavioral Health care for Depressed Medicaid Elders and Near Elders
Unique Project ID: 138980111.1.6 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/138980111

Project Description:
Project Area: Enhance service availability of appropriate levels of behavioral health care
Project Intervention: Other project option: Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above.

The project titled Community-Based Behavioral Health care for Depressed Medicaid Elders and Near Elders will create a mobile mental health team consisting of community health workers (CHWs) and licensed mental health providers (social workers and psychologist) that will provide behavioral health services for depression within Tarrant County to Medicaid-eligible elders (65 and above) and near elders (50 and above). Based on prior literature demonstrating the effectiveness of incorporating CHWs into collaborative teams for depression management (Wennerstrom 2011; Ekers 2011; Patel 2011), CHWs will deploy through existing infrastructures such as the UNT Health clinics, senior citizen centers, food banks, churches, Regional gatherings (e.g., health fairs) and in-home visits to conduct screenings and provide referrals to the social worker or psychologist team members. The intervention will follow the IMPACT model with CHWs filling the roles of providing screenings, referrals and case management with social workers and psychologist serving as the Depression Care Managers (providing counseling as needed). Together, the Depression Care Manager and CHWs will work with the patient's primary care physician for comprehensive depression treatment and management (www.impact-uw.org; Van Leeuwen et al 2009; Arean et al 2008). Psychologists and a social worker will design and implement a training program from evidence-based therapies that is culturally and linguistically appropriate for the target populations, and provide training and supervision to the CHWs, who will conduct provide the behavioral health services throughout Tarrant County. The behavioral health services will include depression screenings, treatment, provide appropriate referrals to social workers and psychologist, and provide as needed, and care coordination for

depressed patients. Therefore, this program will provide a novel skill set to CHWs, generate workforce enhancement at nonspecialist levels, and greatly facilitate access to depression-specific comprehensive behavioral health care. There are an anticipated 18,000+ Medicaid-eligible elders in Tarrant County (as of June 2012) with an anticipated 5,000+ suffering from symptoms of depression. The depression treatment teams will provide depression-related health services to a minimum of 1,500 patients over the course of this five-year project. Therefore, the project fits under Category 1, #12 – Project Area (Enhance service availability) of appropriate levels of behavioral health care, #4 Other project description: mobile depression teams that can provide evidence-based treatment in Tarrant County.

Goals and Relationship to Regional Goals:

Project Goals:
The project goal is to deploy a depression treatment team throughout Tarrant County through hiring psychologists and a, social workers (BSW and LMSW), creating an evidence-based training program for depression behavioral health, hiring and training CHWs, and prioritizing areas to receive project intervention in order to provide evidence-based depression management based on the IMPACT model to (1) increase utilization of community behavioral health, (2) increase depression remission rates at 12-months, (3) increase patient satisfaction with access to care, and (4) improve the quality of life of depressed Medicaid-eligible elders and near elders.

This project meets the following Regional goals:
A major goal of the Region is to improve access to ongoing care. This project will contribute to achieving that goal by focusing on a key population, low-income seniors, along with a prevalent and extremely costly health condition, depression.

Challenges:
Depression is a major source of morbidity and mortality among the elderly (Palsson 1997; Cuijepers 2002). Depression increases risk for complications from other medical issues, impairs activities of daily living and reduces quality of life (Gurland 1992) and increases risk for 30-day hospital readmissions (Silverstein 2005). According to the CDC, depression reflects a substantial cost with an estimated $17-$44 billion annually in lost workdays in the U.S. In Oklahoma depression-related Medicaid costs were the second highest among the population (Garis 2003). Additionally, individuals suffering from a chronic medical condition and depression incur 50-100% increases in health service use and costs (Thomas 2006). Medicaid-eligible elders are at particular risk for depression; in fact, a report from the Substance Abuse and Mental Health Services Administration (SAMHSA) showed that 32% of Medicaid adult enrollees were treated for either minor depression or anxiety disorders, with 17% having been treated for major depression (Buck et al. 1995). In the New Hampshire report on depression, 49% of Medicaid elders suffered from some evidence of depression, which was similar to that found in Oregon

(Finkelstein 2011). Despite the fact that 80% of people suffering from depression can be helped and Medicaid offers therapies through various pathways, the majority of sufferers will not receive care due to lack of access and awareness. The current project proposes to teach create a collaborative depression management team consisting of community health workers (CHWs , social workers and psychologists) to provide depression treatment and management within community-based and clinic-based settings per the IMPACT model to address the major problem of depression within the Medicaid-eligible elder population. According to Oriol (2009), depression screenings through mobile clinics yielded a substantial estimated value of quality adjusted life years saved.

5-Year Expected Outcome for Provider and Patients:
By treating depression among Medicaid-eligible elders and near elders in Tarrant County, the five-year expected outcomes are to (1) increase access to treatment and management for depressed elders and near elders (1,500 patients to be treated), (2) achieve 12-month remission in 10% of treated patients (150 patients), (3) improve patient quality of life by 10% over baseline and (4) improve overall patient satisfaction with involvement in medical decision making by 5%.

Starting Point/Baseline:
As of June 2012, there were over 18,000 elders and near elder Medicaid patients in Tarrant County.[1] Based on prior work, it is anticipated that over 5,000 of these Medicaid patients suffer from symptoms of depression at any given time. This project will provide behavioral health services to a minimum of 1,500 Medicaid elders and near elders throughout Tarrant County by the end of the project. The baseline time period is DY3.

Rationale:
The U.S. population is aging at a rapid rate; however, the availability of geriatric primary care and specialty services to meet the mental health needs of this population is not expanding at the same rate. With its particular strength in aging, UNTHSC has a unique ability to meet the needs of Tarrant County's aging population. This project builds on existing strengths to enhance access to geriatric depression behavioral health services in order to meet the emerging medical needs of our community. Provision of such services at the community level will afford optimal management of depression and improve quality of life through a more cost-effective system.

Project Components:
No core project components are required for this project area. Core activities include: (1) develop a manual for CHW –implemented depression behavioral health program screening and referrals, peer support, and case management -implemented depression behavioral health program, (2) hire and train CHWs, (3) hire social workers and train on IMPACT model, (4)

identify and prioritize areas for intervention, and (4 5) implement depression behavioral health program.

Our milestones were chosen to measure effective implementation of a depression behavioral health team. Specifically: (1) hire and train team (psychologists, social workers, and CHWs), (2) establish extended hours, transportation and/or mobile clinic options, (3) increase utilization of community behavioral health care for targeted population, and (4) deploy the team throughout Tarrant County. Quality Milestone P-10 was selected to promote collaborative learning around shared or similar projects. As a result of these capacity expansions, we will be able to demonstrate effective identification and treatment of depression among a significant number of Medicaid elders.

Unique community need identification numbers the project addresses:
CN.4 Lack of access to mental health services
CN.5 Insufficient integration of mental health care in the primary care medical care system
CN.7 Need to address geographic barriers that impede access to care
CN.8 Lack of access to health care due to financial barriers
CN.9 Need for increased geriatric, long-term, and home care resources
How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
Outcome Measure 1: IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134). Numerator: Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented. Screening – testing done on people at risk of developing a certain disease, even if they have no symptoms. Standardized Tool – an assessment tool that has been appropriately normalized and validated for the population in which it is used. We will utilize the Geriatric Depression Scale (GDS). Follow-up Plan. Proposed outline of treatment to be conducted as a result of clinical depression screen. Such a follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation, and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider. Denominator: All eligible cases. Data source: Program Records.

Rationale: Depression is a major, but under-treated, problem among the elderly population, which is disproportionately experienced by poor elderly. Additionally, access to care for depressed Medicaid eligible elderly is a key issue given the limited numbers of health care providers that provide therapeutic treatment for depression. This project will substantially

increase access to empirically validated depression treatment protocols by incorporation of CHWs, social workers and psychologists into a collaborative depression treatment team as depression therapists for the elderly within community-based settings.

Outcome Measure 2: IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF#0710). Numerator: All eligible cases with a diagnosis of major depression or dysthymia and an initial GDS score greater than 10 who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) GDS score of 10 or less. Denominator: All eligible cases with a diagnosis of major depression or dysthymia and an initial GDS score greater than 10. Data Source: Program Records, Electronic Health Records.

Rationale. Prior work demonstrates the efficacy of psychotherapy in the treatment of depression, including among the elderly. Additionally, psychotherapy (cognitive and cognitive behavioral in particular) typically demonstrates superior relapse rates as compared to medication management. The combined CHW and social worker (or other health professional) team approach as used with the IMPACT program, has been shown effective in a number of studies (Wennerstrom 2011; Patel 2011; Unutzer 2001). Here, we propose that 10% of the 1500 (150) depressed patients receiving treatment will be no longer classified as depressed at 12-months post treatment.

Outcome Measure 3 : IT 10.1 Quality of Life – Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool (SF-36), for the target population. Improvement target is 5% over baseline by DY4 and 10% over baseline for all 1,500 patients by DY5.

Rationale: Prior work shows how quality of life and health status have reciprocal relationships. In fact, the Oregon Health Insurance Experiment (Finkelstein 2011) demonstrated that enrollment in Medicaid had a significant beneficial impact on quality of life, health care utilization (including preventive care measures and hospitalizations), and overall medical expenditures and debt when compared to the control group with no insurance. By implementing community-based depression behavioral health teams, we propose to improve quality of life by 10% over baseline. We will achieve this improvement by providing depression screenings, treatments, referrals, and care coordination through mobile teams. Community health workers, social workers and psychologists will provide the behavioral health depression management according to the IMPACT model in a variety of settings. Improved QOL will translate to significant improvement in a broad range of health outcome measures as outlined above and result in a significant cost savings over the course of the project.

Outcome Measure 4 : IT 6.1 Percent improvement over baseline of patient satisfaction scores: Percent improvement over baseline of patient satisfaction scores for one or more of the

patient satisfaction domains that the provider targets for improvement in a specific tool. Improvement goal is 5% for all 1,500 patients.

(1) Are getting timely care, appointments, and information (Stand-alone measure)
(2) How well their doctors communicate (Stand-alone measure)
(3) Patient's rating of doctor access to specialist (Stand-alone measure)
(4) Patient's involvement in shared decision making (Stand-alone measure)
(5) Patient's overall health status/functional status (Stand-alone measure)

Rationale: Prior work has shown that patient perception of involvement in medical decision making and medical care is directly related to outcomes (Brody et al. 1989). Additionally, patient involvement in decision making for depression management is essential. The Consumer Assessment of Health Plans Survey (CAHPS) module on Patient/Caregiver Experience – Shared Decision Making will be administered prior to receiving a visit by the depression teams for baseline perception based on prior medical experiences. The questionnaire will be administered again after clinic visit and again at follow-up visits to determine the improvement in patient perception of involvement in shared decision making experienced from receiving treatment by the depression teams. This Category 3 improvement target complements and expands on our Category 1 milestones significantly.

Relationship to Other Projects:

13 8980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics; 1.1.3: Community-Based Primary Care for the Elderly. The current project will support and reinforce the Community-Based Primary Care for the Elderly project by providing behavioral health services to appropriate patients, which is not provided by project 138980111.1.2. Therefore, these two projects will work in tandem to provide appropriate level of care within the most appropriate setting based on the individual patient's needs.

13 8980111.1.3 Expand Primary Care Capacity – Expand Existing Primary Care Capacity; 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid-Eligible Elders. The current project will support the project entitled Expanding Geriatric Primary Care and Consultative Services to Medicaid-Eligible Elders by providing depression-specific behavioral health services to patients, which will not be provided by that project. These projects will work in tandem to provide appropriate level of care targeted to the specific patient's needs.

13 8980111.2.5 Implement/Expand Care Transitions Program – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population; 2.12.2: Discharge Planning and Care Coordination for Medicaid-Eligible elders. The current project will provide depression-specific behavioral health as needed to these recently discharged patients, which are services not provided by project 138980111.2.5, thereby supporting the project entitled Discharge Planning and Care Coordination for Medicaid Elders.

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

This project will participate in the Region's Learning Collaborative. Please refer to Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of all participating provider projects for each collaborative.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value was calculated on four outcomes, which included (1) depression screening and treatment, (2) depression remission at 12 months, (3) quality of life and (4) patient satisfaction.

a. For Depression Management: Screening and Treatment Plan for Clinical Depression, UNT Health Science Center defined the population that will be directly impacted by the project as 1,500 individuals who will receive services through this project. We are anticipating that we will provide depression screening and treatment plans for all patients.

Utilizing the pricing matrix developed by Region 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,759.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $704 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, which resulted in a valuation amount of $1,055 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect",

due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For Depression Management: Depression Remission at Twelve Months, UNT Health Science Center defined the population that will be directly impacted by the project as 1,500 individuals who will receive services through this project. We are expecting to decrease depression remission at twelve months for at least 10% of patients, equating to 150 lives positively impacted by this outcome.

Utilizing the pricing matrix developed by Region 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,759.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $704 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, which resulted in a valuation amount of $1,055 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

c. For Quality of Life, UNT Health Science Center defined the population that will be directly impacted by the project as 1,500 dually-diagnosed patients enrolled in the Ft. Worth permanent supportive housing (PSH) program. We are anticipating that we will test the entire population, and are expecting to increase quality of life scores by 10%.

Utilizing the pricing matrix developed by Region 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $16,750 (as cited in the article, "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention.

This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

d. For Patient Satisfaction Percent Improvement over Baseline of Patient Satisfaction scores, UNT Health Science Center defined the population that will be directly impacted by the project as 1,500 individuals who will receive services through this project. We are anticipating that we will test the entire population and are expecting to increase the patient satisfaction scores of patient's involvement in shared decision making by 5%.

Utilizing, the pricing matrix developed by Region 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $16 (per article "BMC Medicine Research" in the journal BioMed Central), which is based on two percent of the expected reduced cost of mobile health care.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.1.6	***1.12.4***	***N/A***	***ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE – "OTHER" PROJECT OPTION: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE IN AN INNOVATIVE MANNER NOT DESCRIBED IN THE PROJECT OPTIONS ABOVE – 1.12.4: COMMUNITY-BASED BEHAVIORAL HEALTH CARE FOR DEPRESSED MEDICAID ELDERS AND NEAR ELDERS***	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER				*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.33* *138980111.3.34* *138980111.3.43* *138980111.3.44*	*3.IT 10.1* *3. IT 6.1* *3. IT 1.8* *3. IT 1.9*	*Quality of Life* *Percent Improvement over baseline of patient satisfaction scores* *Depression Management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134)* *Depression Management: Depression Remission at Twelve Months (NQF#0710)*	
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 (i.e. protocols for a mobile clinic) Metric 1 [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline/Goal: Documentation of completed manual of operations Data Source: Program Records Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,571,778 **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 Baseline/Goal: Documentation of completed hiring of 1 personnel Data Source: Program Record	**Milestone 4**[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: Documentation of completed hiring of 7personnel Data Source: Program Records Milestone 4 Estimated Incentive Payment: $1,639,904 **Milestone 5** [P-5]: Establish extended hours, transportation and/or mobile clinic options Metric 1 [P-5.1]: Number of areas prioritized for intervention with options in operation Baseline/Goal: Prioritize top two areas for project intervention Data Source: Program Records Milestone 5 Estimated Incentive Payment: $1,639,904	**Milestone 7**[I-11]: Increased utilization of community behavioral health care for depressed Medicaid elders and near elders Metric1 [1-11.1]: Percent utilization of community behavioral health care services – specifically, depression services in Medicaid-eligible elders and near elders. Goal:15% (750 patients) to receive depression services Data Source: Program Records Milestone 7 Estimated Incentive Payment: $1,757,203 **Milestone 8** [I.13]: Adherence to scheduled appointments. Metric 1 [I-13.1]:5% decrease in the number of canceled or no-show appointments Goal: 5% decrease in the number of cancelled or no-show appointment over baseline. Data Source: Program Records		**Milestone 10** [I-11]: Increased utilization of community behavioral health care for depressed Medicaid elders and near elders Metric 1 [I-11.1]: Percent utilization of community behavioral health care services – specifically, depression services in Medicaid-eligible elders and near elders. Goal: 30% (1,500 patients) to receive depression services Data Source: Program Records Milestone 10 Estimated Incentive Payment: $1,697,781 **Milestone 11** [I.13]: Adherence to scheduled appointments. Metric 1 [I-13.1]: 7% decrease in the number of canceled or no-show appointments Goal: 7% decrease in the number of cancelled or no-show appointment over baseline Data Source: Program Records

138980111.1.6	***1.12.4***	***N/A***	***ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE – "OTHER" PROJECT OPTION: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE IN AN INNOVATIVE MANNER NOT DESCRIBED IN THE PROJECT OPTIONS ABOVE – 1.12.4: COMMUNITY-BASED BEHAVIORAL HEALTH CARE FOR DEPRESSED MEDICAID ELDERS AND NEAR ELDERS***
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.33* *138980111.3.34* *138980111.3.43* *138980111.3.44*	*3.IT 10.1* *3. IT 6.1* *3. IT 1.8* *3. IT 1.9*	*Quality of Life* *Percent Improvement over baseline of patient satisfaction scores* *Depression Management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134)* *Depression Management: Depression Remission at Twelve Months (NQF#0710)*

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 2 Estimated Incentive Payment: $1,571,778 **Milestone 3** [P-10]: 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. Metric 1[P-10 .1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 3 Estimated Incentive Payment (maximum amount): $1,571,777	**Milestone 6** [P-10]: 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. Metric 1 [P-10 .1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 6 Estimated Incentive Payment (maximum amount): $1,639,905	Milestone 8 Estimated Incentive Payment: $1,757,204 **Milestone 9** [P-10]: 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. Metric 1 [P-10 .1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 9 Estimated Incentive Payment (maximum amount): $1,757,204	Milestone 11 Estimated Incentive Payment: $1,697,781 **Milestone 12** [P-10]: 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. Metric 1[P-10 .1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 12 Estimated Incentive Payment (maximum amount): $1,697,781
Year 2 Estimated Milestone Bundle Amount: ***(add incentive payments amounts from each***	**Year 3 Estimated Milestone Bundle Amount: $4,919,713**	**Year 4 Estimated Milestone Bundle Amount: $5,271,611**	**Year 5 Estimated Milestone Bundle Amount: $5,093,343**

138980111.1.6	***1.12.4***	***N/A***	***ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE – "OTHER" PROJECT OPTION: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE IN AN INNOVATIVE MANNER NOT DESCRIBED IN THE PROJECT OPTIONS ABOVE – 1.12.4: COMMUNITY-BASED BEHAVIORAL HEALTH CARE FOR DEPRESSED MEDICAID ELDERS AND NEAR ELDERS***
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.33* *138980111.3.34* *138980111.3.43* *138980111.3.44*	*3.IT 10.1* *3. IT 6.1* *3. IT 1.8* *3. IT 1.9*	*Quality of Life* *Percent Improvement over baseline of patient satisfaction scores* *Depression Management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134)* *Depression Management: Depression Remission at Twelve Months (NQF#0710)*

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):*$4,715,333**			

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $20,000,000

Project Option 1.2.2 – Increase Training of Primary Care Workforce – Increase the number of primary care providers (i.e., physicians, residents, nurse practitioners, physician assistants) and other clinicians/staff (health coaches and community health workers/promotoras) – 1.2.2: Expansion of Plaza/UNTHSC/TCOM Family Medicine Residency Program

Unique Project ID: 138980111.1.7 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/ 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: Increase the number of primary care providers, particularly family medicine residents, through the expansion of its current 4-4-4 Plaza Hospital/UNTHSC Family Medicine Residency Program to a 6-6-6 program. This is an expansion of a current UNTHSC family medicine residency program at Plaza Hospital.
Need of the project: This project supports the RHP 10 goals of improving the health of the population, decreasing per capita costs of service, and improving experience of care through increased access to primary care and preventive health services by increasing family resident providers in training and subsequently in Texas following their graduation from the program.
Target population: The target population consists of 18 family medicine resident trainees who will serve patients at Plaza Hospital and the additional patients that will be seen by those residents. It is estimated that the additional residents will conduct 2,000 additional patient visits.
Expected patient benefits: The increase in the number resident positions will help to provide care for the anticipated increase of Texans who will gain access to healthcare as a result of the Affordable Care Act.
Category 1 or 2 expected patient benefits:

i. Increase the number of residents by 4 per year by DY4 and by 6 per year by DY5
ii. Increase the number of primary care visits by 750 over baseline by DY4 and by 1,250 over baseline by DY5

Category 3 outcomes:

i. IT-14.6 – 5% increase by DY4 and 10% increase by DY 5 in percent of trainees who have spent the last five years living in a HPSA or MUA by DY5
ii. IT-14.7 – 5% increase by DY4 and 10% increase in percent of trainees who report they plan to practice in HPSAs or MUAs by DY5
iii. IT-14.8 – 5% increase by DY4 and 10% increase in percent of trainees who report they plan to serve Medicaid populations by DY5

Project Option 1.2.2 – Increase Training of Primary Care Workforce – Increase the number of primary care providers (i.e., physicians, residents, nurse practitioners, physician assistants) and other clinicians/staff (health coaches and community health workers/promotoras) – 1.2.2: Expansion of Plaza/UNTHSC/TCOM Family Medicine Residency Program

Unique Project ID: 138980111.1.7 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/ 138980111

Project Description:
Project Area: Increase Training of Primary Care Workforce
Project Intervention: Increase the number of primary care providers (i.e., physicians, residents, nurse practitioners, physician assistants) and other clinicians/staff

UNTHSC seeks to address the DSRIP Category 1 project area of increase training of primary care workforce by increasing the number of primary care providers, particularly family medicine residents, through the expansion of its current 4-4-4 Plaza Hospital/UNTHSC family medicine residency program to a 6-6-6 program. This program will also promote careers in family medicine in medically underserved areas and Health Professional Shortage Areas.

Goals and Relationship to Regional Goals:

Project Goals:
The project goal is to increase primary care residency training in order to increase the workforce in primary care, specifically family medicine and promote careers in family medicine within Texas with emphasis in medically underserved areas and Health Professional Shortage Areas (HPSAs) through the following: (1) Enrolling an additional six trainee physicians in the Plaza/UNTHSC family medicine residency program representing a 50% increase from current baseline numbers. These additional enrollees, with continued UNTHSC support, will graduate into the primary care workforce after DY5. (2) Increasing the percentage of trainees who have spent at least five years living in a HPSA or medically underserved area (MUA). (3) Increasing percentage of trainees who plan to practice in HPSAs or MUAs. (4) Increasing the percentage of trainees who plan to serve Medicaid populations; and (5) Increasing the number of patient visits by at least 750 in DY4 and 1,250 in DY5.

This project meets the following Regional goals:
The Region's goals are to meet and improve the health of the population, decrease per capita costs to serve and improve experience of care. This project supports these goals by increasing access to primary care and preventive health services through an increase in family resident providers in training and in Texas following their graduation from the program.

Challenges:
TCOM has had a longstanding commitment to educate primary care physicians in order to provide access to care for residents of Texas. In 2012, TCOM was recognized by the Texas Academy of Family Physicians for achieving 25% of graduating students entering family medicine residency. Given this consistent percent of students wanting to pursue family medicine, the challenge faced by UNTHSC/TCOM is providing available residency training positions in family medicine within the Fort Worth/Tarrant County Region to accommodate the increased TCOM class size that will graduate in 2015 and beyond. This challenge is coupled with Regional and national statistics that the country will need 39,000 more family physicians by 2020, with the need particularly great in Texas, which ranks 47th among states in active primary care doctors for its population. According to G. Sealy Massingill, president of the Tarrant County Medical Society, Tarrant County will be 10-15% short of primary care physicians needed. The family medicine residency at Plaza Medical Center/UNTHSC is currently capped at 12 funded positions. Therefore, UNTHSC seeks to address these challenges by using Medicaid Waiver funds to increase the current number of family medicine residency program positions by 50% from a 4-4-4 program to a 6-6-6 program.

5-Year Expected Outcome for Provider and Patients:
The five-year expected outcomes are to (1) increase the percentage of trainees within the expanded residency who are from HPSAs/MUAs by 10% over baseline, (2) increase the percentage of residents who report that they plan to practice in HPSAs or MUAs by 10% over baseline, (3) increase the percentage of residents who plan to serve Medicaid populations by 10% over baseline.

Starting Point/Baseline:
The residency program in family medicine at Plaza Medical Center is a dually accredited AOA/ACGME residency program that in October 2012 received its ACGME accreditation for 12 ACGME positions. The program was already AOA accredited for 12 positions and was inspected in 2012, receiving a maximum five-year approval. The program currently receives CMS funding for 12 positions (4-4-4) and is capped at this number despite recent ACGME accreditation. The program has 11 residents enrolled (4-4-4). The current residency continuity ambulatory training site is located on Seminary Drive in Fort Worth within a mile of MUC census tracts 1045.03 and 1046.05 and within four miles of HPSA tracts 1046.01, 1046.04, 1062.01 and 1062.02. Currently the Seminary clinic has a 36% Medicaid payer mix. In 2011-2012, residents provided 5,500 patient visits, which has been consistent for the last three years. This project will allow the number of patient visits to increase by 750 in DY4 and by 1,250 in DY5. The UNTHSC Department of family medicine provides the faculty supervision, teaching, and program directorship for the residency. Currently the department has seven dedicated

residency faculty committing a total of 3 FTE to residency training activities (four residents to one faculty). Baseline rates for Category 3 outcome measures will be established in DY3.

Rationale:
In 2005, the Council on Graduate Medical Education (COGME) issued a report titled Physician Workforce Policy Guidelines for the United States 2000-2020, which projected a shortage of about 85,000 physicians in 2020. In 2008, the Association of American Medical Colleges (AAMC) updated projections indicating a shortage of 124,000 physicians by 2025 and that universal access to health care would increase this deficit by an additional 31,000 doctors. The American Academy of Family Physicians (AAFP) projects similar shortages of 149,000 physicians and 39,000 family physicians by 2020. Health Resources and Services Administration (HRSA) projects a shortage of 65,560 primary care physicians by 2020.

The Affordable Care Act could give millions of uninsured Texans access to health care. The law shifts the health care focus toward prevention, making primary care providers, particularly family physicians, even more important. Tarrant County Commissioner Roy Brooks said, "the requirements of the act itself will force the system to react in certain ways, and one of the inevitable reactions is that we will have to have a highly trained workforce to help make this system work. We will have to go into training mode that will require the participation of all of our educational resources." G. Sealy Massingill, president of the Tarrant County Medical Society reported in a recent article that Tarrant County will be 10-15% short of the primary care physicians needed. He points to one limiting factor to primary care growth is too few residency positions available for first-year medical school graduates. "Last year, 1,404 people graduated from medical schools in Texas, but there were only 1,390 residency slots," said Gary Floyd, vice speaker of the medical association's House of Delegates.

UNTHSC is uniquely poised to address the shortage of primary care providers. TCOM in 2011 has increased its first-year medical school enrollment to 230, an increase of 75positions as compared to six years ago. Despite national trends of fewer students graduating into family medicine residencies, TCOM has consistently graduated a high percentage of students into family medicine. In 2012, over 25% of our graduates entered a family medicine residency. With the increase in students prepared to graduate in 2015, the additional residency positions created by this project will serve to retain these trainees in Tarrant County.

Project Components:
No core project components are required for this project area. Core activities include: (1) increasing training of a primary care workforce by increasing the number of family medicine residents trained over current baseline numbers by 50%, (2) hiring two additional precepting faculty, (3) developing a quality assessment/quality improvement curriculum for residents, (4)

additional residents rotating at UNTHSC facilities, and (5) increasing the number of patient visits.

The milestones and metrics were chosen to measure the expansion of the primary care residency training program and increase in intent to serve in HPSAs and the general Medicaid population. Specifically: (1) we will grow and expand the resident program by 50%, 2) we will expand the precepting faculty available to train and mentor primary care trainees, 3) we will develop and implement a quality assessment/improvement curriculum for trainees, 4) we will increase the percentage of residents with intent to serve in HPSAs and MUAs and to serve the Medicaid population and (5) we will increase access to primary care as reflected in increased patient visits. Increase access to primary care was selected as a customized milestone and increase in number of patient visits was selected as a corresponding metric because an increase in resident trainees will result in an increased number of patient visits. Quality Milestone P-11- was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:
CN.1 Lack of provider capacity
CN.2 Shortage of primary care services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

Outcome Measure 1: IT – 14.6 Percentage of trainees who have spent at least five years living in a health professional shortage area (HPSA) or medically underserved area (MUA). Improvement goal is 10% increase in percentage of trainees who have spent the last five years living a HPSA or MUA.
Rationale: Recruitment of trainees from HPSA/MUAs will increase the likelihood that they will return to their communities upon graduation. Likewise, since the residency is located within a mile of MUC census tracts 1045.03 and 1046.05 and within four miles of HPSA tracts 1046.01, 1046.04, 1062.01 and 1062.02 and serves patients from these areas, residents are more likely to remain in this area. Focusing on these outcomes will provide the necessary primary care services, prevention, and chronic disease management to patients who currently lack access.

Outcome Measure 2: IT- 14.7 Percentage of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey. Improvement goal is 10% increase in percentage of trainees who report that they plan to practice in HPSAs or MUAs.
Rationale: Residents often pursue a location for practice where they trained, grew up, or where their spouse or significant other grew up. Recruitment of trainees from HPSA/MUAs will increase the likelihood that they will return to their communities upon graduation. Likewise, since the residency is located within a mile of MUC census tracts 1045.03 and 1046.05 and within four miles of HPSA tracts 1046.01, 1046.04, 1062.01 and 1062.02 and serves patients from these areas, residents are more likely to remain in this geographical area.

Outcome Measure 3: IT – 14.8 Percentage of trainees who report that they plan to serve Medicaid populations based on a systematic survey. Improvement goal is 10% increase in percentage of trainees who report that they plan to serve Medicaid populations.
Rationale: Residents often pursue a location for practice where they trained, grew up, or where their spouse or significant other grew up. Recruitment of trainees from HPSA/MUAs will increase the likelihood that they will return to their communities upon graduation. Likewise, since the residency is located within a mile of MUC census tracts 1045.03 and 1046.05 and within four miles of HPSA tracts 1046.01, 1046.04, 1062.01 and 1062.02 and serves patients from these areas, residents are more likely to remain in this geographical area. In addition, the current residency clinic has a 36% payer mix.

Relationship to Other Projects: NA

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value was calculated on three outcomes, which included (1) percentage of trainees who have spent at least five years living in a health professional shortage area (HPSA) or medically underserved area (MUA), (2) percentage of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey, (3) percentage of trainees who report that they plan to serve Medicaid populations based on a systematic survey.

a. For percentage of trainees who have spent at least five years living in a HPSA or MUA, UNT Health Science Center expects to increase the number of family medicine residency trainees by six, which will increase the overall number of residency trainees from 12 to 18. It is anticipated that increasing the number of trainees will allow us to increase the number of patient visits by 2,000 for the project period. In addition, it is anticipated this project will increase the percentage of residents who have spent at least five years living in HPSAs or MUAs by 10%.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,131 (as cited by Agency for Healthcare Research and Quality (AHRQ). Mean Expenses per Person with Care for Selected Conditions by Type of Service: United States, 2010. Medical Expenditure Panel Survey Household Component Data, along with recommendations provided by UNT Health), as the result- of decreasing per capita cost per patient case by increasing primary care services, prevention, and chronic disease management to patients who currently lack access.

   For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $1,878 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $1,878 for each positive outcome realized.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For percentage of trainees who report that they plan to practice in HPSAs or MUAs -, UNT Health Science Center expects to increase the number of family medicine residency trainees by six, which will increase the overall number of residency trainees

from 12 to 18. It is anticipated that increasing the number of trainees will allow us to increase the number of patient visits by 2,000 for the project period. In addition, it is anticipated this project will increase the percentage of trainees who report that they plan to practice in HPSAs or MUAs based on systematic survey by 10%.
Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,131 (as cited by Agency for Healthcare Research and Quality (AHRQ). Mean Expenses per Person with Care for Selected Conditions by Type of Service: United States, 2010. Medical Expenditure Panel Survey Household Component Data, along with recommendations provided by UNT Health), as the result- of decreasing per capita cost per patient case by increasing primary care services, prevention, and chronic disease management to patients who currently lack access.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $1,878 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $1,878 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

c. For percentage of trainees who report that they plan to serve Medicaid populations -, UNT Health Science Center expects to increase the number of family medicine residency trainees by six, which will increase the overall number of residency trainees from 12 to 18. It is anticipated that increasing the number of trainees will allow us to increase the number of patient visits by 2,000 for the project period. In addition, it is anticipated this project will increase the percentage of trainees who report that they plan to serve Medicaid populations based on systematic survey by 10%.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,131 (as cited by Agency for Healthcare Research and Quality (AHRQ). Mean Expenses per Person with Care for Selected Conditions by Type of Service: United States, 2010. Medical Expenditure Panel Survey Household Component Data, along with recommendations provided by UNT

Health), as the result- of decreasing per capita cost per patient case by increasing primary care services, prevention, and chronic disease management to patients who currently lack access.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $1,878 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $1,878 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.1.7	***1.2.2***	*N/A*	***INCREASE TRAINING OF PRIMARY CARE WORKFORCE – INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS (I.E., PHYSICIANS, RESIDENTS, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS) AND OTHER CLINICIANS/STAFF (SUCH AS HEALTH COACHES AND COMMUNITY HEALTH WORKERS/PROMOTORAS) – 1.2.2: EXPANSION OF PLAZA/UNTHSC/TCOM FAMILY MEDICINE RESIDENCY PROGRAM***	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)				*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.35* *138980111.3.36* *138980111.3.37*	*3.IT 14.6* *3.IT 14.7* *3.IT 14.8*	*Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)* *Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey* *Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey*	

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-10]:Obtain approval from the Accreditation Council for Graduate Medical Education (ACGME) to increase the number of primary care residents Metric 1 [P-10.1]: Documentation of ACGME approval for residency position expansion Baseline/Goal: Documentation received Data Source: Program Records Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,394,586 **Milestone 2**[P-11-]: 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. Metric 1[P-11-.1]: Participate in semi-annual face-to-face meetings or	**Milestone 3**[P-4]: Develop and implement a curriculum for residents to use their practice data to demonstrate skills in quality assessment and improvement Metric 1 [P-4.1]: Quality assessment and improvement practicum for residents implemented Baseline/Goal: Practicum develop and implemented Data Source: Program Records Milestone 3 Estimated Incentive Payment: $727,517 **Milestone 4** [P-2]: Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists Metric 1 [P-2.2]: Hire additional precepting primary care faculty	**Milestone 7**[I-11]: Increase primary care training and/or rotations Metric 1 [I-11.4]: Increase the number of family medicine residents and/or trainees, as measured by percent change of class size over baseline or by absolute number. Goal: Increase number by 4 over DY2 baseline Data Source: Program Records Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities Baseline/Goal: Increase by 4 residents over DY2 baseline Data Source: Program Records Milestone 7 Estimated Incentive Payment: $1,039,406 **Milestone 8**[I-X]: Customizable Improvement Milestone: Increase access to primary care capacity.	**Milestone 10**[I-11]: Increase primary care training and/or rotations Metric 1 [I-11.4]: Increase the number of family medicine residents and/or trainees, as measured by percent change of class size over baseline or by absolute number. Goal: Increase number by 6 over DY2 baseline Data Source: Program Records Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities Goal: Increase by 6 residents over DY2 baseline Data Source: Program Records Milestone 10 Estimated Incentive Payment: $1,004,257 **Milestone 11**[I-X]: Customizable Improvement Milestone: Increase access to primary care capacity.

138980111.1.7	***1.2.2***	*N/A*	***INCREASE TRAINING OF PRIMARY CARE WORKFORCE – INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS (I.E., PHYSICIANS, RESIDENTS, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS) AND OTHER CLINICIANS/STAFF (SUCH AS HEALTH COACHES AND COMMUNITY HEALTH WORKERS/PROMOTORAS) – 1.2.2: EXPANSION OF PLAZA/UNTHSC/TCOM FAMILY MEDICINE RESIDENCY PROGRAM***	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)				*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.35* *138980111.3.36* *138980111.3.37*	*3.IT 14.6* *3.IT 14.7* *3.IT 14.8*	*Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)* *Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey* *Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey*	

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)**
seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,394,587	members demonstrating improvement over DY2 faculty numbers. Baseline/Goal: Hire 2 additional precepting primary care faculty members Data Source: Program Records Milestone 4 Estimated Incentive Payment: $727,517 **Milestone 5** [I-11]: Increase primary care training and/or rotations Metric1 [I-11.4]: Increase the number of family medicine residents and/or trainees, as measured by percent change of class size over baseline or by absolute number. Goal: Increase number by 2 over DY2 baseline Data Source: Program Records Metric 2 [I-11.2]: Increase the number of primary care trainees rotating at the Performing Provider's facilities	Metric 1 [I-X.1]: Increase number of primary care visits over baseline performed by residents Baseline/Goal: Increase number of primary care visits by 750 over DY2 baseline Data Source: Program Records Milestone 8 Estimated Incentive Payment: $1,039,406 **Milestone 9** [P-11-]: 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. Metric 1[P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting	Metric 1 [I-X.1]: Increase number of primary care visits over baseline performed by residents Goal: Increase number of primary care visits by 1250 over DY2 baseline Data Source: Program Records Milestone 11 Estimated Incentive Payment: $1,004,257 **Milestone 12**[P-11-]: 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. Metric 1[P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting

138980111.1.7	***1.2.2***	*N/A*	***INCREASE TRAINING OF PRIMARY CARE WORKFORCE – INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS (I.E., PHYSICIANS, RESIDENTS, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS) AND OTHER CLINICIANS/STAFF (SUCH AS HEALTH COACHES AND COMMUNITY HEALTH WORKERS/PROMOTORAS) – 1.2.2: EXPANSION OF PLAZA/UNTHSC/TCOM FAMILY MEDICINE RESIDENCY PROGRAM***	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)				*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.35* *138980111.3.36* *138980111.3.37*	*3.IT 14.6* *3.IT 14.7* *3.IT 14.8*	*Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)* *Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey* *Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey*	
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)**
	Goal: Increase by 2 residents over DY2 baseline Data Source: Program Records Milestone 5 Estimated Incentive Payment: $727,516 **Milestone 6**[P-11-]: 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. Metric 1[P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 6 Estimated Incentive Payment *(maximum*		notes Milestone 9 Estimated Incentive Payment *(maximum amount):* $1,039,405	notes Milestone 12 Estimated Incentive Payment *(maximum amount):* $1,004,256

138980111.1.7	***1.2.2***	*N/A*	***INCREASE TRAINING OF PRIMARY CARE WORKFORCE – INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS (I.E., PHYSICIANS, RESIDENTS, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS) AND OTHER CLINICIANS/STAFF (SUCH AS HEALTH COACHES AND COMMUNITY HEALTH WORKERS/PROMOTORAS) – 1.2.2: EXPANSION OF PLAZA/UNTHSC/TCOM FAMILY MEDICINE RESIDENCY PROGRAM***
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.35* *138980111.3.36* *138980111.3.37*	*3.IT 14.6* *3.IT 14.7* *3.IT 14.8*	*Percent of trainees who have spent at least 5 years living in a health-professional shortage area (HPSA) or medically underserved area (MUA)* *Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey* *Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey*

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)
	amount):$727,516		
Year 2 Estimated Milestone Bundle Amount: ***(add incentive payments amounts from each milestone):*** **$2,789,172**	**Year 3 Estimated Milestone Bundle Amount: $2,910,066**	**Year 4 Estimated Milestone Bundle Amount: $3,118,217**	**Year 5 Estimated Milestone Bundle Amount: $3,012,770**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$11,830,226			

Project Option – 1.7.2 - Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement remote patient monitoring programs for diagnosis and/or management of care – 1.7.2: Managing Chronically Ill Medicaid Patients using Interventional Telehealth

Unique Project ID: 13898-0111.1.8 (Pass 3)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: This project will use an innovative telehealth monitoring system to manage chronically ill adult patients discharged from hospitals in RHP 10. This project is a new initiative on the part of UNTHSC that utilizes patient monitoring services provided through Care Cycle Solutions (CCS) who have developed proprietary software systems to monitor and manage patients and improve care coordination.
Need of the project: The project is related to the goals of improving the overall health of the population being served, improving the health care experience (quality of care), and providing the best care possible while reducing health care costs over time. Our own research based on CCS telehealth monitoring data (published in 2011 in the Journal of Primary Care & Community Health and the American Journal of Managed Care) showed how telehealth monitoring was associated with reduced 30-day hospitalization rates and, thus, better quality care for Medicare home health patients. The project is consistent with the RHP 10 goals of improved patient health, quality of care and lower costs.
Target population: Chronically ill Medicaid patients discharged from RHP 10 hospitals and enrolled in the telehealth monitoring program. Estimate 700 patients to be served over course of waiver.
Expected patient benefits: A remote monitoring device is placed at the home of each patient and it allows clinicians to communicate with patients and/or their caregivers. The monitoring device tracks vital signs and it can be adapted to work with a glucometer or a peak-flow meter. Patients benefit from intensive monitoring through better care coordination, individualized needs assessments, the initiation of other needed services, and improved access to health care services. This in turn will lead to substantial, measurable improvements in quality of life and activities of daily living given the poor baseline health levels of the population targeted. The patient benefits derived from these improvements will be best captured directly by increases in physical/mental health indicators (e.g., SF-12 scores) and activities of daily living (e.g., Barthel Index scores). The proposed project is important in that the Medicaid population we are targeting (older adults with multiple chronic health conditions) will be costly to CMS in the medium to long-term if these health conditions are not managed properly (and the costs will be incurred by both Medicaid and Medicare).
Category 1 or 2 expected patient benefits:

4. Initiate use of other needed services (e.g., visits from nurses, health educators, respiratory therapists; continuous remote patient monitoring; improved chronic disease management

skills) for the first time for 50% (150) of enrolled patients by DY4 and 55% (385) of enrolled patients - by DY5

5. Improved access to health care services for 700 (300 DY4 and 400 DY5) residents of communities that did not have such services locally before the program

Category 3 outcomes:

i. 3-% increase in SF-12 scores over baseline by DY4- and 5% increase over baseline by DY5 (average improvement in patient SF-12 summary scores from beginning to end of program participation)

ii. 3-% increase in Barthel Index scores over baseline by DY4- and 5% increase over baseline by DY5 (average improvement in patient Barthel Index scores from beginning to end of program participation)

Project Option – 1.7.2 - Managing Chronically Ill Medicaid Patients Using Interventional Telehealth

Unique Project ID: 13898-0111.1.8 (Pass 3)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:
Project Area: Introduce, Expand, or Enhance Telemedicine/Telehealth
Project Intervention: Implement remote patient monitoring programs for diagnosis and/or management of care. Providers should demonstrate that they are exceeding the requirements of the EHR incentive program.
This project will use an innovative telehealth monitoring system to manage chronically ill adult patients discharged from hospitals in RHP 10. We will use proprietary software systems developed by Care Cycle Solutions (CCS) to monitor and manage patients and improve care coordination. A telehealth monitoring services company based in Dallas, with 33 offices in Louisiana and Texas, CCS provides daily patient monitoring to 2,200 patients, making it one of the largest telehealth services provider in the United States. Over the last six years, CCS has provided telehealth monitoring services to 16,000 patients—most of them Medicare patients, but many of them dual-eligibles (Medicare and Medicaid). The CCS approach includes a remote monitoring device that is placed at the home of each patient, a transmission system to transfer clinical data to the monitoring center, and a communication system (phone line or a wireless adapter) to allow clinicians to communicate with patients and/or their caregivers. The monitoring device is able to track, for example, blood pressure, heart rate, body weight, and oxygen saturation levels, and it also can be adapted to work with a glucometer or a peak-flow meter depending on individual needs. Patient monitoring data will be reviewed continuously by clinicians with acute care experience (e.g., a nurse or respiratory therapist), and the data will be utilized to identify and design interventions as well as for overall care coordination. Medicaid patients discharged from selected RHP 10 hospitals will be identified and enrolled in the proposed interventional telehealth program. Each patient will be on the program an average of six months. We will be able to manage 150 patients per month during DY4 and 200 patients per month during DY5 (for a total of 700 Medicaid beneficiaries).

Goals and Relationship to Regional Goals:

Project Goals:
The main goal of this project is to implement a telehealth monitoring program to more effectively manage the multiple health conditions of chronically ill Medicaid patients. The project is designed to: (1) Implement a remote patient monitoring program based on evidence-based models and adapted to fit the needs of the population and local context; (2) improve access to specialist care and other needed services (e.g., community-based nursing, case management, patient education and counseling); (3) implement interventions to achieve improvements in

access to care of patients receiving telemedicine/telehealth services using an innovative project option; (4) improve overall quality of life; and (5) improve functional independence (activities of daily living).

This project meets the following regional goals:
The project is related to the goals of improving the overall health of the population being served, improving the health care experience (quality of care), and providing the best care possible while reducing health care costs over time. Our own research based on CCS telehealth monitoring data (published in 2011 in the Journal of Primary Care & Community Health and the American Journal of Managed Care) showed how telehealth monitoring was associated with reduced 30-day hospitalization rates and better quality care for Medicare home health patients. The proposed project is important in that the Medicaid population we are targeting (older adults with multiple chronic health conditions) will be costly to CMS in the medium to long-term if these health conditions are not managed properly (and the costs will be incurred by both Medicaid and Medicare). The project is consistent with the RHP 10 goals of improved patient health, quality of care and lower costs.

Challenges:
Adults with chronic health conditions account for about 30% of personal health care spending in the United States ($635 billion) and inefficiencies in chronic disease management and health care coordination are partly responsible for these disproportionately high health care costs. Telehealth monitoring ("the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance") may be a cost-effective solution to manage the Medicaid population with chronic health conditions. Several studies using either randomized or pre/post test study designs have shown that telehealth monitoring systems can reduce the number of hospitalizations and emergency department visits for chronically ill patients, and they can also lead to improvements in quality of life and better control of chronic health conditions (e.g., stable levels of glycosylated hemoglobin for patients with diabetes).

5-Year Expected Outcome for Provider and Patients:
The five-year expected outcomes for participating Medicaid patients are to: (1) improve quality of life scores by 5% and (2) improve functional independence (activities of daily living) by 5%.

Starting Point/Baseline:
This project will begin during DY2 and DY3 with a needs assessment to identify needed specialties/services, participation in collaborative learning activities, and program implementation. The proposed interventional telehealth program will serve 700 Medicaid beneficiaries with chronic health conditions in DY4 and DY5. Medicaid patients discharged from RHP 10 hospitals will be identified and enrolled in the proposed interventional telehealth program. Each patient will be on the program an average of six months, and we will be able to manage an average of 150 patients per month during DY4 and 200 patients per month during DY5 (with new Medicaid beneficiaries added to the interventional telehealth program as patients leave the program—mainly because their chronic health condition has been stabilized). Baseline

measures, established for each patient upon enrollment in the intervention, will be compared to their last measure for quality of life and activities of daily living to assess program effectiveness.

Rationale:
Inefficiencies in chronic disease management and health care coordination are costly to the health care system and telehealth monitoring is an evidence-based approach that may prove to be a practical and cost-effective health care delivery mode for Medicaid patients with chronic health conditions. Implementing a remote patient monitoring program for health care management may improve access to needed health services (such as community based nursing, case management, patient education and counseling). The proposed remote patient monitoring program may also improve access to care coordination in ways that would not have occurred for the Medicaid population targeted for the intervention.

Project Components:
No core project components are required for this project area. Core activities include:

- Conducting a needs assessment to identify needed specialties that can be provided via telemedicine
- Conducting a needs assessment to identify needed services that could be delivered via telehealth
- Participating 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
- Implementing remote patient monitoring program based on evidence-based models and adapted to fit the needs of the population and local context
- Creating a plan to monitor and enhance technical properties, bandwidth, of telemedicine/telehealth program

Our project involves the implementation of a remote patient monitoring program to manage chronically ill adult patients discharged from hospitals in RHP 10. The milestones and metrics selected were chosen based on community needs in RHP 10. More specifically, the milestones selected focus on conducting a needs assessment to identify needed specialties and services that can be provided via telehealth, implementing a remote patient monitoring program based on evidence-based models and adapted to fit the needs of the population and local context, and create a plan to monitor and enhance the technical properties of the telehealth program. The improvement milestones were selected to improve access to services and different types of much needed care options in RHP 10 for chronically ill patients. Functional status (activities of daily living) and quality of life measures will be tracked to inform the progress of the proposed telehealth monitoring program in meeting the needs of Medicaid beneficiaries with chronic health conditions in RHP 10. Quality Milestone P-11- was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.7 – Need to address geographic barriers that impede access to care
- CN.9 – Need for increased geriatric, long-term, and home care resources
- CN.11 – Need for more care coordination.
- CN.13 – Necessity of patient education programs.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and reasons/rationale for selecting the outcome measures:

IT-10.1 Quality of Life

Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool, for the target population.
Improvement Target: Improvement goal is 5% increase in quality of life scores over baseline by the end of the waiver period. Quality of life will be measured using a validated, widely used instrument (SF-12).
Rationale: Remote patient monitoring has been shown to lower the risk of hospitalization for Medicare and Medicare/Medicaid dual eligible patients with chronic health conditions. These reductions in hospitalization rates are a direct consequence of better care coordination and chronic disease stabilization resulting from intensive patient monitoring. The SF-12 is a general survey instrument designed to capture different dimensions of health and quality of life. The instrument allows for the measurement of not only general physical and mental health but also other important health domains (physical functioning, role functioning, bodily pain, vitality, and social functioning). These health outcomes are expected to improve for our targeted low-income population as a result of better care coordination and chronic disease management achieved by our interventional telehealth program.

IT-10.2 Activities of Daily Living

Demonstrate improvement in ADL scores, as measured by evidence-based and validated assessment tool, for the target population.
Improvement Target: Improvement goal is 5% increase in functional independence (activities of daily living (ADLs)) scores over baseline by the end of the waiver period. Functional independence will be measured using the Barthel Index, a validated, widely used score.
Rationale: Remote patient monitoring has been shown to lower the risk of hospitalization for Medicare and Medicare/Medicaid dual eligible patients with chronic health conditions. These reductions in hospitalization rates are a direct consequence of better care coordination and chronic disease stabilization resulting from intensive patient monitoring. The Barthel Index is a general assessment score of functional independence that includes ten items (bathing, grooming, feeding, dressing, bowels, bladder, toilet use, stairs, transfers, and mobility). The overall index score ranges from 0 to 100, with a higher number indicating more independence. Functional independence is expected to improve for our low-income population as a result of better care coordination and chronic disease management achieved by our interventional telehealth program.

Relationship to Other Projects:
N/A

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B

Specifically, this project's value was calculated on two outcomes, which included (1) Quality of Life and (2) Activities in Daily Living.

a. For Quality of Life, UNT Health Science Center defined the population that will be directly impacted by the project as patients selected for remote patient monitoring, which would be approximately 700 patients. We anticipate that we will remotely monitor the entire population selected using interventional telehealth and are expecting to increase the quality of life (SF-12) scores by 5%.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,755 (as cited in the article, "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to the customary $50,000 per life-year gained due to the intervention -. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For Activities in Daily Living (ADLs), UNT Health Science Center defined the population that will be directly impacted by the project as patients selected for remote patient monitoring, which would be approximately 700 patients. We anticipate that we will remotely monitor the entire population selected using interventional telehealth and are expecting to increase the Barthel Index of ADL (functional independence) scores by 5%.

Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $2,500 (as cited in the article, "Assessment of post-stroke quality of life in cost-effectiveness studies: The usefulness of the Barthel Index and the EuroQoL-5D" from the journal *Quality of Life Research*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which used the Barthel Index to assess the impact of the target population as a means to calculate an incremental quality-adjusted life-year and applied it to the customary $50,000 per life-year gained due to the intervention -. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.1.8	*1.7.2*	*N/A*	*Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement remote patient monitoring programs for diagnosis and/or management of care – 1.7.2: Managing Chronically Ill Medicaid Patients using Interventional Telehealth*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.38* *138980111.3.39*	*3.IT 10.1* *3.IT 10.2*	*Quality of Life/Functional Status – Quality of Life* *Quality of Life/Functional Status – 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-1]: Conduct needs assessment to identify needed specialties that can be provided via telemedicine. Metric 1 [P-1.1]: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel. Baseline/Goal: Personnel needs assessment to inform program implementation will be completed. Data Source: Care Cycle Solutions records. Milestone 1 Estimated Incentive Payment: $**1,571,778** **Milestone 2** [P-2]: Conduct needs assessment to identify needed services that could be delivered via telehealth. Metric 1 [P-2.1]: Needs assessment Baseline/Goal: Needs assessment to inform program implementation will be completed. Data Source: Care Cycle Solutions records. Milestone 2 Estimated Incentive Payment: $**1,571,778** **Milestone 3** [P-11-]: Participate in	**Milestone 4** [P-5]: Implement remote patient monitoring program based on evidence-based models and adapted to fit the needs of the population and local context Metric 1 [P-5.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. Baseline/Goal: Implementation plan developed. Data Source: Program records. Milestone 4 Estimated Incentive Payment: $**1,639,904** **Milestone 5** [P-7]: Create plan to monitor and enhance technical properties, bandwidth, of telemedicine/telehealth program Metric 1 [P-7.1]: Documentation of bandwidth capacity in relationship to program needs. Baseline/Goal: Determine technical properties needed to implement program effectively. Data Source: Program records and technical specifications/capacity of telehealth monitoring equipment.	**Milestone 7** [I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time. Goal: Initiate use of other needed services for the first time for 50% of patients enrolled in the program. Data Source: Care Cycle Solutions electronic health records. Milestone 7 Estimated Incentive Payment: $**1,757,204** **Milestone 8** [I-18]: Implement interventions to achieve improvements in access to care of patients receiving telemedicine/ telehealth services using innovative project option. Metric 1 [I-18.3]: Improved access to health care services for residents of communities that did not have such services locally before the program. Demonstrate improvement over prior reporting period. Goal: 300 patients encountered	**Milestone 10** [I-17]: Improved access to specialists care or other needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1 [I-17.1]: Percentage of patients in the telemedicine/ telehealth program that are seeing a specialist or using the services for the first time. Goal: Initiate use of other needed services for the first time for 55% of patients enrolled in the program. Data Source: Care Cycle Solutions electronic health records. Milestone 10 Estimated Incentive Payment: $**1,697,781** **Milestone 11** [I-18]: Implement interventions to achieve improvements in access to care of patients receiving telemedicine/ telehealth services using innovative project option. Metric 1 [I-18.3]: Improved access to health care services for residents of communities that did not have such services locally before the program. Demonstrate improvement over prior reporting period. Goal: 400 patients encountered

138980111.1.8	*1.7.2*	*N/A*	*Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement remote patient monitoring programs for diagnosis and/or management of care – 1.7.2: Managing Chronically Ill Medicaid Patients using Interventional Telehealth*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.38* *138980111.3.39*	*3.IT 10.1* *3.IT 10.2*	*Quality of Life/Functional Status – Quality of Life* *Quality of Life/Functional Status – 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)
face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 3 Estimated Incentive Payment: $**1,571,777**	Milestone 5 Estimated Incentive Payment: $**1,639,904** **Milestone 6** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 6 Estimated Incentive Payment: $**1,639,905**	(served). Data Source: Care Cycle Solutions electronic health records. Milestone 8 Estimated Incentive Payment: $**1,757,204** **Milestone 9** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 9 Estimated Incentive Payment: $**1,757,203**	(served). Data Source: Care Cycle Solutions electronic health records. Milestone 11 Estimated Incentive Payment: $**1,697,781** **Milestone 12** [P-11-]: 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. Metric 1 [P-11-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 12 Estimated Incentive Payment: $**1,697,781**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,715,333	Year 3 Estimated Milestone Bundle Amount: $4,919,713	Year 4 Estimated Milestone Bundle Amount: $5,271,611	Year 5 Estimated Milestone Bundle Amount: $5,093,343

138980111.1.8	*1.7.2*	*N/A*	*Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement remote patient monitoring programs for diagnosis and/or management of care – 1.7.2: Managing Chronically Ill Medicaid Patients using Interventional Telehealth*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.38* *138980111.3.39*	*3.IT 10.1* *3.IT 10.2*	*Quality of Life/Functional Status – Quality of Life* *Quality of Life/Functional Status – 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)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $20,000,000			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 1.9.2 – Expand Pain Management Care Services

Unique Project ID: 162334001.1.1 (Pass 2)
Performing Provider Name/TPI: JPS Health Network Physician Group/162334001

Provider: The provider system consists of approximately 130 physicians and 30 midlevel providers. The service area is all of Tarrant County. Provider works almost exclusively in JPS Health Network facilities (the region's public/safety net hospital system) treating JPS patients. Approximately 30% of JPS PG patients are Medicaid and 48% are indigent/uninsured.
Intervention: This project will increase access to specialized pain management as well as expand scope of services to patients needing both medical and complex interventional pain medicine services. By designing a single site pain management clinic and implementing four satellite Patient Centered Medical Home (PCMH) clinics designed for chronic pain management as well as creating an inpatient consult program for those admitted with pain, this will improve access to specialty care for a vulnerable population. This project includes both the expansion and re-design of an existing pain program, as well as many new initiatives and innovative service delivery.
Need for the project: Pain Management currently lacks adequate access to a centralized pain management clinic, interventional pain procedures and inpatient pain consults. Additionally, there are several challenges for the performing provider. There are currently not enough providers to see the volume of patients that require services. Also, there is a shortage of clinic space and no dedicated clinic for pain services causing wait times for the limited interventional services available to be several weeks. Lastly, many advanced pain therapies are unavailable to the indigent patient population. This project will provide funds to hire providers, build a new dedicated pain clinic within a procedure suite, provide inpatient services and allow the full range of advanced pain treatments to become available to patients
Target population: The underserved/Self-Pay population of Tarrant County and will serve >25,000 over the course of the waiver. The benefit of this project for the Self-Pay and Uninsured population of the region will be to have access to specialized pain management services including both medical management as well as interventional pain services for complex and chronic pain patients. The resulting benefit should be more appropriate dispensing, management and reduced extended utilization of pain medication with better availability to interventional pain procedures to better manage acute pain. This should allow for reduced utilization of Emergency services as well as better inpatient pain management for oncology and related pain inpatient stays with an overall reduced utilization of inpatient services as well.
Expected patient benefits:

- The project seeks to increase specialty care clinic volume of visits and evidence of improved access for patients seeking services from current rate of <30 to >45 in DY4/5.
- IT 2.13 Reduce inpatient admits on those with pain as primary diagnosis by 15%.
- IT 4.10 Reduce ALOS of Oncology patients admitted with pain as primary diagnosis by 40%.

- IT 9.2 Reduce inappropriate utilization of ED with those of pain diagnosis by 20%.

Project Option 1.9.2 – Expand Pain Management Care Services

Unique Project ID: 162334001.1.1 (Pass 2)
Performing Provider Name/TPI: JPS Health Network Physician Group/162334001

Project Description:
This project will increase access to specialized pain management as well as expand scope of services to patients needing both medical and complex interventional pain medicine services. By designing a single site pain management clinic and implementing four satellite Patient Centered Medical Home (PCMH) clinics designed for chronic pain management as well as creating an inpatient consult program for those admitted with pain, this will improve access to specialty care for a vulnerable population.

This redesign will be the most efficient for the staff providing care, the patients receiving care and enhance procedure cost controls. Most of the procedures currently performed in a JPS Health Network operating room can be done in a procedure room setting with appropriate sedation and monitoring. This would be a significant cost savings and we would be able to provide care to a greater number of patients. The clinic staff would utilize the pain clinic procedure room for most procedures, with operating room utilization only when required.

JPS Physician Group will recruit pain specialists to be housed in this central clinic. This will include the recruiting of a medical director and several mid-level providers. This redesign will support pharmacy services, clinic security, drug testing policy and procedures, patient termination policy procedures, and protocol for violators as well as referral guidelines. We are projecting to have two board certified pain physicians and two mid-levels dedicated to this center. For our inpatient consults, we will have one dedicated board certified pain physician along with one mid-level dedicated to service the inpatient population.

We expect introduction of this centralized pain management program to reduce inpatient days, cost of care and ER appropriate utilization measures.

Goals and Relationship to Regional Goals:
Project Goals:
The purpose of this project is to bring acute and chronic pain management services to patients cared for in the indigent care program of Tarrant County. This will bring cutting-edge treatments not currently available to patients with both malignant and non-malignant pain conditions. The centralized pain clinic will provide services for >45 patients per day with minimal wait times. At this site, patient care will be provided by board certified pain medicine specialists and, as a

result, we expect great improvement in availability and level of services as well as overall patient satisfaction.

This project meets the following Regional goals:
As noted in the RHP 10 Community Needs Assessment, lack of access to specialty care and lack of provider capacity likely contribute to poor patient satisfaction and potential overuse of emergency services.

Challenges:
Pain management currently lacks adequate access to a centralized pain management clinic, interventional pain procedures and inpatient pain consults. Additionally, there are several challenges for the performing provider. There are currently not enough providers to see the volume of patients who require services. Also, there is a shortage of clinic space and no dedicated clinic for pain services, causing wait times of several weeks for the limited interventional services available. Lastly, many advanced pain therapies are unavailable to the indigent patient population. This project will provide funds to hire providers, build a new dedicated pain clinic within a procedure suite, provide inpatient services and allow the full range of advanced pain treatments to become available.

5-Year Expected Outcome for Provider and Patients:
In addition to increasing patient satisfaction, by the end of the Waiver, we plan to reduce emergency department appropriate utilization for chronic pain conditions by 20%, reduce hospital admissions for pain diagnosis by 15% and reduce average length of stay due to uncontrolled pain for oncology patients by 40%. We will also provide the full scope of pain medicine services for patients and develop medical homes for patients needing long-term chronic pain management.

Starting Point/Baseline:
The time period used for our initial baseline was January 2011 – December 2011. We used only the population of JPS Connections patients as well as any self-pay patients. During this period, we had 2.5 FTE providers trained as pain specialists and no mid-levels. This population includes approximately 70% of ED visits with a primary diagnosis of pain, 38% of oncology admits related to pain needs, and 59% of admissions related to pain.

Rationale:
This clinical structure is needed in part because it is no longer possible to adequately assist primary care providers and meet patients' pain management needs at JPS Health Network under a traditional clinic structure. This is due to the inability to perform many advanced procedures efficiently in a clinic environment and improved management by highly trained providers.
Project Components:

To provide a complete spectrum of pain management services at a single site for the JPS Health Network and pain-focused PCMH clinics in four strategic locations. The goal is to be able to provide care for >45 patients per day at a primary site with coordinated delivery at other locations to be able to accommodate >50 patients per day bringing the total to >100. Increased numbers of specialist and extenders to meet procedural demand and referral demands for in-person specialty visits, consults and procedures will allow patients to receive more timely services.
The core components addressed:

- Increase service availability with extended hours
- Increase number of specialty clinic locations
- Implement transparent, standardized referrals across the system
- 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

Our milestones measure an increased population receiving pain management by increasing the number of specialists to meet the demand for in-person visits and procedures, allowing patients to receive more timely services. Implementing a single-site pain management facility with medical management and procedural capability creates efficiency. This will be in concert with four additional highly trained physicians operating in PCMH clinics in strategic locations to service chronic pain patients across Tarrant County. There will also be the ability to provide inpatient pain consults and a specialized pain clinic for oncology patients.
Unique community need identification numbers the project addresses:

CN.3	Shortage of specialty care
CN.8	Lack of access to health care due to financial barriers
CN.10	Overuse of emergency department services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will increase access for the pain management population, resulting in decreased wait times by providing pain services for >45 patients per day at a central location and - >50 patients per day at satellite PCMH clinics, as well as >30 inpatient pain consults. This will also expand scope of pain services to multiple categories of both medical and interventional complex pain patients including inpatient and ambulatory oncology patients.

This redesign will be the most efficient for the staff providing care, the patients receiving care and enhance procedure cost controls. Most of the procedures currently performed in a JPS Health Network operating room can be done in a procedure room setting if sedation and monitoring are available. This will be a significant cost savings and we will be able to provide care to a greater

number of patients. The clinic staff will utilize the pain clinic procedure room for most procedures, with the main operating room used only when absolutely necessary.

Implementing a single site pain management facility with medical and procedural management capability will create an efficiency not seen today. This will be in concert with four additional highly trained physicians operating in PCMH clinics in strategic locations to serve chronic pain patients across Tarrant County. There will also be the ability to provide inpatient pain consults and a specialized pain clinic for oncology patients.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
Potentially Preventable Admissions IT – 2.13 Other Admissions Rate: Expansion of a pain management clinic will reduce the need for inpatient admissions receiving specialized pain management services. Also, if admitted, the inpatient consult will directly benefit the patient by having a specialized pain consult during his or her stay. Currently, 59% of admissions related to pain could be affected by having a pain management program. Our goal is to reduce admissions of this population by 15% by the end of the Waiver.

Potentially Preventable Complications and Healthcare Acquired Conditions IT – 4.10 Other Outcome Improvement Target to Decrease ALOS: With an inpatient consult for those oncology admissions related to pain , the average length of stay will be shortened as the patient will be treated by a specialized pain physician. Today, 38% of oncology admits are admitted due to a primary diagnosis of pain and with no inpatient consult provided by a specialized pain physician, the ALOS is >6. Our goal by the end of the Waiver is to reduce ALOS by 40% to this population making the ALOS 3.6.

Right Care, Right Setting IT – 9.2 ED Appropriate Utilization: With the availability of a centralized pain management clinic, the available wait times to be seen will be substantially reduced, eliminating the need to visit the ED. This population includes 70% of ED visits with a primary diagnosis of pain that may not require an ED visit if the availability of an appointment at a pain center was accessible. Our goal by the end of the Wavier is to reduce inappropriate utilization of ED for pain diagnosis by 20%.
Relationship to Other Projects:

Related Project(s)	Description of relationship of project(s)
126675104.2.2 PCMH	Decrease avoidable ED admissions
126675104.1.2 Call Center	Increase utilization of ED for preventable ambulatory care conditions.
126675104.2.11 Patient experience: JPS Cares	Establish a patient experience team to improve patient satisfaction scores

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the Region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Physician Group has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Physician Group defined the population that will be directly impacted by the project as patients with a primary diagnosis code of pain, both inpatient and outpatient. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is 4.

162334001.1.1	***1.9.2***	***1.9.2 (A-D)***	Expand high impact specialty care capacity in the pain management area including both increased interventional and medical pain management for JPS patients.	
JPS Physician Group				162334001
Related Category 3 Outcome Measure(s):	*162334001.3.1* *162334001.3.2* *162334001.3.3*	*IT-2.13* *IT-4.10* *IT-9.2*	*Other Admissions Rate* *Other Outcome Improvement Target: Lower Oncology Inpatient ALOS with Primary Pain Diagnosis* *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 specialty care gap assessment based on community need. Metric 1 [P-1.1]**:** Documentation of gap assessment. Goal: Produce a comprehensive gap assessment to meet demand for services and improve specialty care access. Data Source: Needs assessment pulled from EHR. Milestone 1 Estimated Incentive Payment: $1,728,710 **Milestone 2** [--- P-11]: Launch/expand a specialty care clinic for pain management. Metric 2 [- P-11.1]: Establish/expand	**Milestone 3** [- P-17]**:** Implement the re-design of pain specialty clinic in order to increase operational efficiency, shorten patient cycle time and increase provider productivity. Metric 3 [- P-17.1]: Number of medical specialty clinics that have completed clinic redesign. Goal: To shorten appointment cycle time and maximize provider productivity allowing the most efficient utilization of specialty provider resources. Data Source: Specialty clinic appointment tracking system Milestone 3: Estimated Incentive Payment: $1,803,639		**Milestone 5** [- I-2]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 5 [- I-2.1]: Documentation of increased number of visits. Goal: In DY4, increase volume of visits at pain center from current rate of <30 to >- 50 -. As well as >50 at the four satellite PCMH offices and >30 inpatient consults. Data Source: Enrollment reports, EHR Milestone : Estimated Incentive Payment: $1,932,650 **Milestone 6** [- I-6]: Patient satisfaction with pain management services**.**	**Milestone 7** [- I-2]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 7 [- I-2.1]**:** Documentation of increased number of visits. Goal: In DY5, increase volume of visits at pain center from current rate of <30 to >- 60 -. As well as >50 at the four satellite PCMH offices and >30 inpatient consults. Data Source: Enrollment reports, EHR Milestone 7: Estimated Incentive Payment: $1,867,294 **Milestone 8** [- I-6]: Patient satisfaction with pain management services**.**

162334001.1.1	***1.9.2***	***1.9.2 (A-D)***	Expand high impact specialty care capacity in the pain management area including both increased interventional and medical pain management for JPS patients.
JPS Physician Group			162334001
Related Category 3 Outcome Measure(s):	*162334001.3.1* *162334001.3.2* *162334001.3.3*	*IT-2.13* *IT-4.10* *IT-9.2*	*Other Admissions Rate* *Other Outcome Improvement Target: Lower Oncology Inpatient ALOS with Primary Pain Diagnosis* *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)**
specialty care clinics The redesign will include: • Clinic & procedure suite layout and design • Clinic mgt & staffing • Physician/provider staffing • Referral guidelines and requirements • Overall protocol guidelines for full pain clinic operations • Patient termination policy, procedure, and protocol for violators • Drug testing policy and procedures • Spine surgical backup and surgery services • Pharmacy services support • Clinic security • Establish 4 primary care PCMH's specializing in care for chronic pain patients which will increase outpatient visits • Develop a pain management	**Milestone 4** [- I-1]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties. <u>Metric 4</u> [- I-1.1]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted pain management specialty. Goal: Increase number of specialists to meet demand and referral demand for in-person visits and procedures that will allow patients to receive more timely services. This entails two board certified pain specialists and two mid-levels at the pain center along with four PCP's with a primary emphasis in pain at the PCMH clinics. For inpatient, one board certified pain specialist and one mid-level.	<u>Metric 6</u> [- I-6.1]: Patient satisfaction scores Goal: Improve patient satisfaction scores in HCAPHS for pain management by 1.5 points over baseline of 80.5 in DY4 Data Source: HCAPHS report Milestone 6: Estimated Incentive Payment: $1,932,649	<u>Metric 8</u> [- I-6.1]: Patient satisfaction scores Goal: Improve patient satisfaction scores in HCAPHS for pain management by 3.0 points - over baseline of 80.5 in DY5 Data Source: HCAPHS report Milestone 8: Estimated Incentive Payment: $1,867,294

162334001.1.1	***1.9.2***	***1.9.2 (A-D)***	Expand high impact specialty care capacity in the pain management area including both increased interventional and medical pain management for JPS patients.	
JPS Physician Group				162334001
Related Category 3 Outcome Measure(s):	*162334001.3.1* *162334001.3.2* *162334001.3.3*	*IT-2.13* *IT-4.10* *IT-9.2*	*Other Admissions Rate* *Other Outcome Improvement Target: Lower Oncology Inpatient ALOS with Primary Pain Diagnosis* *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)**
consult service for complex inpatient pain management Goal: Prepare specialty care plan to include items listed above to enhance care coordination for those patients requiring specialty paint services. Data Source: Site gap assessment, program documentation and EHR. Milestone 2: Estimated Incentive Payment: $1,728,709	Data Source: EHR information demonstrating employed specialists' productivity. Milestone 4: Estimated Incentive Payment: $1,803,638			
Year 2 Estimated Milestone Bundle Amount $3,457,419	**Year 3 Estimated Milestone Bundle Amount: $3,607,277**		**Year 4 Estimated Milestone Bundle Amount: $3,865,298**	**Year 5 Estimated Milestone Bundle Amount: $3,734,588**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $14,664,582				

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 1.1.2 – Expand Primary Care Capacity – Expand existing primary care capacity by expanding primary care clinic hours

Unique Project ID: 216719901.1.1
Performing Provider Name/TPI: Glen Rose Medical Center / 216719901

Provider: GRMC is a rural 16 bed hospital in Glen Rose, Texas serving a population of 7584 in 2011 with a 23% growth in Seniors (65 and over). GRMC is the county hospital in Somervell County for all indigent care as well as being the only facility in Somervell County.
Intervention: Expand clinic hours to allow residents of Somervell County to receive primary care services in an office environment therefore reducing the amount of ER visits for "clinic" type services & reducing readmissions. This is a new initiative.
Need for the project: 216 admissions last year were readmits at a cost of $9000 per patient – reducing this by 10% saves $198,000 in one year.
Target population: Uninsured and underinsured of Somervell county. Estimated number of patients to be served over course of waiver period: 663 additional. Having after hours clinic times available will allow Medicaid and uninsured patients the ability to be seen for well checks and hospital follow ups in an office environment instead of waiting until their conditions exacerbate. The opportunity for convenient, local healthcare is more likely to draw lower income patients that can not afford to drive to Fort Worth where public care might be available.
Category 1 or 2 expected patient benefits: Patient numbers – either new patients or the numbers that come during additional hours. The Category 1 or 2 milestones give us a blueprint to follow enabling us to measure the improvement achieved with this project.
Category 3 outcomes: Reduction in readmissions. The Medicaid and Uninsured patients of our county will be able to make follow up visits after hospital discharges.

Project Option 1.1.2 – Expand Primary Care Capacity – Expand existing primary care capacity by expanding primary care clinic hours

Unique Project ID: 216719901.1.1
Performing Provider Name/TPI: Glen Rose Medical Center/216719901

Project Description:

Expand existing primary care capacity by expanding the primary care clinic hours. We propose to add additional hours to our existing primary care clinics so that patients in the ZIP codes 76043, 76070 and 76077 will have access to the services needed in a timely manner. Currently our clinics are open 8:30 a.m. to 5 p.m. Monday-Thursday and 8:30 a.m. to noon on Fridays. We plan to open an after-hours clinic one night a week so that patients, including the working poor, will have access to their primary care physicians at least 8 non traditional workplace hours. Primary care at the right time is essential in preventive care particularly in chronic conditions such as COPD, CHF and diabetes. A delay in care in these conditions can lead to exacerbation of symptoms, onset of new illnesses that causes the patient to be seen in the emergency department and readmission in cases of recent discharge from an acute stay. The addition of clinic service hours will increase access to primary physicians providing enhanced outpatient management of chronic medical conditions, increase self-management and quality of life for patients served, and reduce readmissions.

Goals and Relationship to Regional Goals:

Project Goals:

The five-year goal of this project is to better serve patients in our area by seeing 15% more patients on an outpatient basis sooner, decreasing preventable hospital admissions and decreasing hospital readmissions by 10%.

This project meets the following Regional goals:

Challenges:

Three of the most common causes for readmissions in acute care hospitals are CHF, COPD and diabetes. Around 5.8 million people in the United States have heart failure with an additional 670,000 people diagnosed with it each year.[120] About 1.8 million adults have diabetes in Texas,[121] and COPD is the third leading cause of death in the United States.[122] In Somervell

[120] Heart Failure Fact Sheet – cdc.gov

[121] Texas Behavioral Risk Factor Surveillance System, 2010. Center for Health Statistics, Department of State Health Services.

[122] American Lung Association. www.lung.org/lung-disease/copd.

County, these three diagnoses are responsible for 45% of the deaths, according to the Texas Center for Health Statistics. A study in the New England Journal of Medicine shows 50.1% of the Medicare patients discharged from the hospital and rehospitalized within 30 days after discharge had not had an outpatient visit at a cost to Medicare of approximately $17.4 billion.[123] Currently a new patient in Somervell County must wait an average of six weeks before being seen by a primary care physician and an established patient must wait seven to ten weeks for the first available appointment. The expansion of "after hours" clinic is essential to allow patients to be seen in a timely manner, and to receive the right care at the right time in the right setting, thereby decreasing readmissions.

5-Year Expected Outcome for Provider and Patients:

The five-year expected outcome of this project is to reduce readmissions to GRMC by 10% by increasing our physicians' office visits by 15%. In a year, this will allow an additional 663 patients per physician to be seen, allowing for follow-up after discharge from the hospital. These additional follow-up appointments will assist in increasing self-management and preventive care.

Starting Point/Baseline:

From October 2011 to August 2012, of the 934 acute care and observation stays, 216 patients were readmitted within a 30-day time frame. We currently have five physicians employed by the hospital as well as two nurse practitioners with outpatient clinics open all day Monday through Thursday and half a day on Fridays.

Rationale:

The Community Health Needs Assessment points to access to primary care as an issue within our county. It also establishes an aging population, and as primary care physicians become increasingly fewer and harder to find in rural areas, it is incumbent on our facility to try to provide the right care at the right time in the right setting.

Project Components:

When patients in our community have timely access to their primary care providers, readmissions will decrease, and cost to patients will be reduced. With the expansion of clinic hours, Component A is not a necessity since we will use the same space we currently use for normal business hours. To defer adding any cost, we will not use Component C, expanding primary care staffing, but will instead flex our current staff to cover the additional hours.

Our milestones will measure the additional clinic hours and visits provided, as well as documenting the correlation in Category 3 of decreased readmissions.

[123] Jencks SF. Rehospitalizations among patients in the Medicare fee-for-service program. The New England Journal of Medicine 2009; 360:1418–1428.

Unique community need identification numbers the project addresses:

- CN.2– Lack of provider capacity

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

This project is a new initiative. No federal funding has been received for it.

Related Category 3 Outcome Measures:

Reasons/Rationale for Selecting the Outcome Measures:

Outcome Measure 1: Potentially Preventable Readmissions – 30-day Readmission Rates (stand-alone) The National Prevention Council has created the national prevention strategy, which places emphasis on wellness and prevention, with patients being seen in a clinic setting postdischarge, and with earlier intervention to decrease readmissions and lower costs associated with readmissions.

Relationship to Other Projects:

N/A

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

There are no other providers in the RHP proposing similar project with the same patient base. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Glen Rose has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

Glen Rose defined the population that will be directly impacted by the project as readmitted inpatients. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

216719901.1.1	*1.1.2*	*1.1.2.B*	*EXPAND PRIMARY CARE CAPACITY: EXPAND EXISTING PRIMARY CARE CAPACITY BY EXPANDING PRIMARY CARE CLINIC HOURS*	
Glen Rose Medical Center				*216719901*
Related Category 3 Outcome Measure(s):	*216719901.3.1*	*3.IT – 3.1*	*All-cause 30- day readmission rate NQF 1789*	
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]: Develop baseline of number of hours and patients seen during business hours Metric 1 [P-X.1] Baseline/Goal: Develop baseline of # of hrs and pt seen Data Source: Patient Census Milestone 1 Estimated Incentive Payment *(maximum amount):* $47,109 **Milestone 2 [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: Increase number of clinic hours by minimum of 8hrs a month Data Source: Assessment of clinic hours and census Milestone 2 Estimated Incentive Payment *(maximum amount):* $47,110	**Milestone 3 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2) Baseline/Goal: 5% improvement over baseline for 5 providers and 2 mid-levels Data Source: Patient Census Milestone 3 Estimated Incentive Payment: $103,145		**Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2) Goal: 10% improvement over baseline for 5 providers and 2 mid-levels Data Source: Patient Census Milestone 4 Estimated Incentive Payment: $110,341	**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 for DY2) Goal:15% improvement over baseline for 5 providers and 2 mid-levels Data Source: Patient Census Milestone 5 Estimated Incentive Payment: $94,538

216719901.1.1	***1.1.2***	***1.1.2.B***	***EXPAND PRIMARY CARE CAPACITY: EXPAND EXISTING PRIMARY CARE CAPACITY BY EXPANDING PRIMARY CARE CLINIC HOURS***	
Glen Rose Medical Center				*216719901*
Related Category 3 Outcome Measure(s):	*216719901.3.1*	*3.IT – 3.1*	*All-cause 30- day readmission rate NQF 1789*	
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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $94,219	Year 3 Estimated Milestone Bundle Amount: $103,145		Year 4 Estimated Milestone Bundle Amount: $110,341	Year 5 Estimated Milestone Bundle Amount: $94,538
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $402,243				

Category 2: Program Innovation and Redesign

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.4.1– Implement a strategic improvement program for patient satisfaction (Redesign to Improve Patient Experience)

Unique Project ID: 020950401.2.1
Performing Provider Name/TPI: Medical Center of Arlington /020950401

Provider: Medical Center of Arlington is 278 bed acute care hospital with a primary and secondary service area population of 570,000. It is also a level 4 trauma center with 32% inpatient Medicaid and Uninsured, 51 % ED patients are Medicaid and uninsured.
Intervention: The goal of the project is to implement process improvement plans that target specific patient experiences. The purpose is to change the organizational culture and impact patient safety and quality with improved patient experience. This is would be a new intervention.
Need for the project: Patient experience scores reflect a deficiency in key areas that are critical for patient safety and quality of care. These include communication with physicians and nurses, communication regarding medications and discharge process. Patients who are Medicaid eligible or uninsured are most vulnerable to communication matters due to greater language and cultural barriers. These patients also face greater obstacles for discharge planning with lack of resources and support in post-acute care. Underserved and Medicaid patients will benefit to greater degree with improvement in processes that make for a better patient experience.
Target population: Target population is all patients served by hospital. Estimated number of patients to be served over course of waiver period: This would be difficult to quantify since the all patients are targeted priority on inpatients; we estimate 15,000 a year or 60,000 over course of the waiver will be impacted. We do actively survey 100 patients a month/1200 a year . Patients who are Medicaid eligible or uninsured are most vulnerable to communication matters due to greater language and cultural barriers. These patients also face greater obstacles for discharge planning with lack of resources and support in post-acute care. Underserved and Medicaid patients will benefit to greater degree with improvement in processes that make for a better patient experience.
Category 1 or 2 expected patient benefit: How do they tie into project's purpose? The project seeks to improvement in patient satisfaction scores as measured by HCAHPS Grand Composite . This will be a benefit to patients from better communication with nurses and doctors , better medication management, pain management and discharge planning. Studies have shown with improved patient experience, the quality of care patients experience also improves. This will result in reduce preventable complications such as infections, less readmissions and reduced medication errors. It is estimated patients impacted will be DY 2-15,000, DY 3-15,450, DY 4-16,222, DY5-17,033.

Category 3 outcomes: IT-6.1 Our goal is to improve Percent Improvement over baseline of patient satisfaction scores from 64% currently to 75% by DY5. Improvement in scores is part of the purposed of project.

Project Option 2.4.1– Implement a strategic improvement program for patient satisfaction (Redesign to Improve Patient Experience)

Unique Project ID: 020950401.2.1
Performing Provider Name/TPI: Medical Center of Arlington /020950401

Project Description:
Medical Center of Arlington is proposing a project to establish baseline Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey scores and implement a patient/family experience strategic plan.

A steering committee will be formed and workgroups of the committee will work on process improvements for patient experience targets. Evaluation will be performed and documented to measure implementation progress, results and make adjustments to improvement plans. As part of the strategic plan, patient experience will be an integral part of employee orientation. A communication plan on work being done to improve the patient experience will be developed and implemented to ensure all employees and physicians are included on progress and initiatives. Studies have shown that improved patient experience can improve patient health outcome and quality.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of the project is to implement process improvement plans that target specific patient experiences. The purpose of performing this project is to engage all stakeholder such as leader and employees who can be the high-level role to drive the patient experience improvement across the hospital for a cultural change at the organizational level.

This project meets the following Regional goals:
A major goal of the Region is to pursue the triple aim of improving patient experience of care, improving health of populations and reducing health care costs. Redesigning the patient experience in the Region will impact the health of our community by keeping patients engaged in the health care system.

Challenges:
The hospital has been participating in HCAHPS to measure patient experience in the hospital setting. Implemented training plans have not improved scores. Medical Center of Arlington has achieved grand composite scores of 64% for 2010Q3-2011Q2 and 64% for 2010Q4-2011Q3, which is consistently been below the CMS national average. The scores summarize:

- How well nurses and doctors communicate with patients
- How responsive hospital staff are to patients' needs
- How well hospital staff help patients manage pain
- How well the staff communicates with patients about medicines, and whether key information is provided at discharge
- Cleanliness and quietness of patients' rooms
- Patients' overall rating of the hospital and whether patients would recommend the hospital to family and friends

The project will address targeted patient experiences with that have not been improved by other initiatives.

5-Year Expected Outcome for Provider and Patients:
We expected to be > 75th percentile on grand composite scores for CMS HCAHPS at the end of the Waiver period.

Starting Point/Baseline:
Medical Center of Arlington has achieved grand composite score of 64% in 2010Q3-2011Q2 and 64% 2010Q4-2011Q3, which has consistently been below the CMS national average.

Rationale:
Patient experience scores are measured internally and reported quarterly from a Gallup Survey. These scores are shared with senior leaders and staff in Dashboards and reports. Various committees work on departmental and process issues, but a coordinated, system wide approach is lacking. A patient/family experience strategic plan will eliminate duplication of time and effort and provide a roadmap for improvement and best practice. Engaging patients and families in the process will strengthen the organization's resolve to get better and stay better.

The overall approach to redesigning patient experience will be centered on cultural change at the organizational level. This will involve clinicians, patients and their families or caregivers. An organizational strategy will be developed so that we manage patient experience and create avenues to implement the strategic plan/vision. This project option is best for organizational integration, which is critical to successful patient experiences.

Project Components:
All core components will be implemented.

a) Organizational integration and prioritization of patient experience;
b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and

Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;

c) Implementing processes to improve patients' experience in getting through to the clinical practice;
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

Establishing a steering committee with high-level leadership is necessary to drive cultural change to impact patient experiences. A communication plan will be developed to inform all employees and physicians of the work of the steering committee and results to better integrate the process and changes into the culture. Process improvements needed will be identified and analyzed with Lean Six Sigma tools. The work groups will be empowered to implement changes identified and report back to the steering committee. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Evaluation, control and sustain activities are necessary for continuous quality improvements. We will measure the impact of the improvements implemented from CMS HCAPS scores.

Unique community need identification numbers the project addresses:

- CN.10 – Overuse of the emergency department services
- CN.11 – Need for more care coordination
- CN.12 – Need for more culturally competent care to address unmet needs

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

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:
IT-6.1 Percent improvement over baseline of patient satisfaction scores

An organizational strategy will be developed so that hospital will manage patient experience and create avenues to implement the strategic plan/vision. Performance will be measured, among other factors, by the extent to which patient experience improves.

In October 2005, the Joint Commission's Journal on Quality and Patient Safety published a series of case studies of health care institutions' efforts to improve both quality and safety. One

of these was from Lehigh Valley Hospital in Allentown, Penn., which used active engagement of patients and families in attempting to improve patient safety.[124]

Weingart and colleagues (2006) examined inpatients' reports of service incidents — deficiencies in service quality such as waits/delays, poor communication, poor care coordination, lack of respect for personal preferences, or environmental issues. They found that roughly 40% of patients reported at least one incident and that reporting of incidents was associated with diminished patient satisfaction.[125]

Also, Kaldenberg and Trucano (2007) examined facility-level relationships between hospital-acquired infection (HAI) rates and patient perceptions of specific aspects of hospital quality in the State of Pennsylvania. Specifically, they chose three questions from an inpatient survey thought to measure practices that, when poorly executed, could create a more infection-prone environment: ratings of cleanliness; of the skill of the person who took the patient's blood; and of nurses' response to the call button. All three were found to be significantly, negatively correlated with HAI rates.[126]

Relationship to Other Projects:

This project is to redesign to improve the patient experience. Projects 020950401.2.3 will enhance the coordinated care model for access to care to better meet the needs of patients and family.

This project supports 020950401.4.5, RD-4 Patient-centered health care. The project will implement training and improvement work on experience targets aimed to increasing patient satisfaction with the hospital, nurses and physicians that will result in a better patient experience.

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

The other providers proposing similar projects:

- JPS
- Plaza Medical Center Fort Worth
- Glen Rose Medical Center

[124] Anthony R, Ritter M, Davis R, Hitchings K, Capuano TA & Mawji Z. (2005). Lehigh Valley Hospital: engaging patients and families. *Joint Commission Journal on Quality and Patient Safety.* 31(10), 566-572.

[125] Weingart SDN, Pagoviceh O, Sands DZ, Li JM, Aronson ,MD, Davis RB, Phillips, RS & Bates DW. (2006). Patient-reported service quality on a medicine unit. *International Journal of Quality in Health Care*, 18(2), 95-101.

[126] Kaldenberg D. & Trucano M. (2007). The relationship between patient perceptions of hospital practices and facility infection rates: Evidence from Pennsylvania hospitals. *Patient Safety and Quality Health Care.*

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Medical Center of Arlington has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Medical Center of Arlington defined the population that will be directly impacted by the project as patients with Medicare and all patients who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 4 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The rate per Medicare case of $10,661 was used to calculate the estimated loss of revenues using these penalty % for DY 2- 0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.05% . This totaled $1,236,300.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $ 532,000. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $ 539,000.

The total value of the project was calculated at $2,307,724. Approximately 79% of the project value was assigned to the Category 2 project, $1,824,718 and 21% to the Category 3 project, $483,010.

020950401.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***
Medical Center of Arlington			*020950401*
Related Category 3 Outcome Measure(s):	*020950401.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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]: Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee should meet at least twice a month. Metric 1 [P-3.1]**:** Documentation of committee proceedings and list of committee Members. Baseline/Goal: Establish committee and meeting schedule Data Source: Meeting minutes, agendas, participant lists, and/or list of steering committee members Milestone 1 Estimated Incentive Payment *(maximum amount):* $226,915 Milestone 2 [P-2]: Write and disseminate a patient/family experience strategic plan	**Milestone 3** [P-11]: Orchestrate improvement work on identified experience targets (IP and Ambulatory strategies for improved caregiver communication (i.e. nurse and physician communication), responsiveness of staff and pain management). Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup. Metric 1 [P-11.1]: Submission of implementation plan. Baseline/Goal: Work plan write up and implementation of phase 1 Data Source: Implementation plans Milestone 3 Estimated Incentive Payment *(maximum amount):* $154,720 **Milestone 4** [P-13]: Perform a mid-course evaluation of the results	**Milestone 6** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 20 displays Data Source: Verification of displays, methodology and CEO report to employees, physicians and steering committee Milestone 6 Estimated Incentive Payment *(maximum amount):*	**Milestone 7** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 25 displays Data Source: Verification of displays, methodology and CEO report to employees, physicians and steering committee Milestone 7 Estimated Incentive Payment: $410,187

020950401.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Medical Center of Arlington				*020950401*
Related Category 3 Outcome Measure(s):	*020950401.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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)**
Metric 1 [P-2.1]: Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization Baseline/Goal: Documented patient experience plan and communication strategies well defined Data Source: Completed patient experience plan, verification of communication throughout the organization. Milestone 2 Estimated Incentive Payment *(maximum amount):* $226,914	of improvement projects / Make necessary adjustments and continue with implementation Metric 1 [P-13.1]*:* Submission of evaluation results. Goal: Evaluate 100% of improvement projects Data Source: Evaluation write –up Milestone 4 Estimated Incentive Payment: $154,720 **Milestone 5** [P-4]: Integrate patient experience into employee training. Metric 1 [P-4.1]: 100 % of new employees who received patient experience training as part of their new employee orientation. Baseline/Goal: Develop training Data Source: Implementation plans Milestone 5 Estimated Incentive		$496,543	

020950401.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Medical Center of Arlington				*020950401*
Related Category 3 Outcome Measure(s):	*020950401.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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)**
	Payment *(maximum amount):* $154,719			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $453,829	Year 3 Estimated Milestone Bundle Amount: $464,159		Year 4 Estimated Milestone Bundle Amount: $496,543	Year 5 Estimated Milestone Bundle Amount: $410,187
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,824,718				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.8.11– Apply Process Improvement Methodology to Improve Quality/Efficiency (Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications)

Unique Project ID: *020950401.2.2*
Performing Provider Name/TPI: Medical Center of Arlington /020950401

Provider: Medical Center of Arlington is 278 bed acute care hospital with a primary and secondary service area population of 570,000. Level 4 trauma center with 32% inpatient Medicaid and Uninsured, 51 % of ED patients are Medicaid and uninsured.
Intervention: This project will implement process improvement methodologies in a sepsis evidenced based care program to reduce sepsis complications. Sepsis Resuscitation and Management Bundle program was kicked off in 2012 as a hospital specific program. Process improvement would be an expansion/enhancement.
Need for the project: Mortality for sepsis nationally is >30%. Regional readmissions for sepsis are was 22% in 2011 with mortality for readmission at 10.5%. Sepsis was also top 50% of reasons patients readmitted for each of the 10 index conditions and a higher mortality rate for readmission than all other conditions. Readmission for sepsis can occur due to early discharge, improper antibiotic treatment and lack of continuation of medication .(DFW Hospital Council data)
Target population: The target population is patients presenting to ED and all patients diagnosed with sepsis shock, severe sepsis. Approximately 50% of patients to be screened are Medicaid and indigent. It is estimated currently 15% of our patients treated for sepsis are Medicaid eligible or indigent. Estimated number of patients to be served over course of waiver period: Based on current processes over 625 patients, however with improvement in diagnosis a key element of the program, this number is expected to increase to estimated 1200 patients in 5 years. Patients who are Medicaid eligible or uninsured will benefit as they more often use the ED and their illness is farther progressed when presenting to ED along with greater complexity of co-morbid diseases. Due to lack of access to medical care patients tend to delay seeking care which can lead to harmful results. The quicker diagnosis of sepsis and evidence-based care will prevent greater mortality and disability from sepsis.
Category 1 or 2 expected patient benefits: The project seeks to increase the timeliness of correctly diagnosing sepsis in order the begin evidence-based care with improved the compliance with Sepsis Bundle and Resuscitation for patients diagnosed with severe sepsis and septic shock. We expect to diagnose and treat 1200 sepsis patients (estimated at DY 1- 112, DY2-235, DY 3-259, DY 4- 284, DY 5-310). 112 patients were diagnosed in DY 1 with the implementation of the sepsis program. However only 82 patients were properly treated with the evidence based care plan from the program. In addition it is estimated based on similar size hospitals with sepsis programs, we should expect to diagnosis between 235 and 300 patients a year. Potentially we are

not properly diagnosing 125 patients a year. Patients that may not diagnosed/diagnosed timely or not receive evidence based treatment may have resulted in death or disability. The program will have great benefit to patients to reduce harm from lack of proper and timely diagnosis and/or lack of evidence based treatment.

Category 3 outcomes: The outcomes selected reflect the effectiveness of implementing evidence-based care such as reduction in mortality and decreased length of stay.
IT-4.8 Our goal is to reduce the Sepsis Mortality of patients diagnosed with sepsis estimated DY 1 mortality was 27% and improvement of 25% by DY 5, morality would be 20%.
IT -4.9 Our goal is the reduce the Average length of stay of patients with sepsis Estimated DY 1 ALOS was 8.9, a reduction goal by DY 5 of 2 days to ALOS of 6.9.
Project Option 2.8.11– Apply Process Improvement Methodology to Improve Quality/Efficiency (Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications)

Unique Project ID: *020950401.2.2*
Performing Provider Name/TPI: Medical Center of Arlington /020950401

Project Description:
The project will design and implement a process improvement plan to increase the utilization and compliance with sepsis resuscitation and management bundles to improve patient outcomes.

Medical Center of Arlington is committed to continuous quality improvement so all of our patients receive the safest and highest quality health care possible. We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis. Our processes and interventions are based upon evidence-based care models, which include a sepsis resuscitation bundle for emergency department (ED) patients and a sepsis management bundle for ongoing care. Rapid diagnosis and management are cornerstones to successful outcomes.

The ICU and ED plans for improvements in sepsis identification and treatment includes revising the electronic nurse sepsis screening at triage, implementing an electronic nurse sepsis screen to aid in early detection of inpatients, staff education regarding sepsis screening, and refining the Rapid Response Team (RRT) processes to include sepsis screening and initial resuscitation. This allows the RRT to begin fluid resuscitation on the in-house patient who screens positive for severe sepsis or septic shock and is hypotensive.

Medical Center of Arlington will also track primary endpoints of mortality and ICU LOS. Process and other measures that will be tracked include percentage of patients initiated on vasopressors and mean days of vasopressor use, percentage of patients initiated on the

mechanical ventilator and mean ventilator days, and initiation of hemodialysis or continuous renal replacement therapy.

Our target population is any patient diagnosis of severe sepsis, septic shock, and/or lactate >4 mmol/L (36 mg/dl).

Although great work has been done to implement protocols and interventions, utilization and compliance of sepsis resuscitations and management bundles still remains a challenge. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of this project is to implement Process Improvement plan to improve safety and quality for those patients with sepsis. We will:

1. Achieve 90% compliance with the sepsis resuscitation and management bundles in patients admitted to the ICU.
2. Substantially improve early sepsis identification, reduce sepsis-related mortality by 25% from baseline.
3. Develop an effective and fully implemented measurement and reporting system supporting compliance with the sepsis resuscitation and management bundles.
4. Continue to work with Emergency Medical Services to improve delivery of care provided to patients with suspected infection.
5. Improve identification of sepsis patients housewide by implementing nursing admission screening and shift assessments for sepsis screening.
6. Improve identification of sepsis, compliance with current sepsis resuscitation and management bundles in the emergency department.

This project meets the following Regional goals:
This project supports the Regional goals to improve the patient care experience, health outcomes for the population and the per capita cost of care. Specifically, this project will improve the early diagnosis of patients with severe sepsis and septic shock so that evidence-based care can be delivered. Improved recovery of patients with severe sepsis and septic shock will reduce unnecessary death and harm and reduce cost of posthospital care in addition to quality-adjusted life gained.

Challenges:

According to the CDC 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic shock, each year, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Proactive analysis of the factors contributing to the design of evidenced-based standardized care sets and subsequent adoption of those tools will reduce variation and associated cost. Early recognition and management of sepsis results in lives saved.

5-Year Expected Outcome for Provider and Patients:

We expect to reach 100% compliance in identification/diagnosing of patients with severe sepsis, septic shock, and/or lactate > 4 mmol/L (36 mg/dl). We also expect to be 90% compliant with application of the sepsis bundles for patients who meet specified criteria.

Starting Point/Baseline:

The number of patients with severe sepsis, septic shock and/or lactate>4mmol/L (36mg/dl) that would qualify for sepsis resuscitation and management bundles based on expected sepsis claims from similar size hospital and mature sepsis programs would be 235 to 300 per year for a total of 1200 patient over course of the waiver. The hospital only diagnosed 112 patients in DY 1. Of those patients diagnosed only 82 received evidenced based care for sepsis bundles. Active implementation of sepsis resuscitation and management bundles and data collection is beginning in 2012. Early data collection indicates compliance with sepsis bundles is a low as 50%.

Rationale:

According to the CDC 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic shock, each year, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Our internal data shows a mortality rate as high as 60%. Identification and treatment protocols have been developed and implemented to impact mortality and ICU LOS, which has improved. We are in the early stages of implementing the program components, and we still face challenges. Additional interventions will be implemented (e.g., shift assessments on all in-house

patients). To be successful, we need to eliminate/correct processes that create time delays, non-compliance to order set, and failure to identify/diagnose sepsis. We have been as low as 50% in compliance in implementing sepsis bundles. We believe in order to continue to see improvement from initial implementation, continuous quality improvement through data collection, analysis and review will accelerate change through our multidisciplinary teams.

Project Components:
The project components to report number of patients diagnosed correctly and for sepsis bundle compliance are necessary to measure the success of implementing the sepsis improvement plan.

A sepsis improvement plan must have key elements to be successful. A project plan is necessary to identify and engage all stakeholders (ED, inpatient units, EMS), understand current status, resources, baselines, roles and responsibilities, expectations of individuals and outcomes. In order to have an impact on reduction in mortality and average length of stay, compliance with sepsis diagnosis and protocols for sepsis bundles are critical. In implementation, it is necessary to examine the plan, understand what is working and what is not, identify barriers and make corrective action. Continuous quality improvement (CQI) activities will be conducted to ensure successful implementation. In DY2 and DY 3, milestones to implement a program to improve efficiencies and/or reduce program variation are essential to the success of sepsis program. The practice strategy for PDSA and CQI will be a Lean Six Sigma DMAIC approach. A Value Stream Mapping will allow us to document the current state of the program implemented in 2012. The Value Stream Mapping and metric results will determine where variation exits and which processes are constraints to the success of the program. This will help us identify the priority for processes improvement events to be conducted. The team will conduct events utilizing tools to find root causes of variations or process delays. Changes will be implemented with appropriate tools to update the program process. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Each year a Value Stream Mapping can be utilized to validate change, document current state and continue the cycle of process improvement.

Unique community need identification numbers the project addresses:

- CN 11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Sepsis resuscitation and management bundle program kicked off in 2012 as a hospital-specific program. Applying process improvement methodologies to the sepsis program will greatly enhance the chances of success in implementing the plan and seeing reduction in mortality and average length of stay.

Related Category 3 Outcome Measures:
We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Outcome Measures and Reasons/Rationale For Selecting The Outcome Measures:
IT-4.8 Sepsis mortality (Stand-alone measure)

By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early treatment and decrease length of stay, reduce health care cost and mortality. Institute for Healthcare Improvement; Surviving Sepsis Campaign; Society of Critical Care Medicine; IDSA Guidelines for appropriate antibiotic selection.

IT-4.9 Average length of stay (Non-stand-alone measure)

By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early treatment and decrease complications with resulting length of stay in ICU and overall LOS.

Relationship to Other Projects:
This project supports the population-focused improvements 020950401.4.4, RD-3 Potentially Preventable Complications (PPCs). Improved quality with evidence-based care for sepsis increases education, training, and screening that will reduce preventable complications in the hospital setting.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
The following providers are also proposing projects to address sepsis resuscitation and management improvement:

- JPS
- Plaza Medical Center Fort Worth
- North Hills Hospital
- Huguley Memorial Medical Center
- Texas Health Harris Methodist HEB

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Medical Center Arlington has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Medical Center Arlington defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The percentage of the population expected to be positively impacted by the project for mortality is 3%, which was determined based on outcome target for reduction in mortality by 25% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 50. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $500,000 for 5 years.
The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 9 days per patient. This was estimated at total of reduced in patient days by DY 5 of 1765. The estimated cost per day for a sepsis patient is $907. This totaled approximately $1,600,000

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $500,000.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 1. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $962,000

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $440,000.

To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $641,000.

The total value of the project then was estimated at $4,643,316. Approximately 79% of the total value was assigned to Category 2 project and the remaining 11% of value assigned to Category 3 outcome for Sepsis Mortality and 9.7% assigned to Category 3 outcome for reduced Average Length of Stay.

020950401.2.2	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE-BASED INTERVENTION THAT WILL LEAD TO REDUCTIONS IN SEPSIS COMPLICATIONS***	
Medical Center of Arlington				*020950401*
Related Category 3 Outcome Measure(s):	*020950401.3.2* *020950401.3.3*	*3.IT-4.8* *3.IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
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.1]: Documentation of Sepsis Improvement Plan Baseline/Goal: Plan Data Source: Plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $228,284 **Milestone 2** [P-6.]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events Baseline/Goal: Implement events Data Source: Plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $228,284 **Milestone 3** [P-X]: Participate in a	**Milestone 5** [P-6]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events (Documentation of all steps conducted in the PDSA) Baseline/Goal: Develop a sepsis improvement plan Data Source: Plan Milestone 5 Estimated Incentive Payment: $311,307 **Milestone 6** [I-13.1]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal: Improve compliance to 50%, 129 cases on bundle Data Source: EHR Milestone 6 Estimated Incentive Payment: $311,308 **Milestone 7** [I-13]: Progress toward target/goal (Compliance with correct		**Milestone 8** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1] Number or percent of all clinical cases that meet target/goal Goal: Improve compliance to 70%, 198 cases in bundle Data Source: EHR Milestone 8 Estimated Incentive Payment: $499,540 **Milestone 9** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance by 20% from baseline Data Source: EHR Milestone 9 Estimated Incentive Payment: $499,540	**Milestone 10** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal : Improve compliance to 90%, 279 cases on bundle Data Source: EHR Milestone 10 Estimated Incentive Payment: $412,664 **Milestone 11** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal : Improve Sepsis Diagnosis Compliance by 25%from baseline Data Source: EHR Milestone 11 Estimated Incentive Payment: $412,663

020950401.2.2	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE-BASED INTERVENTION THAT WILL LEAD TO REDUCTIONS IN SEPSIS COMPLICATIONS***	
Medical Center of Arlington				*020950401*
Related Category 3 Outcome Measure(s):	*020950401.3.2* *020950401.3.3*	*3.IT-4.8* *3.IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
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)**
learning collaborative Metric 1 [P-X.1]: Submit report for Sepsis Improvement Plan findings Baseline/Goal: Annual conference Data source: Conference meeting attendance and minutes Milestone 3 Estimated Incentive Payment *(maximum amount):* $228,285 **Milestone 4** [P-X]: Establish baseline, in order to measure improvement over self (for correct timely diagnosis of sepsis and bundle compliance) Metric 1 [P-X]: Conduct assessment of targeted population Baseline/Goal: Percent compliance with correct timely diagnosis of sepsis Data source: EHR Metric 2 [P-X]: Conduct assessment of targeted population Baseline/Goal: 2011 Sepsis Bundle compliance 3% Data source :EHR	timely diagnosis of Sepsis) Metric 1 [I-13.1.2]: Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance by 15% from baseline Data Source: EHR Milestone 7 Estimated Incentive Payment: $311,308			

020950401.2.2	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE-BASED INTERVENTION THAT WILL LEAD TO REDUCTIONS IN SEPSIS COMPLICATIONS***	
Medical Center of Arlington				*020950401*
Related Category 3 Outcome Measure(s):	*020950401.3.2* *020950401.3.3*	*3.IT-4.8* *3.IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
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 4 Estimated Incentive Payment *(maximum amount):* $228,285				
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $913,138	Year 3 Estimated Milestone Bundle Amount: $933,923		Year 4 Estimated Milestone Bundle Amount: $999,080	Year 5 Estimated Milestone Bundle Amount: $825,327
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $3,671,468				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.12.2– Implement a Care Transition Program for Patient at high risk of readmission

Unique Project ID: 020590401.2.3
Performing Provider Name/TPI: Medical Center of Arlington / 020590401

Provider: Medical Center of Arlington is 278 bed acute care hospital with a primary and secondary service area population of 570,000. Level 4 trauma center with 32% inpatient Medicaid and Uninsured, 51 % of ED patients are Medicaid and uninsured.
Intervention: The project is to implement a program for improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Medical Center of Arlington has not had a formal care transition program only discharge planning and placement.
Need for the project: Readmissions within 30 days of admission was 14% in 2011 (71,153). Of the total readmission in the region, 22% were Medicaid eligible or uninsured (15,653). Reduction in readmissions in region will save lives and reduce overall health care costs.
Target population: The target population of inpatient admissions that are high risk for re-admission. We estimate 34% of patients that are at risk for re-admission are a high risk. Based on studies of readmissions, 20% of high risk patients are readmitted in 30 days and 32% are readmitted in 90 days. Estimated number of patients to be served over course of waiver period: It is estimated 1,050 patients will be served over the course of the waiver. Patients who are Medicaid eligible or uninsured will benefit as they more often have higher risk to transition from hospital care due to lack of financial resources, language and cultural barriers and lack of support systems.
Category 1 or 2 expected patient benefit: The purpose of the project is to select the patients at high risk of readmission and selected interventions to reduce readmission. The process milestone to standardized care transition processes and create a patient identification system are necessary to have program for those interventions needed and a way to identify high risk patients. Reducing preventable hospitalizations and preventable rehospitalization lowers health costs and improves patients' quality of life. In DY3 we expect to have 250 patients in the care transition program, by DY 4 this will increase to 525 additional patients and by DY 5, 787 additional patients. This is expected to be unique patients will be receiving targeted interventions to reduce the risk of re-admission.
Category 3 outcomes: IT -3.2 Congestive Heart Failure 30 day readmission rate. Congestive Heart Failure readmission at Medical Center of Arlington has been > 20%. Purpose is to reduce high risk patient, it is known that patients with CHF are high risk due to chronic nature of illness and medications.

Project Option 2.12.2– Implement a Care Transition Program for Patient at high risk of readmission

Unique Project ID: 020950401.2.3
Performing Provider Name/TPI: Medical Center of Arlington/020950401

Project Description:
This project will establish a Care Transition program for discharged patients who are at high risk of readmission in need of care coordination.

The project corresponds to Project Area 2.12 Implement/Expand Care Transitions Programs, Option 2.12.2. In developing the program, various interventions will be tested and piloted to decide best work for what patients. These will include discharge checklists, hand-off communication plans with receiving providers, and early follow-up such as home care visits, primary care outreach, and/or patient callbacks. Resources such as staffing, service providers (internal or external) and partners necessary to carry out the interventions will be indentified and acquired.

Care Transition plan processes will be developed along with policies and procedures to implement the interventions identified as best practices.

A risk assessment tool will be used to identify patients at high risk for readmission and most in need of intensive case management on a routine basis A case management registry will be implemented to demonstrate case management functionality.

A monthly meeting for collaboration will be held with eight other providers in the Region (RHP 9, 10 and 18) implementing care transition programs. Those participating in the collaborative include case management, quality, and chief medical officer. The goal will be to decide on protocols and interventions, partnering with other providers, and sharing experiences and results.

Goals and Relationship to Regional Goals:

Project Goals:
The ultimate goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, postacute care, and home care settings in order to prevent increased health care costs and hospital readmissions. In order to achieve this goal, care transitions must be safe and effective. The purpose of this project is to assure a comprehensive, evidence-based program including written policies and procedures with protocols, staff training and quality improvement activities is put into practice to reduce readmissions.

This project meets the following Regional goals:
Regional goals include having better health outcomes and reduced health cost. This project contributes to these goals with better/optimal health outcomes achieved by improving patient education, self-management skills, and safe, effective care transition to postacute to avoid gaps/failures in care delivered to patients. Reducing readmission prevents morbidity declines, stabilizes health and prevents hospitalization costs.

Challenges:
Medical Center of Arlington, like many acute care hospitals, faces challenges in ensuring appropriate discharge and safe, effective care transition. We rely on other providers for the postacute care of patients. There are inherent issues with relying on other providers, such as hand-off communications, standard of care variations, and lack of feedback on results of postacute care. Patients' circumstances can also present challenges. These include but are not limited to, barriers from patients' socioeconomic status, lack of support (family/community), and lack of insurance/ financial coverage for postacute services.

A Care Transition program will implement interventions such as hand-off communication tools and follow-up with postacute care providers to bridge the gap to better ensure care is provided timely and appropriately. The program will also attempt to identify patients' individual barriers before discharge. Once the barriers are known, case managers can proceed with effective interventions to mitigate risk of ineffective discharge and transition.

5-Year Expected Outcome for Provider and Patients:
Medical Center of Arlington's goal is to register at least 50% of patients identified as high risk for readmission in registry. In DY3 we expect to have 250 patients in the care transition program, by DY 4 this will increase to 525 additional patients and by DY 5, 787 additional patients. This is expected to be unique patients, that will be receiving targeted interventions to reduce the risk of re-admission. We expect the re-admissions for these patients to be reduced by 50%.

Starting Point/Baseline:
Medical Center of Arlington has identified 16,000 cases at risk for readmission from Q1 2011 to Q4 2011. We estimate 34% of patients are at risk for readmission. Based on studies of readmissions, 20% of high-risk patients are readmitted in 30 days and 32% are readmitted in 90 days. In DY2, we will establish a baseline number for high-risk patients using appropriate risk assessment tools to establish the defined population that will be targeted with the care transition program. We estimate there are 1,050 patients in a year at high risk for readmission in 30 days based on these trends.

Rationale:
Patients face many obstacles in discharging from acute care hospitals to ensure a safe and effective transition to the next care setting. We have identified and measured readmissions over time and have improved the rate of readmission with traditional discharge planning. However,

the traditional discharge planning process is proving less effective with more patients with chronic diseases and patients with multiple comorbidities, as the care transition is often too complex for standard discharge planning

Care transition coordination at postdischarge from an acute care setting with specific evidence-based interventions is necessary to reduce risk factors and avoid readmissions.

Project Components:
The components in this project option allow for more innovation with testing and piloting of interventions such as discharge checklists, hand-off communication with receiving providers, which is important to Medical Center of Arlington. Preset interventions limit the tailoring of care, and Medical Center of Arlington seeks the opportunity to test new interventions with population and market changes, as well as with updated evidence-based interventions available in the next five years.

The milestones selected reflect the actions necessary to develop a care transition program. The project will need to pilot and test interventions on the patient population targeted for care transition programs. The risk assessment tool will be developed and utilized to select the patients in need of care management. Interventions will be added to policy and procedures to allow for system adoption by identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care. Tracking patients, interventions and outcomes will be a part of the project. As such, a case management registry will be implemented.

Unique community need identification numbers the project addresses:

- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Medical Center of Arlington has not had a formal care transition program. Discharge planning for postacute services has been provided for patients based on medical need. Ensuring appropriate services are carried out to avoid discontinuity of care and follow-up to measure results on interventions have not been consistently in place.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
IT-3.2 Congestive heart failure 30-day readmission rate

Congestive heart failure was the top cause of preventable hospitalizations (194.8 per 1,000 Medicare enrollees) in RHP 10. Reducing preventable hospitalizations and preventable rehospitalization lowers health costs and improves patients' quality of life.

The basis for selecting a Care Transition program is the evidence-based studies that have tested various interventions and measured successful outcomes of reduced readmissions.

The care transition from acute care to postacute care setting can be fragmented without appropriate standards of care in place to avoid gaps in transition. Actively screening patients for risk factors is the first step. Communications and expectations of patients and providers must be improved. Patient education and coaching are also key to allow patients the best chance of success in self-management of their care.
We believe Care Transition programs provide best prospect to address these issues and to be successful in reducing readmissions.

There are many validated evidence-based programs/models that have been developed and tested for care transition programs' effectiveness in reducing readmissions. These include Naylor, RED and BOOST. Also the Institute for Health Care Improvement has issued a report detailing various care transition programs/models and interventions tested and effective in reducing readmissions.[127]

Relationship to Other Projects:
This project supports and reinforces 020950401.2.1 Redesign to Improve Patient Experience. Part of redesigning the patient experience includes the discharge planning process, which the Care Transition program will address.

This project supports the focused improvement of 020950401.4.3, RD-2 30-day readmission, as it will enable patients to receive appropriate targeted interventions aimed at preventing the need for hospitalization. It also supports 020950401.4.5, RD-4 Patient –centered health care, as the patient experience will be improved through comprehensive care management assisting patients with discharge to their next care setting..

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
Other providers in the RHP will be implementing Care Transitions projects:

- JPS
- UNTHSC
- Wise Regional Health System

This project will participate in the Region's Learning Collaborative activities. *(See Appendix G for a discussion of the Region's two proposed learning collaboratives, along with a list of participating provider projects for each.)*

Project Valuation:

[127] Boutwell A. Griffin F. Hwu, S. Shannon, D. Effective interventions to reduce rehospitalizations: a compendium of 15 promising interventions. Cambridge, MA: Institute for Healthcare Improvement; 2009.

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Medical Center of Arlington has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Medical Center of Arlington defined the population that will be directly impacted by the project as patients admitted with congestive heart failure who are at risk for readmission. The percentage of the population expected to be positively impacted by the project is 5%, which was determined based on studies of similar projects implemented elsewhere. This was approximately 16 CHF readmissions per year, for 5 years would be 80 readmissions. The cost saved per admission was striated between $7,000 to $8,500 in the region. Our cost estimate was $7250 per readmission saved for a total of $590,000 saved. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted by avoiding a hospitalization, there is an avoided financial burden, better health outcomes and improved quality of life. The value calculated was based on a proportion of total value of readmission reduction savings of $590,000. An index value of 3 for five years was valued at $354,000.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases, and the burden on society is reduced. The value calculated was based on a proportion of total value of readmission of $590,000. An index value of 1 for five years was valued at $118,000.

The total value for avoided costs, value to the individual and community was calculated at $1,063,000. The Category 2 Project was valued at 79.11% of total value based on the funding protocol guidance on values share by category.

020950401.2.3	*2.12.2*	*N/A*	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS*
Medical Center of Arlington			*020950401*
Related Category 3 Outcome Measure(s):	*020950401.3.4*	*3 IT-3.2*	*Congestive Heart Failure 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]: Implement standardized care transition processes Metric 1 [P-2.1]**:** Documented Care transitions policies and procedures Goal: Complete checklist of policies and procedures Data Source :Policies and procedures of care transitions program Milestone 1 Estimated Incentive Payment *(maximum amount):* $69,776 **Milestone 2** [P-5]: Using a validated risk assessment tool, create a patient identification system. Metric 1 [P-5.1]: Patient stratification system Goal: Complete risk assessment tool Data Source: Submission of risk assessment tool and patient stratification report and description of provider utilization of report findings. Milestone 2 Estimated Incentive Payment *(maximum amount):* $69,777	**Milestone 4** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [I-11.1]: 250 Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: 25% Data Source: Case Management Registry Milestone 4 Estimated Incentive Payment: $107,047 **Milestone 5** [I-13]**:** Increase the number or percent of patients in the case-management- related registry Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case-management-related registry; patients may be targeted from ED and inpatient areas **Goal: 25% high risk patients**	**Milestone 6** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [I-11.1]: 525 Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: 40% improvement over baseline Data Source: Case Management Registry Milestone 6 Estimated Incentive Payment: $114,515 **Milestone 7** [I-13]: Increase the number or percent of patients in the case-management-related registry Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case-management-related registry; patients may be targeted from ED and inpatient areas	**Milestone 8**[I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [I-11.1]: 787 Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: 75% improvement over baseline Data Source: Case Management Registry Milestone 8 Estimated Incentive Payment: $94,599 **Milestone 9** [I -13]: Increase the number or percent of patients in the case-management-related registry Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case-management-related registry; patients may be targeted from ED and inpatient areas

020950401.2.3	***2.12.2***	***N/A***	***IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAMS***	
Medical Center of Arlington				*020950401*
Related Category 3 Outcome Measure(s):	*020950401.3.4*	*3 IT-3.2*	*Congestive Heart Failure 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 3 [P-9]**:** Implement a case-management-related registry Metric 1 [P-9.1]: Documentation of registry implementation Goal: Created registry Data Source: Registry reports demonstrating case management functionality Milestone 3 Estimated Incentive Payment *(maximum amount):* $69,776	Data Source: Case Management Registry Milestone 5 Estimated Incentive Payment: $107,047		**Goal: 50% high risk patients** **Data Source:** Case Management Registry Milestone 7 Estimated Incentive Payment: $114,515	**Goal: 75% high risk** **Data Source:** Case Management Registry Milestone 9 Estimated Incentive Payment: $94,600
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $209,329	Year 3 Estimated Milestone Bundle Amount: $214,094		Year 4 Estimated Milestone Bundle Amount: $229,030	Year 5 Estimated Milestone Bundle Amount: $189,199
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $841,652				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Official project name:

Implementation of the use of antenatal steroids in prevention of preterm birth and low birth weight

Unique project identifier: 022817305.2.1

Name of provider system: Tarrant County/dba Tarrant County Public Health

Size of provider system/service area: 420 FTEs, 20 sites, providing public health services to 1.9 million in Tarrant County

Provider's role in region's health care infrastructure (especially for Medicaid and indigent/uninsured): Tarrant County Public Health services as the public health entity for the county of 1.9 million with the goal to focus on population based services and data.

Project intervention: -Implement the use of antenatal steroids to prevent preterm birth in women with a history of spontaneous preterm birth.

Is project intervention new or an expansion of an existing initiative?: -New

What is regional need for project (Any data? Why should CMS fund this to improve care for Medicaid and underserved of Region 10?): CN.19 Tarrant County has the second highest infant mortality rate in counties with over 10,000 births/year. Most babies that do not survive the first year are born early and are low birth weight. - The high incidence of - preterm births and low birth weight in combination with the availability of an intervention to help prevent preterm births in women with a history of preterm birth, makes the implementation of the antenatal steroids a viable option for reducing preterm birth. The expected results are lower immediate costs of Medicaid and long term financial for Medicaid as preterm babies (IT 8.4) and low birth weight babies (IT 8.2) are likely to have life-long physical and developmental concerns,

Who is the target population? Pregnant women with a history of spontaneous preterm birth.

Estimated number of patients to be served over course of waiver period. -The annual average number of preterm births to women with a history of spontaneous preterm birth is 110. Approximately 330 women will be served over the time period of DY3-DY5. Although, not a part of the waiver, some women who do not have a history of preterm, but have a short cervix due to lack of progesterone may benefit from the provider usage as well.

What is the project's benefit for Medicaid and Uninsured of your Service area? (This is a critical component.) Per the March of Dimes, the cost of a - preterm birth and low birth weight is 10 times that of a - term birth with a birth weight above 2500 grams. There will be cost savings in

the short term as well as less long term concern for the families - when babies have a longer gestation.

What is expected project/intervention benefit as measured by:
Category 1 or 2 milestones selected for project? How do they tie into project's purpose?
- Implementation of the use of antenatal steroids for pregnant women with a history of spontaneous preterm has been proven to help reduce preterm birth, therefore helping to reduce Medicaid costs. Because most preterm babies are also low birth weight, the incidence of low birth weight should be reduced in women who have a history of preterm birth and receive antenatal steroids. Category 3 outcomes selected? How does this tie back to the project's purpose? Implemented changes in years DY3- DY5 should help reduce the incidence preterm birth by 20% (IT 8.4) and in the incidence of low birth weight by 20% (IT 8.2).

Project Option 2.7.4 – - Implementation of the use of antenatal steroids in prevention of preterm birth and low birth weight

(Implement innovative evidence-based strategies to reduce low birth weight and preterm birth)
Unique Project ID:022817305.2.1
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/022817305
Project Description:
Implement innovative evidence-based strategies to reduce low birth weight and preterm birth

- -Over 70% of the infant deaths in Tarrant County are short gestation (defined by less than 27 weeks) and low birth weight (defined as a birth weight of less than 2500 grams). The implementation of the use of antenatal steroids in pregnant women with a history of spontaneous preterm birth, to prevent a subsequent preterm birth is an evidenced practice. There is a need to educate providers and women about the use of the antenatal steroids in the prevention of recurrent preterm birth. The measures will include: 1) the number of providers; 2) the outcomes both before and after the education of the providers; 3) the number of women educated in the target population; and 4) the preterm birth rate for Tarrant County. The incidence of preterm birth in Texas in 2009 was 13.0/1000 live births. For Tarrant County in 2010 the incidence was 10.9/1000 live births.[1]

Goals and Relationship to Regional Goals:
Project Goals:

-The goals of this project include:

[1] http://www.dshs.state.tx.us/vs/reqproc/certified.copy.shtn

Provide education for providers regarding antenatal steroids for prevention of preterm birth. (Implementation of best practices)
Develop and implement a campaign for women who have a history of spontaneous preterm birth.(Better health for infants).
Monitor preterm birth incidence and vital statistics. (Better health for infants and lower costs)
Monitor low birth weight incidence and vital statistics. (Better health for infants and lower costs)

This project meets the following Regional goals:
This project addresses CMS aims: (1) Better care with the implementation of best practices to prevent - spontaneous preterm birth; (2) Better health for infants who are born at a normal gestation; and (3) Lower costs, as reducing the incidence of - preterm and low birth weight births will reduce costly hospital stays for infants.

Challenges:

Tarrant County has eleven delivery hospitals. Because most of the prenatal care is provided outside of the hospital systems (with the exception of JPS) it will be necessary to capture the attention of health care providers who deliver at these hospitals in a variety of venues, including in person, via the medical society, and grand rounds. In addition, the population that the antenatal steroids benefits are women with a history of spontaneous preterm birth, reaching this group with the antenatal steroid message is challenging as it has a more narrow focus than all pregnant women or all women of childbearing age. Finally, the vital statistics data to measure the success of the use of the antenatal steroids lags about 2 years. Therefore, data collection will be more labor intensive on the part of public health staff, working with the providers and the delivery hospital systems.

5-Year Expected Outcome for Provider and Patients:

-Our 5- year expected outcome is an increase in the use of antenatal steroids for the prevention of spontaneous preterm birth in pregnant women with a history of preterm birth, when appropriate. The reduction of the incidence of preterm birth (IT 8.4) will be 20%, by the end of DY5. With increased gestational age, the incidence of low birth weight (IT 8.2) should be reduced by 20% as well by the end of DY5.

Starting Point/Baseline:

-The baseline for the number of preterm births comes from the 2010 numbers for Tarrant County births. The total number of births 2010 was 27,885. Of those births, the total number of preterm

births was 3029. Because the antenatal steroid project is targeted to women who have had a previous spontaneous preterm birth, the Texas vital statistics data were further examined to find there are approximately 110 preterm births to women who have had a history of spontaneous preterm birth annually in Tarrant County. In Tarrant County, the 2010 the race/ethnicity breakdown of the preterm births to women with a history of spontaneous preterm birth was: White women had a 28.7% subsequent preterm birth; Black women had a 31.8%; Hispanic women had a 26% of the subsequent preterm births and Other was the category for 25.8% of the preterm births. The 110 pregnant women who have a history of preterm pregnancy also have a history of low birth weight (less than 2500 grams) so that number will serve as the baseline for low birth weight.

Rationale:

-Preterm birth is a birth that happens before 37 weeks of gestation. Babies that are born too soon may have many health problems which require NICU treatment, as well as long term physical and developmental concerns. These babies may also suffer a fetal or infant death. Progesterone may help prevent these preterm deliveries and deaths. Progesterone is a hormone that supports a healthy pregnancy. In a normal pregnancy this hormone gradually rises to 300-400 mg per day during the third trimester. This promotes a healthy uterus, supports gestation, inhibits uterine activity, blocks effects of oxytocin and relaxes the myometruim which is the smooth muscles of the uterus.[2]

There have been studies of the use of 17 Alpha-Hydroxyprogesterone Caproate to prevent the recurrent of preterm delivery. In one study 19 centers enrolled 1039 women with a documented history of spontaneous preterm birth at 20 to 36 weeks of gestation in a previous pregnancy. The gestation age at entry was at 15-20 weeks confirmed by ultrasound and needed to be a singleton gestation, with no major fetal anomalies. Of the 1039 women enrolled: 576 refused consent; 463 randomized. Of these, 310 were given 17-P and 153 given placebo. This study concluded that 5-6 women with a previous spontaneous preterm birth would need to be treated to prevent one < 37 weeks.[3]

The use of 17 Alpha-Hydroxyprogesterone Caproate to prevent the recurrent of preterm delivery is now considered an evidenced based practice that should be promoted for the prevention of preterm term birth in pregnant women with a history of spontaneous preterm birth. This progesterone hormone therapy has been approved by the FDA hydroxyprogesterone caproate injection, commonly known as 17P, which is a synthetic form of the hormone produced during

[2] http://extra.dshs.state.tx.us/grandrounds/gr-10-10-12.pdf

[3] Prevention of recurrent preterm delivery by 17 alpha-hydroxyprogesterone caproate. Meis PJ, et al. N Engl J Med. 2003 Jun 12;348(24):2379-85.

pregnancy. It will be marketed under the brand name Makena and given in weekly injections to pregnant women between 16 and 20 weeks gestation and continuing until 37 weeks gestation.[4] The hormone would be used on women with a previous preterm pregnancy that had a loss between 20 weeks and 36 weeks 6 days due to spontaneous labor or pPROM.[5] This hormone does not work on twins, triplets or nulliparous women with CL<3 cm.[6]The strategy will be promoted in selected hospital systems in Tarrant County to reduce preterm births in women with previous spontaneous PTB.

Project Components:

This project does not have required components.

-The use of antenatal steroids for the prevention of preterm birth in women who have had a history of preterm birth is an evidenced based practice. The major component of the proposal is to increase knowledge about the use of antenatal steroids with providers and women with a history of spontaneous preterm birth. The provider education will be will be provided by experts in maternal medicine. In addition, a campaign will be developed to inform women in the target population about the availability of antenatal steroids as well as other healthy pregnancy tips. The education will be ongoing for both groups as there will be changes in both populations.

DY2: To develop plan to recruit a full-time prematurity prevention coordinator, part-time interviewer and part-time record abstractor. The TCPH maternal health coordinator will train the newly hired staff. Staff will complete training. Provider contact information will be secured from the delivery hospitals. Providers of education regarding the use of antenatal steroids will be secured.

DY3: The education for the providers will be conducted throughout the year. The message will focus on the use of antenatal steroids as a mechanism for prevention of preterm birth and low birth weight in women with a history of preterm birth. Plans for the outreach campaign for the target population of the women will be developed.

DY4: Provider education will continue. The campaign for the women in the target population will be launched. The focus will be on the use of antenatal steroids as a possibility to discuss with their health care provider for the prevention of preterm birth.

DY5: Education for providers and the target population of women will continue.

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

[4] http://www.marchofdimes.com/news/feb4_2011.html

[5] 17 alpha-hydroxyprogesterone caproate to prevent prematurity in nulliparas with cervical length less than 30 mm. Grobman WA, et al. Am J Obstet Gynecol. 2012 Sep 17. pii: S0002-9378(12)01016-2; Prevention of preterm birth in triplets using 17 alpha-hydroxyprogesterone caproate: a randomized controlled trial. Caritis SN, et al. Obstet Gynecol. 2009 Feb;113(2 Pt 1):285-92

[6] A trial of 17 alpha-hydroxyprogesterone caproate to prevent prematurity in twins. Rouse DJ, et al. N Engl J Med. 2007 Aug 2;357(5):454-61

- CN.19 – Need for more and earlier onset of prenatal care.

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

- This project is a new project. No federal funds have ever been received for this project.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
- **IT 8.4 Reduce Preterm birth rate**
- **IT 8.2 Reduce low birth weight**

Selection of the Category 2 project to implement the use of antenatal steroids for the prevention of preterm birth and low birth weight, in women with a history of preterm birth is listed as an evidenced based practice. Data from Institute of Medicine of the National Academies reveals that a - preterm birth has an associated annual societal economic cost of $51,600 per preterm birth.[7]

Relationship to Other Projects:

- **Related Category 1 and 2 projects**

- JPS Health Network # 126675104.2.16 Journey to Life: Prenatal Care and Healthy Babies Initiative (Develop and implement a comprehensive Perinatal Services Program that includes preconception, prenatal and interconception care for low-income women of childbearing age in Tarrant County.)

Related Category 4 population-focused improvements: N/A

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
-TCPH is unaware of a learning collaborative for infant health outcomes. However, there are related projects submitted by both JPS and UNTHSC. Partnering with these entities would benefit all efforts and can be done easily.

Project Valuation:

- Institute of Medicine of the National Academies

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and

[7] http://nap.edu

outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Tarrant County Public Health defined the population that will be directly impacted by the project as the annual number of pregnant women with a history of spontaneous preterm birth or for the project term approximately 330 individuals. The percentage of the population expected to be positively impacted by the project in DY5 is 20% or approximately 22 full term births. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.27% of the total project valuation was allocated to Category 1 and 2. The DY5 goal is for the estimated 110 pregnant women with a history of spontaneous preterm birth at least 20% will have infants born full term or approximately 22 full term births. As well, the DY5 goal for low birth weight is a 20% reduction in women who have a history of preterm birth. It is estimated that 22 of the 110 women in DY5 will have a normal birth weight baby greater than 2500 grams.

Outcome Measure 1: -IT 8.4 Reduce Preterm birth The 2005 annual United States societal economic cost associated with a preterm birth is $51,600 (22 X $51,600 = $1,135,200). This total value is multiplied by the individual impact of 3 and the community impact of 2 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the actual total outcome valuation of IT-8.4 of $14,757,600. Based on the RHP 10 valuation model Category 2 is 89.27% of the total project value or $13,173,706.

If the Bureau of Labor Statistics Consumer Price Index calculation was applied to the 2005 societal economic costs for 2012 dollars the cost would be $60,660 per preterm birth. In 2012 dollars the total project valuation would be $17,348,760. Therefore the project valuation is discounted by 14.9% to a $14,757,600 total project valuation.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because a full term birth contributes to improved health outcomes and quality of life.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2**.** We believe this to be the correct number because reducing preterm births reduces the annual societal economic cost associated with preterm birth.

Valuation Reference
Outcome Measure 1: -IT 8.4 Reduce Preterm birth rate

$51,600 economic cost associated with preterm birth. This is the 2005 annual societal economic burden associated with preterm birth in the United States.
Institute of Medicine of the National Academies
Preterm Birth Causes, Consequences, and Prevention 2007 Report

Outcome Measure 2: - IT 8.2 – Reduce low birth weight is valued at zero. As the population that is being addressed is the same population that is being addressed in Outcome Measure IT 8.4. It is expected that the increased gestational age will yield increased birth weights.

022817305.2.1	*2.7.4*	*N/A*	IMPLEMENT EVIDENCE-BASED STRATEGIES TO REDUCE **PRETERM BIRTH AND LOW BIRTH WEIGHT** – Reducing Preterm Birth and Low Birth Weight Using Antenatal Steroids
Tarrant County/ dba Tarrant County Public Health			*22817305*
Related Category 3 Outcome Measure(s):	*-022817305.3.19* *-022817305.3.21*	*IT--8.4* *IT – 8.2*	-Incidence of preterm births – reduce by 20% -Incidence of low birth weight – reduce by 20%

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]: Develop plan to recruit a full time - Prematurity Prevention Coordinator, part time interviewer and part time abstractor. Metric 1 [P-X.1]:Written approval from Tarrant County Commissioners Court and Human Resources to hire a full time - Prematurity Prevention Coordinator, part time - interviewer and part time abstractor. Baseline/Goal: Hiring one fulltime and 2 part time employees Milestone 1 Estimated Incentive Payment: - $1,036,285 **Milestone 2** [P-X]: - Maternal Health Advisor - will train all newly hired staff. Metric 1 [P-X.1]: Staff will be trained within 30 days of hire date. Baseline/Goal: Training Data Sources: Tarrant County Job Description -Antenatal Steroid Use	**Milestone 4** [I-X]: -Train providers on the use of antenatal steroids to prevent preterm birth and low birth weight. Metric 1[I-X.1]: -Training records, curriculum, evaluation and articles. Goal:-Provide 5 presentations and use 2 other media to educate providers. Data Source- Training Attendance Records and evaluations Milestone 4 Estimated Incentive Payment - $1,621,606 **Milestone 5** [I-X]: -Draft an awareness campaign for women who have had a history of spontaneous preterm birth. Metric 1 [I-X.1]: -Draft Campaign materials and evaluation -Educate women who have a history of preterm birth regarding the antenatal steroid option. -Campaign launch plans. Milestone 5 Estimated Incentive	**Milestone 6** [I-X]: -Continue to provide trainings to providers for the use of antenatal steroids, with adjustments based on evaluations. Metric 1[I-X.1]: -Schedule venues for provider trainings and regular updates.-Assure that all providers receive the initial training and needed updates. Date Source-Training Attendance records (based on media), evaluations and updated documents. -Milestone 6 Estimated Incentive Payment: -$1,734,741 **Milestone 7** [I-X]: -Launch the information campaign for women who have a history of premature birth. Metric 1 [I-X.1]: -Final campaign materials, evaluation and records of campaign dissemination. -Launch campaign in a minimum of 5 venues using 3 types of media.	**Milestone 8** [I-X]: -Continue to offer provider trainings with adjustments based on evaluations. Metric 1 [I-X.1]:-. Schedule venues for provider trainings and regular updates. -Assure that all providers receive the initial training and regular updates. - Date Source Training attendance records (based on media), evaluations and updated documents Milestone 8 Estimated Incentive Payment: - $1,676,078 **Milestone 9** [I-X]: -Continue to educate women who have a history of spontaneous preterm birth as to the option from antenatal steroids. Metric 1 [X-1]: -Logs outlining outreach activities and outreach evalutaion. Goal: -Continue campaign with at least 5 venues and using 3 types of media.

022817305.2.1	***2.7.4***	***N/A***	**IMPLEMENT EVIDENCE-BASED STRATEGIES TO REDUCE PRETERM BIRTH AND LOW BIRTH WEIGHT** – Reducing Preterm Birth and Low Birth Weight Using Antenatal Steroids	
Tarrant County/ dba Tarrant County Public Health				*22817305*
Related Category 3 Outcome Measure(s):	*-022817305.3.19* *-022817305.3.21*	*IT--8.4* *IT – 8.2*	-Incidence of preterm births – reduce by 20% -Incidence of low birth weight – reduce by 20%	
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 2 Estimated Incentive Payment:- $1,036,285 **Milestone 3** [I-X]: -Develop the training plan and evaluation for providers. Metric 1 [I-X.1]: -Training notices. -Establish training plan and secure venues. Data Source: -Delivery Hospitals Milestone 3 Estimated Incentive Payment - $1,036,285	Payment- $1,621,606		-Campaign materials and records of dissemination. Milestone 7 Estimated Incentive Payment: - $1,734,741	-Records of dissemination Milestone 9 Estimated Incentive Payment: - $1,676,078
Year 2 Estimated Milestone Bundle Amount: - $3,108,855	Year 3 Estimated Milestone Bundle Amount: - $3,243,212		Year 4 Estimated Milestone Bundle Amount: - $3,469,482	Year 5 Estimated Milestone Bundle Amount: - $3,352,157
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $- $13,173,706				

Project Option 2.6.4 – Implement Evidence-based Strategies for Youth in Targeted Populations – PRIDE Program
Unique Project ID: 022817305.2.2
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305

Project Summary

Provider: Tarrant County Public Health has 420 FTEs, 20 sites, and provides public health services to 1.9 million in Tarrant County. The role in region's health care infrastructure especially for Medicaid and indigent/uninsured is to provide Public Health STD/HIV services for Tarrant County.

Intervention: Evidence-based Intervention designed to inform and educate youth about Sexually Transmitted Diseases and how to make appropriate choices regarding sexual activities. This is a new project for the Arlington, Texas area.

Need for the project: STD rates continue to rise in Arlington with 51% of new syphilis cases; 73% of chlamydia cases and 35% of HIV cases occurring in 15 – 24 year old youth in 2011.

Target population: The intervention targets minority youth 15 – 24 in the City of Arlington, which has 365,483 population (2010 census). 4-5 local organizations where trained youth leaders administer PRIDE curriculum to 300-500 youth.

Expected patient benefits: Reduce the level of disease (STD's) in the community by 15% over 2011 levels. Fewer STD infected youth in the community will reduce transmission of STD's and the complications from untreated infections.

Category 1 or 2 expected patient benefits: Recruit and train STD staff to train the organizational leaders who will educate the youth. Cat. 1 & 2 set the foundation for implementation of group sessions with the youth about STD education.

Category 3 outcomes: Cat. 3 will asses disease trends in the target population to determine if a reduction in youth diagnosed with an STD have decreased over time.

Project Option 2.6.4 – Implement Evidence-based Strategies for Youth in Targeted Populations – PRIDE Program

Unique Project ID: 022817305.2.2
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Project Description:
The PRIDE Program is an evidence-based intervention designed to inform and educate youth between the ages of 14-24, in Tarrant County, Texas, about sexually transmitted diseases (STDs) and how to make appropriate choices regarding sexual activities. PRIDE provides a foundation for discussions with an informed individual (youth leader) about the signs and symptoms of different STDs, what to do if an individual acquires an infection, and how to reduce the possibility of contracting an STD. PRIDE uses current group leaders in teen clubs and community organizations as the conduit of information to the youth. The agency group leaders are given training in how to communicate STD information in a non-threatening, non-judgmental manner to youth, engage them in meaningful discussions, develop educational projects that participants can share with peers, and assess and determine if the youth response results in increased awareness of STDs.

STD trends in Tarrant County and Arlington, Texas continue to increase annually. Youth under the age of 24 are the fastest growing group of individuals acquiring STD/HIV infections. Current disease trends list ages 15-24 as having 51% of new syphilis infections, 73% of the chlamydia cases and 35% of the new HIV cases. Syphilis and HIV cases have increased by 20% over the 2010 year. This training of community-based organization (CBO) leaders in the PRIDE Program will help increase STD/HIV awareness, allowing youth to make appropriate sexual health choices.

Goals and Relationship to Regional Goals:
Project Goals:
The Goal of PRIDE is to inform and educate youth regarding the consequences of risky behaviors that may lead to contracting an STD. When youth are aware of the risks and have current knowledge about prevention, they are less likely to become infected with an STD. When youth become infected with an STD, because of their STD knowledge, they are less likely to spread that infection to others. When youth know the correct information and have appropriate options, the rates for STDs will decrease in the Arlington area and throughout Tarrant County. In five years, the overall STD rates should decrease by 15% from baseline 2011 totals.

This project meets the following Regional goals:

The CDC reports that young people have four times the reported gonorrhea rate of the total population and four times the reported chlamydia rate of the total population. CDC reports that in 2009, African-Americans had 8.7 times the reported chlamydia rate of Whites. Women had 2.7 times the reported chlamydia rate as men in 2009. CDC continues to work to reduce the disease incidence in the country.[135]

Challenges:
There are many youth who are not involved in community organizations. The challenge is to insure that STD information also reaches those individuals. The PRIDE program encourages youth to have open discussions with peers who may not be part of the program to spread current accurate STD information. Ultimately, the PRIDE program should be part of the Arlington ISD curriculum. When sufficient numbers of community individuals begin to discuss the STD problem, then there will be a change in the general opinion that STDs are not a problem in most communities.

5-Year Expected Outcome for Provider and Patients:
The five-year outcome will be a 15% reduction in STD rates in Arlington and Tarrant County when compared to 2011 reported cases.

Starting Point/Baseline:
STD trends in Arlington and Tarrant County, Texas, continue to increase annual. The population (2010 Census) is 365,483 people with 43% White (non-Hispanic), 29% Hispanic and 17% African-American. Youth under the age of 24 are the fastest growing group of individuals acquiring STD/HIV infections. Current disease trends list ages 15-24 as having 51% of new syphilis infections, 73% of the chlamydia cases and 35% of the new HIV cases. This young age group is less likely to seek medical services in other areas of the county, especially since there is a transportation deficit in Arlington. Syphilis and HIV cases have increased by 20% over the previous year.

2011 Tarrant County Totals (under age 24) Cases

Chlamydia Reported	5,642	Minority Youth 4,829
Gonorrhea Reported	1,750	
Syphilis (early) – Reported	124	
HIV diagnosed – Reported	85	

Rationale:

[135] STD Surveillance Report – 2010. National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, November 2011.

This evidence-based intervention was first developed in Chicago in the 1980's and used by Chicago and Cleveland public schools for students. Student involvement is key to making this a successful intervention. The PRIDE outcome results have been analyzed and refined by community organizations and Stephen R. Sroka, PhD. (1987)

Project Components:
This is a patient-centered project, focusing on a targeted population with specific disease indicators. Disease levels are measurable, allowing for individuals to make appropriate choices for sexual health, based upon perception of risk.

The milestones and metrics for PRIDE are based upon evidence-based interventions developed in the 1980's. Using group leaders, already known to the youth, allows for a trust and willingness to communicate within the group. Developing a structured curriculum that conveyed accurate STD information, the dangers and consequences of sexual activity in a non-threatening, non-judgmental setting has been proven successful. Identifying venues where youth meet in a structured supervised environment is the key to working with youth. Group leaders are known and accepted by the youth. The organization is responsible for the safety and well-being of each person. The PRIDE curriculum builds an STD information foundation that is communicated between participants.

Unique community need identification numbers the project addresses:

- CN.16 – Higher incidence of sexually transmitted diseases in Arlington and Tarrant County

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
There are currently no public initiatives in Arlington, related to STD awareness and education for youth.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
The PRIDE Program is a client-centered project, focusing on a targeted population with specific disease indicators. Disease levels are measurable, for the population as a whole or any sub-set of the disease formula. Reducing STD transmission will reduce STD infections in youth. PRIDE allows individuals to make appropriate choices for sexual health, based upon their perception of risk.

Reducing STD levels in the target population in Arlington will help reduce rates in Tarrant County, Texas and in the United States.

IT-11.1 Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider.
The CDC discusses the national problem of STDs and the alarming trends identified in the southern states. Nationally, 1,307,893 cases of chlamydia were reported to CDC for 2010. Between 2006 and 2010 the chlamydia rate for males increased 36.4%. Chlamydia rates are the highest in the south, with Texas over 12.7 per 100,000 population in the 15- to 24-year-old females.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**:
  - 022817305.2.3 Arlington Clinic Project – STD reduction plan
- **Related Category 4 population-focused improvements**: N/A

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Early identification and treatment of STDs reduces the risk of complications and hospitalizations for individuals and will reduce medical costs. This program will increase the knowledge levels of the youth, allowing better choices, understanding what is required to reduce individual risk, and providing factual information to seek medical services when certain symptoms are noticed in the individual. friend or partner. Early identification and treatment of STDs reduces the risk of complications and hospitalizations for individuals who are diagnosed with an infection. In 1994 dollars, the cost for chlamydia and associated sequelae in the U.S. was $1,513.9 million with the STD total $5.025.0 million nationally. Hospital costs for treating pelvic inflammatory disease (a complication of gonorrhea or chlamydia) was $4.148. million in direct cost services.

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Tarrant County Public Health defined the population that will be directly impacted by the project as individuals identified as the number of Tarrant County minority STDs under age 24. The percentage of the population expected to be positively impacted by the project in DY5 with a 11.11% decrease in chlamydia rates for Tarrant County minority youth ages 15-24 by the end of DY5. That means that a minimum of 537 youth will not contract chlamydia by the end of DY5. The medical cost savings per person is $1,700.42. This total value of $912,279.00 is multiplied by the individual impact of 3 and the community impact of 2 to determine the values per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the project valuation of $11,859,621.00. This actual amount had to be discounted due to Public Health DSRIP available funding to a total value of $5,618,849.00 or a 52.6% valuation discount.
We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because this program will increase the knowledge levels of the youth, allowing better choices, understanding what is required to reduce individual risk, and providing factual information to seek medical services when certain symptoms are noticed in the individual, friend or partner.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2**.** We believe this to be the correct number because; by reducing the STD rates the benefits are also realized by sexual partners and the community.

**The Hidden Epidemic* Institute of Medicine, 1997

022817305.2.2	***Reference number 2.6.4***	***NA***	Implement Evidence-based Strategies for Youth in Targeted Populations – PRIDE Program	
Tarrant County Public Health				022817305
Related Category 3 Outcome Measure(s):	022817305.3.5	*3.IT-11.1*	*11.1 – Improvement of 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-X]: Recruit an individual as coordinator for PRIDE program activities and trainings. Train the coordinator as a Disease Intervention Specialist (DIS) to have the skill sets providing current medical and socio-sexual information and agency trainings. Identify community organizations where youth congregate. Metric 1 [P-X.1]: Identify and recruit 2 Arlington organizations where youth congregate. Complete the train the trainer sessions with agency leaders for both organizations. Goal: Begin PRIDE implementation and training. Data Source: Tarrant County Personnel Data File and Arlington Business Community directory. Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,183,674	**Milestone 2** [P-X]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. Metric 1 [P-X.1]: Document learning and diffusion strategic plan (Oversee the presentation of PRIDE to 125 youth in the target area) Baseline/Goal: Observe the agency leaders conduct PRIDE curriculum with the youth groups and provide assessment as to delivery of information. Implement targeted marketing campaign for PRIDE Program to increase awareness and knowledge regarding STD's in Arlington. Data Source: Semi-Annual TCPH/DSHS Narrative. Milestone 2 Estimated Incentive Payment: $617,415 **Milestone 3** [P-14]: Participate in at least bi-weekly interactions (meetings, conference calls, or		**Milestone 4** [I-X]: Review project 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 [I-X.1]: Number of new ideas, practices, tools or solutions test by each provider Goal: Expand to two additional r community organizations in the target area. Provide independent assessment of current PRIDE curriculum and modify as recommended by UNT Health Science Center. Data Source: University of North Texas, Data Review Milestone 4 Estimated Incentive Payment: $660,490 **Milestone 5** [I-X]: Increase access to health promotion programs and	**Milestone 6** [I-X]: Increase access to health promotion programs 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-X.1]: Increase percentage of target population reached. After completion of UNT program assessment, modifications implemented and new agencies are identified for inclusion in PRIDE curriculum. Goal: Increase the number of agencies with youth programs utilizing PRIDE by 10% over DY-4. Data source: Semi-Annual TCPH/DSHS Narrative. Milestone 6 Estimated Incentive Payment: $1,276,309

022817305.2.2	***Reference number 2.6.4***	***NA***	Implement Evidence-based Strategies for Youth in Targeted Populations – PRIDE Program	
Tarrant County Public Health				022817305
Related Category 3 Outcome Measure(s):	022817305.3.5	*3.IT-11.1*	*11.1 – Improvement of 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)**
	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-14.2]: Share challenges and solutions successfully during this bi-weekly interaction Goal: Use the positive results from PRIDE to implement discussions with the local Arlington school boards to determine the level of acceptance for PRIDE within the school system. Continue to expand the number of community organizations where PRIDE curriculum is utilized. Data Source: Tarrant County STD Statistics for 2014		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-X.1]: Increase percentage of target population reached. After completion of UNT program assessment, modifications implemented and new agencies are identified for inclusion in PRIDE curriculum. Goal: Increase the number of agencies with youth programs utilizing PRIDE by 5% over DY-3. Data source: Semi-Annual TCPH/DSHS Narrative. Milestone 5 Estimated Incentive Payment: $660,490	

022817305.2.2	***Reference number 2.6.4***	***NA***	Implement Evidence-based Strategies for Youth in Targeted Populations – PRIDE Program	
Tarrant County Public Health				022817305
Related Category 3 Outcome Measure(s):	022817305.3.5	*3.IT-11.1*	*11.1 – Improvement of 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 3 Estimated Incentive Payment: $617,415			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,183,674	Year 3 Estimated Milestone Bundle Amount: $1,234,829		Year 4 Estimated Milestone Bundle Amount: $1,320,980	Year 5 Estimated Milestone Bundle Amount: $1,276,309
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $5,015,792				

Project Option 2.7.6 – Implement evidence-based strategies and referrals for targeted populations to reduce STD rates in Arlington. (STD testing and case analysis)
Unique Project ID: 022817305.2.3
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305

Project Summary

Provider: Tarrant County Public Health has 420 FTEs, 20 sites, and provides public health services to 1.9 million in Tarrant County, plus a small percentage of clients from surrounding counties. Public Health insures the health of the community and is working to reduce the STD rates in the community.

Intervention: Reduce syphilis, gonorrhea, chlamydia and HIV infection in the City of Arlington, through increased availability of clinical and epidemiological services. This is an expansion of STD services for the Arlington, Texas area.

Need for the project: Tarrant County population consist of 26% Medicaid & 23% uninsured residents. Expanded STD prevention and treatment in Arlington will reduce the transmission of STDs and therefore reduce the Medicaid cost and cost to the community. There were 11,621 cases of STD's reported from Arlington zip code areas.

Target population: Target population is the resident in City of Arlington, 365,483 population (2010 census). The expanded Arlington clinic should provide STD services to 3,500 individuals during the waiver period.

Expected patient benefits: Reduce the level of disease (STD's) in the community by 15% over 2011 levels. The Medicaid and uninsured population are estimated at 49% of the Tarrant County population.

Category 1 or 2 project benefits/category 3 outcomes: Fewer STD infected individuals in the community and fewer medical complications and conditions due to untreated STD infections. As more clients are seen and diagnosed, the reservoir of untreated infections will be reduced. Disease levels will decrease in minority populations as more clients are serviced in the clinic and educational information is disseminated to the public.

Project Option 2.7.6 – Implement evidence-based strategies and referrals for targeted populations to reduce STD rates in Arlington. (STD testing and case analysis)
Unique Project ID: 022817305.2.3
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Project Description:
The number of sexually transmitted diseases (STDs) cases diagnosed (syphilis, chlamydia, gonorrhea and HIV) continues to increase in Tarrant County. The Arlington area continues to produce a high number of new STD infections. The Arlington area does not have a full-time STD/HIV medical provider to serve the population daily. Minority populations, Blacks and Hispanics, are disproportionately affected by chlamydia, syphilis, gonorrhea and HIV infections. Implementing a full-service STD/HIV clinic, five days per week, within the City of Arlington, will provide essential STD services and begin to reduce the STD reservoir. The outcome measure is to reduce STD/HIV morbidity by 10% from 2011 STD/HIV levels.

Goals and Relationship to Regional Goals:

Project Goals:
The goal is to reduce STD/HIV morbidity by 10% from 2011 STD/HIV levels by providing STD clinical and epidemiological services to the target populations. Services will include the clinical assessment and the community educational component. STD awareness in the community will help in identifying potential new infections and insuring the possibility of rapid assessment and treatment.

This project meets the following Regional goals:
The CDC reports that young people have four times the reported gonorrhea rate of the total population and four times the reported chlamydia rate of the total population. CDC reports that in 2009, African-Americans had 8.7 times the reported chlamydia rate of Whites. Women had 2.7 times the reported chlamydia rate as men in 2009. CDC continues to work to reduce the disease incidence in the country.

Challenges:
The Arlington area is experiencing an increase in disease trends in minority populations. There is no transportation system for clients to seek care in Fort Worth. This program will allow Arlington residents to receive care in Arlington. It will also allow services on Saturday, a first in the metroplex. Sixty-two percent of the newly diagnosed syphilis cases occurred in the Black population, with an additional 21% Hispanic, means that 83% of the newly diagnosed syphilis cases are occurring in minority populations. Informing the community that STDs are still a

significant problem and that there is a facility specifically for testing and treatment is a major challenge.

5-Year Expected Outcome for Provider and Patients:
By the end of the five-year plan, there will be a measurable reduction in the STD rates of infection. When the pool of infected persons is reduced in Arlington, fewer individuals will be infected with an STD. As more individuals are screened and treated, the rate of infection will decline in the community reducing STDs in Arlington and Tarrant County.

Starting Point/Baseline:
Tarrant County operates a two-day-per week STD/HIV clinic in Arlington; daily operations allow an average of 16 clients to be seen each week at that location. The clinic is staffed by using full-time county personnel from the Fort Worth STD/HIV clinic to work in Arlington, reducing the number of clients to be seen in Fort Worth on the Arlington days. There is no increase in patients seen between the two locations. This project will allow Arlington to be open five days per week (including Saturday) with no loss of services in Fort Worth. Additional staff will be added to support the Arlington location with support from disease intervention specialists (DIS) who interview and follow each newly diagnosed individual to insure all potential source or spread candidates are located and brought in for medical assessment and care.

STD trends continue to increase in Arlington ZIP codes. The target for this intervention is the minority populations in the City of Arlington. The current population is 365,438 (2010 Census) with 29% Hispanic and 17% African-American, 8% other (mixed race, Native American, Asian and not listed) for a total minority population of about 54%. Youth under the age of 24 are the fastest growing group of individuals acquiring STD/HIV infections. Current disease trends list ages 15-24 as having 51% of new syphilis infections, 73% of the chlamydia cases and 35% of the new HIV cases. This young age group is less likely to seek medical services in other areas of the county, especially since there is a transportation deficit in Arlington. Syphilis and HIV cases have increased in Arlington by 20% over the previous year.

2011 Arlington Total STD Cases Reported

Chlamydia and Gonorrhea	2,241	Minorities = 1,431 or 63.86%
Syphilis (early) Reported	245	Minorities = 203 or 83%

Rationale:
The STD rates in Texas continue to climb from the 2000 levels as reported by the CDC. The rates in southern states are some of the highest in the nation. To reduce the rates of STD transmission, according to CDC, it is necessary to reduce the disease reservoir in the community. CDC has demonstrated in programs across the country that full-service STD/HIV clinics play a significant role in the process of identifying and reducing STD infections.

Project Components:
These project components were selected because they are factors that will help reduce the level of STD infections in the Arlington community. This factor has been demonstrated in Centers for Disease Control and Prevention STD/HIV program areas to reduce STD levels. **community need identification numbers the project addresses:**

- CN.16 – Higher incidence rates of syphilis, gonorrhea, HIV and chlamydia

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative because there are no existing federal or state STD programs related to STDs in the City of Arlington.

- CQI – Disease Information data is maintained and assessed quarterly to determine if program indicators are met. Objective and Indicators reports (O&I) are submitted monthly to the State to insure program outcomes meet grant requirements. These O&I reports define level and quality of services received. Clients will be able to rate their visit and provide feedback to the organization that will be utilized to increase positive outcomes and clinic utilization. These findings will be part of the O&I report analysis for program enhancement.

Related Category 3 Outcome Measures:

- IT-11.1 – Improvement in clinical indicators in identified disparity group. This is the number of clients seeking services over initial 2011 service utilization rates. (By increasing the number of minority clients seeking services the cases identified will reduce the reservoir of infection and will Reduce STD rates by 10% in minority populations in the City of Arlington).
- IT-11.1 – Improvement in clinical indicators in identified disparity group. This is the number of new cases of syphilis identified in the clinic compared to the syphilis rates in 2011. (Reduce minority syphilis rate by 10% in minority populations in the City of Arlington).

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Tarrant County Public Health defined the population that will be directly impacted by the project, as individuals identified as the number of reported Arlington STDs. The percentage of the population expected to be positively impacted by the project in DY5 with a 10% decrease in the Arlington minority chlamydia and gonorrhea rates and syphilis rates are anticipated by the end of DY5. The cost savings for a reduction of 20 minority syphilis cases in 3,000 clients using the Arlington location annually, at a potential savings of $15,000.00 for the prevention of a central nervous system case of syphilis. This total value of $304,500.00 is multiplied by individual impact of 3 and a community impact of 2 to determine values per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total syphilis outcome valuation of $3,958,500.00 project valuation. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

The cost savings for 143 minority gonorrhea and chlamydia cases at a savings of $1,562.29 per case for each case prevented. This total value of $223,564.00 is multiplied by individual impact of 3 and a community impact of 2 to determine values per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total gonorrhea and chlamydia outcome valuation of $2,906,328.00.

The combined category 3 valuation equals $6,864,828.00. The actual project value was discounted due to the amount of total Public Health DSRIP funds available to $3,252,417.00. This is a 52.6% valuation discount.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because; by providing expanded STD treatment in Arlington will reach individuals who may not have been able to receive medical treatment and therefore benefit from the project.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2**.** We believe this to be the correct number because; reducing the STD rates benefits are also realized by sexual partners and the community.

022817305.2.3	***2.7.6***	***2.7.6***	***IMPLEMENT EVIDENCE-BASED STRATEGIES AND REFERRALS FOR TARGETED POPULATIONS TO REDUCE MINORITY STD RATES ARLINGTON.***
Tarrant County/dba Tarrant County Public Health			***022817305***
Related Category 3 Outcome Measure(s):	*022817305.3.6* *022817305.3.7*	*IT-11.1* *IT-11.1*	*Improvement in clinical indicator in identified disparity group.* *(-Reduce Chlamydia and Gonorrhea rates by 10% in minority populations in Arlington,* *- Reduce Syphilis rate by 10% in minority populations in Arlington)*

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]: Recruit ,hire and train the following full-time positions: a Clinic RN, LVN or MA, Clerk, and Microbiologist to provide STD assessments and treatment for clients seen in the Arlington STD clinic. Train all staff in current TCPH-DSHS clinical protocols for clinical assessment and treatment. Metric 1 [P-X.1]: Increase clinical services in the second year from 7 to 10 clients per day- 2day operations: to 70 clients per month with 5 day operations. Baseline/Goal: Data Source: Adult Health Services (AHS) STD Monthly Clinic statistical Report. Milestone 1 Estimated Incentive Payment (maximum amount): $685,158	Milestone 2 [P-2]: Implement targeted marketing campaign to increase awareness and knowledge regarding STD's Identify 4 community billboards where STD/HIV messages can be displayed within target ZIP codes.) Metric 1 [P-2.1]: Document implementation strategy and testing outcomes (Display billboards with STD/HIV messages for 60 days in the high morbidity areas) Baseline/Goal: Increase the client services from 40 to 100 clients seen per month. Data Source: AHS STD monthly clinic statistical report. Milestone 2 Estimated Incentive Payment: $714,769	**Milestone 3** [I-X]: Develop and implement client satisfaction survey for all individuals seen in the clinic. Utilize results to make improvements in AHS clinical services. Begin internal referral system to see case related clients in the area where they reside. Metric 1 [X.1] Increase the number of client visits and assess satisfaction of clients for services. Goal: 30% of clients surveyed indicate the additional hours were the reason they used the services. Data Source: AHS quarterly clinic survey. Milestone 3 Estimated Incentive Payment: $382,319 **Milestone 4** [I-7]: Increase access to disease prevention programs using innovative project option Metric 1 [I.7.2]: Increase number of encounters as defined by intervention (services and awareness) Goal: Increase client utilization by 5% Data Source: AHS STD monthly clinic statistical report.	**Milestone 5** [I-X]: Develop and implement client satisfaction survey for all individuals seen in the clinic. Utilize results to make improvements in AHS clinical services. Begin internal referral system to see case related clients in the area where they reside. Metric 1 [X.1] Increase the number of client visits and assess satisfaction of clients for services. Goal: 50% of clients surveyed indicate the additional hours were the reason they used the services. Data Source: AHS quarterly clinic survey. Payment 5: $369,390 **Milestone 6** [I-7]: Increase access to disease prevention programs using innovative project option Metric 1 [I.7.2]: Increase number of encounters as defined by intervention (services and awareness) Goal: Increase client utilization by 10% Data Source: AHS STD monthly clinic statistical report.

022817305.2.3	***2.7.6***	***2.7.6***	***IMPLEMENT EVIDENCE-BASED STRATEGIES AND REFERRALS FOR TARGETED POPULATIONS TO REDUCE MINORITY STD RATES ARLINGTON.***
Tarrant County/dba Tarrant County Public Health			***022817305***
Related Category 3 Outcome Measure(s):	*022817305.3.6* *022817305.3.7*	*IT-11.1* *IT-11.1*	*Improvement in clinical indicator in identified disparity group.* *(-Reduce Chlamydia and Gonorrhea rates by 10% in minority populations in Arlington,* *- Reduce Syphilis rate by 10% in minority populations in Arlington)*

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 4 Estimated Incentive Payment: $382,319	Milestone 6 Estimated Incentive Payment: $369,390
Year 2 Estimated Milestone Bundle Amount: $685,158	Year 3 Estimated Milestone Bundle Amount: $714,769	Year 4 Estimated Milestone Bundle Amount: $764,637	Year 5 Estimated Milestone Bundle Amount: $738,779
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,903,343			

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.6.2. – Implement Evidence-based Health Promotion Programs- Establish self-management programs and wellness using evidence-based designs : Tarrant County Chronic Disease Self-Management Program
Unique Project ID: 022817305.2.4
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305

Provider: Tarrant County Public Health has 420 FTEs, 20 sites, and provides public health services to 1.9 million in Tarrant County. Health education resource and provider of epidemiologic support to hospitals and PCPs.

Intervention: The purpose of project 2.6.2 is to reduce the number of preventable admissions pertaining to hypertension by implement the evidence-based Stanford Chronic Disease Self-Management Program in the offices of Medicaid providers within the Texas Health Resources system. Preventable hospital and emergency room admissions pertaining to hypertension will be reduced by teaching clients the necessary self-management techniques that will help the clients to control blood pressure. This is a new initiative for Tarrant County Public Health .

Need for the project: Tarrant County has 12% of population enrolled in Medicaid programs. Tarrant County residents spent $87 million on preventable hypertension admissions in 5 years. Patients with Medicaid visited emergency department 2 times as much as those with private insurance or uninsured. 25% of Tarrant County adults have been diagnosed with hypertension.

Target population: Medicaid and uninsured clients who have been diagnosed with hypertension or diabetes. Estimated 2,600 individuals will be impacted over the period of the waiver.

Expected patient benefit: Reduce the number of dollars spent on preventable hypertension related admissions for Medicaid and uninsured clients.

Category 1 or 2 expected patient benefit/category 3 outcome: A reduction in preventable admissions related to hypertension is achieved by develop and implement evidence-based project ties into the purpose by ensuring that the program is evidence-based and meets the needs of the Medicaid and uninsured clients who are in the target population. The Stanford Chronic Disease Self-Management program has been shown to decrease the number of emergency room and hospitalizations for those who complete the program. The goal is to enroll 2,600 participants the program and follow up to verify a decrease in hypertension admission rates among program participants. This ties back to the project purpose because we are aiming to reduce the amount of dollars being spent on hospitalizations related to hypertension.

Project Option 2.6.2. – Implement Evidence-based Health Promotion Programs- Establish self-management programs and wellness using evidence-based designs : Tarrant County Chronic Disease Self-Management Program
Unique Project ID: 022817305.2.4
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305

Project Description:
Implement evidence-based, Stanford Chronic Disease Self-management Program for targeted patients who are at risk of potentially preventable admission related to hypertension.

Project 2.6.2 will use a combination of the evidence-based Stanford Chronic Disease Self-Management Program (CDSMP)[1,2,3] and the evidence-based practice of using community health workers (CHWs) to help improve patient outcomes and reduce potentially preventable admissions to the hospital or to the emergency department[4]. Our project will be a collaboration with Texas Health Resources clinics and hospitals in areas identified by the Tarrant County Behavioral Risk Factor Surveillance System to have the highest rates of diabetes and hypertension in the county.[5] The project will provide CDSMP and CHW support for clients who have disease processes that could potentially lead them to the hospital if they are not managing their illness and using their primary care provider efficiently. This project has evidence-based components that have proven that self-management education and CHWs help to reduce the medical financial burden by improving patient outcomes and improving patient quality of life.[1,-4,6]. Furthermore, Tarrant County Public Health has five Stanford lay leaders who will also participate in the project.

Target ZIP Codes:

76117	76036	76020	76148	76106	76135	76051
76112	76105	76120	76012	76010	76013	76179

We propose to target ZIP codes in Tarrant County that have the highest percentages of cardiovascular disease as indicated in the Tarrant County Behavioral Risk Factor Surveillance System.

Goals and Relationship to Regional Goals:
The primary goals of this project are to develop and implement a CHW-facilitated chronic disease self-management program that works with care providers who have low-income adult patients who have been diagnosed with diabetes and/or hypertension. The primary goal of the project is to provide evidence-based self-management for clients in an effort to help to decrease potentially preventable hypertension admission rates among program participants. According to the Tarrant County BRFSS, one of four adults in the county reports being diagnosed with

hypertension.[5] According to the TX DSHS PHP Tarrant County residents spent nearly $500 million on preventable cardiac-related hospitalizations[8]. Additional expected outcomes include a reduction in long- and short-term complications of diabetes that could lead to unnecessary ED visits and potentially preventable hospitalizations,[1-4] although these outcomes will not be measured during this project. CHW will contact program participants quarterly to reinforce the elements learned in the[136] CDSMP [4]. This program will be culturally and linguistically appropriate for English- and Spanish-speaking clients.

This project is in line with the Regional goal based on the CMS aim of making health care more patient-centered, and safe. The Stanford Chronic Disease Self-Management Program provides self-management techniques that help to empower program participants. Another Regional goal is to lower cost of care delivery for individuals, families, employers, and the government. Cost of care has been shown to be reduced with use of the fundamentals taught in the Stanford Chronic Disease Self-Management Program. Our project will contribute to the implementation of a CHW program that also imparts health literacy and disease self-management techniques for Tarrant County participants. This innovative project combines two evidence-based programs that have demonstrated success in decreasing health care expenditures, and in improving client health and quality of life.[1-4]

Project Goals:

- Provide evidence-based self-management for clients in ZIP code areas that are high risk for cardiovascular disease.
- Decrease potentially preventable hypertension admission rates among program participants.

This project meets the following Regional goals:

- Improve the health system by making health care more patient-centered.
- Improve health of the population by supporting proven interventions to address social determinants of health.
- Reduce the cost of the improved care delivery for individuals, families, employers and the government by reducing the number of potentially preventable admissions due to hypertension and stroke.

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[136] Lorig, K, Sobel, D, Ritter, P., Laurent, D., Hobbs, M. Effect of a self-management program on patients with chronic disease. *American College of Physicians*. www.acponline.org.

[2] Lorig, K, Ritter, P, Stewart, A et al. Chronic disease self-management program: 2-year health status and health care utilization outcomes. *Medical Care,* 2001. Vol. 39, pp.1217-1223.

[3] Sobel, D. Lorig, K, Hobbs, M. Chronic disease self-management program: from development to dissemination. *The Permanente Journal*, Spring 2002, Vol. 6 No.2.

[4] U.S. Department of Health and Human Services, Health Resources and Services Administration, August 2011. Community Health Workers Evidence-Based Models Toolbox.

Challenges:
The primary challenge will be to engage the targeted population in completion of the program. A percentages of the targeted population does not have a primary care provider and seeks care at the emergency department. The use of community health workers will enable us to go into the target ZIP code areas, introduce the program and advocate for participation. Currently, Tarrant County Public Health (TCPH) collaborates with the Tarrant County Diabetes Collaboration and with Senior Citizen Services of Tarrant County to provide free diabetes education. The Chronic Disease Prevention division of TCPH also provides prevention education on obesity, hypertension, diabetes, dyslipidemia, osteoporosis, and tobacco prevention. Our strategic plan includes providing culturally sensitive community-based prevention education to the citizens of Tarrant County. We have taken our chronic disease prevention message to local businesses as a part of their worksite wellness plans, we do presentations at faith-based events and participate in city and municipal community and worksite events to provide information on preventing chronic diseases. Because of the increased incidence of hypertension and diabetes, we have created a curriculum on living with these diseases. This project will enable us to do a more extensive job of facing hypertension, diabetes, and related illnesses.

5-Year Expected Outcome for Provider and Patients:
Our five-year outcome is to provide at least 2,600 citizens of Tarrant County with the CHW benefits and CDSMP. These contacts will be recorded in our database of program enrollment and completion. We expect a decrease in the percentage of clients in the target ZIP codes who are admitted to the emergency department or inpatient with uncontrolled hypertension.

Starting Point/Baseline:
This project will be a pilot, in that it does not currently exist in this innovative context. The Texas Department of State Health Services Potentially Preventable Hospitalizations (PPH) report indicates that between 2005 and 2010, Tarrant County adults spent more than $1.2 billion on potentially preventable hospitalizations involving high blood pressure, short-term and long-term diabetes complications.[8] Tarrant County residents spent nearly $87 million on preventable hospitalizations relating to hypertension between 2005-2010.[8] These hospitalizations could have possibly been prevented if the clients had been in follow-up care with a primary care provider or knew how to self-manage the disease processes. Texas is not a participant in the State Emergency Department Databases; therefore, we will establish a baseline of emergency department admissions within our cohort from the THR system. The CDC/NCHS National Health Interview Survey lets us know that adult patients with Medicaid coverage were twice as likely to visit the emergency department at least once in 12 months than those with private

coverage or those who were uninsured.[10] The baseline for hospitalizations and emergency visits will be set within DY2.[137]

Rationale:

Tarrant County BRFSS demonstrate that just over 25% of the adults in Tarrant County have been diagnosed with hypertension, 33% have been diagnosed with high cholesterol.[5] According to the Texas DSHS PPH, Tarrant County residents spent nearly $500 million on preventable cardiac-related hospitalizations and nearly $700 million on diabetes-related hospitalizations.[8] These numbers indicate that Tarrant County is in need of self-management programming and CHW assistance with regard to educating citizens about diabetes and hypertension.

Project Components:

This project does not have any required components.

Reasons/Rationale for Selecting the Outcome Measures:

We selected milestone **P-2:** Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community with a metric: document innovational strategy plan, and milestone **P-3**: Implement, document and test an evidence-based innovative project for target population with a metric: document implementation strategy and testing outcomes, because TCPH currently has two stand-alone evidence-based programs—Stanford Chronic Disease Self-Management (CDSMP) and Community Health Workers (CHWs). Chronic disease prevention staff have been certified in the Stanford CDSMP and are currently assisting Senior Citizen Services of Tarrant County with their program focused on training seniors to use disease self-management as a means to avoid potentially preventable trips to the emergency department. The Community Health Promotions division uses CHWs to assist with providing general health and wellness education to the community, as well as providing information about benefits that are available to women, infants and children living in Tarrant County. We thought that it would be innovative to combine the foundations of these two programs. We are not currently receiving funding for either of the programs. The combination program, CDSMP and CHW, can be implemented within the first year of funding although these two programs are practiced within different divisions. We thought

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[5] Tarrant County Public Health. Behavioral risk factor surveillance system 2009/2010: Turning Information Into Health, pp. 96-119.

[6] U.S. Department of Health and Human Services. Agency for Healthcare Research and Quality, 2012. Designing and implementing Medicaid disease and care management programs. www.ahrq.gov.

[7] Lorig, K, Gonzalez, V. Community-based diabetes self-management education: definition and case Study. *Diabetes Spectrum*, 2000, 13:(4). www.journal.diabetes.org/diabetesspectrum/00v13n4/page234.asp.

[8] Department of State Health Services. Potentially Preventable Hospitalizations, Tarrant County. www.dshs.state.tx.us/ph.

[9] Melchio, M. Investigating the outcomes of two chronic disease self-management programs and understanding the correlates of completion for each program. http://digitalcommons.fiu.edu/dissertations/AAI3517025.

[10] Centers for Disease Control and Prevention. National Health Interview Survey. www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm.

it innovative to combine the two as a project that would help to decrease the expenditures for hospitalizations relating to diabetes and hypertension, as well as help to improve quality of life for program participants[1]. Tarrant County does not currently have a program that combines the efforts of CHW and CDSMP that targets clinic-centered adults. As evidenced by our BRFSS, Tarrant County has a 25% rate of hypertension and nearly 9% rate of diabetes among adults, and has spent more than $1.2 billion in hospitalizations relating to these two dieseases.[5,8] The project is needed in order to provide self-management education and community resources guidance and support. Milestone 9 [I-X] will meet the recertification requirement that Stanford has for all who implement their programs.

Unique community need identification numbers the project addresses:

- CN 13 – Necessity of patient education programs
- CN 15 – Need for more education, resources and promotion of healthy lifestyles

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

This is a new Initiative, but we have health educators who are certified lay leaders for the Stanford Chronic Disease Self-Management Program. We have not received any local, state or federal funding to provide the program.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/ Rationale for Selecting the Outcome Measures:

IT-2.3- Hypertension Admission Rate – PQ#7-Tarrant County residents spent nearly $87 million on preventable hospitalizations relating to hypertension between 2005-2010.[8] Between 2005 and 2010, the number of PPH increased by 25%.[8] Evidence shows that the CDSMP has helped to decrease the number of hospitalization days, thereby saving medical dollars while helping to sustain individual quality of life.[1,2,10] The program has realized a savings between $390 and $520 per participant over a study period of two years, due in part to participants being hospitalized fewer days in the first six months of the program.[2] This project will help clients self-manage their blood pressure and make appropriate use of the primary care provider setting as opposed to using the ED for management.[1] By the end of DY5 want to see a 35% increase in controlled BP. Per the National Institutes of Health, of all the risk factors for stroke, the most powerful is hypertension. By the end of DY5 the CDSMP is estimated to prevent 35 possible strokes.

Relationship to Other Projects:

It appears that the Texas Health Harris Methodist Hospital Azle will develop a Health Education and Lifestyles Program and Chronic Disease Self-Management Program (127304703.2.1) for clients who live in Parker County, and Tarrant County residents living near Parker County. A learning collaborative will be beneficial if they are using a similar program. The master list of projects does not indicate whether they focus on hypertension, as does our program.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Tarrant County Public Health defined the population that will be directly impacted by the project as individuals identified as the number of participants in the Chronic Disease Self-Management Program (CDSMP) education. The percentage of the population expected to be positively impacted by the project in DY5 is 35%. Of that 35%, 10% will possibly have been hospitalized for a stroke. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because with the CDSMP education the participants will have increased knowledge to assist them in managing their hypertension.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person does not successfully manage hypertension, it can result in lost productivity and increased medical costs to employers.

022817305.2.4	2.6.2	N/A	IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS- IT-2.6.2 ESTABLISH SELF-MANAGEMENT PROGRAMS AND WELLNESS USING EVIDENCE-BASED DESIGNS (TARRANT COUNTY CHRONIC DISEASE SELF-MANAGEMENT)	
Tarrant County Public Health				022817305
Related Category 3 Outcome Measure(s):	-022817305.3.8	*3.IT-2.3*	Hypertension Admission Rate – PQI#7	
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]: 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 innovational strategy plan (Documentation of hiring and training CHW in the evidence-based programs, Stanford Chronic Disease Self-management Program (CDSMP) and Texas State Certification program for Community Health Workers) Goal: Eight Certified Community Health Workers who are certified to be Lay Leaders for Stanford CDSMP. Data Source: Program database and manual Milestone 1 Estimated Incentive Payment *(maximum amount):* $306,533 **Milestone 2** [P-3]: Implement,	**Milestone 3** [I-6]: Identify 600 more patients in the defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Documented self-management education for clients. Goal: 600 program participants. Data Source**:** Program participant records. Milestone 3 Estimated Incentive Payment: $319,780 **Milestone 4** [I-8]: Increase access to health promotion programs and activities using innovative project option. Using Social Media advertisement within targeted communities. Metric 1 [I-8.1]: Increase percentage of target population reached (Advertising Campaign that is culturally sensitive) Goal: Distribution of campaign to three unique ZIP codes		**Milestone 5** [I-6]: Identify 800 more patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Documentation of self-management education clients Goal: 800 program participants Data Source**:** Program participant records. Milestone 5 Estimated Incentive Payment: $342,090 **Milestone 6** [I-8.1]: Increase percentage of target population reached (Advertising Campaign that is culturally sensitive) Metric 1 [I-8.1]: Increase percentage of target population reached Goal: Distribution of campaign to Four unique ZIP codes Data Source: Public Information Officer and campaign materials	**Milestone 7** [I-6]: Identify 1,000 more patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Documented self-management education for clients Goal: 1,000 program participants Data Source: Program participant records. Milestone 7 Estimated Incentive Payment *(maximum amount):* $220,348 **Milestone 8** [I-8.1]: Increase percentage of target population reached (Advertising Campaign that is culturally sensitive) Metric 1 [I-8.1]: Increase percentage of target population reached Goal: Distribution of campaign to Five additional unique ZIP codes Data Source: Public Information Officer

022817305.2.4	2.6.2	N/A	IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS- IT-2.6.2 ESTABLISH SELF-MANAGEMENT PROGRAMS AND WELLNESS USING EVIDENCE-BASED DESIGNS (TARRANT COUNTY CHRONIC DISEASE SELF-MANAGEMENT)	
Tarrant County Public Health				022817305
Related Category 3 Outcome Measure(s):	-022817305.3.8	*3.IT-2.3*	Hypertension Admission Rate – PQI#7	
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)**
document and test an evidence-based innovative project for targeted population. Metric 1 [P-3.1]: Document implementation strategy and testing outcomes (Documentation of evidence-based practices of Stanford Chronic Disease Self-Management and Community Health Worker will used as the programs for this project). Goal: Implement project in Texas Health Resources clinics for 200 participants. Data Source: Provider records Milestone 2 Estimated Incentive Payment *(maximum amount):* $306,533	Data Source**:** Public Information Officer campaign materials Milestone 4 Estimated Incentive Payment: $319,780		Milestone 6 Estimated Incentive Payment: $342,090	Milestone 8 Estimated Incentive Payment: $220,348 **Milestone 9** [I-X]: Re-certification of CDSMP facilitator and CHW Metric 1 [I-X.1]: All CHW will attend and complete the required Stanford recertification training and testing in order be able to continue facilitating the program. Goal: All CDSMP facilitators and CHW will be re-certified by Stanford. Data Source: Certificates received from Stanford. Milestone 9 Estimated Incentive Payment: $220,348
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $613,065	Year 3 Estimated Milestone Bundle Amount: $639,560		Year 4 Estimated Milestone Bundle Amount: $684,180	Year 5 Estimated Milestone Bundle Amount: $661,044

022817305.2.4	**2.6.2**	**N/A**	IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS- IT-2.6.2 ESTABLISH SELF-MANAGEMENT PROGRAMS AND WELLNESS USING EVIDENCE-BASED DESIGNS (TARRANT COUNTY CHRONIC DISEASE SELF-MANAGEMENT)	
Tarrant County Public Health				022817305
Related Category 3 Outcome Measure(s):	-022817305.3.8	*3.IT-2.3*	Hypertension Admission Rate – PQI#7	
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,597,849				

Project Option 2.7.6 – Implement Evidence-based Disease Prevention Programs
Unique Project ID: 022817305.2.5
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Project Description:
This project involves the creation of a medication program to treat for latent TB infection (LTBI) with a drug (rifapentine) recommended by the CDC in December 2011. Recent studies involving rifapentine have shown higher LTBI treatment completion rates; which can be attributed to the regimen consisting of 12, once-weekly doses. Completion of LTBI treatment is essential to prevent individuals from developing active TB Disease.

Goals and Relationship to Regional Goals:
Project Goals:
The goal of the project is to increase the LTBI treatment completion rates for high-risk groups; which will prevent those clients from developing active TB. The rifapentine LTBI database to be created will assist in preventing the loss of patients during treatment and ensure their completion.

This project meets the following Regional goals:
Treating patients diagnosed as LTBI with rifapentine supports the Regional goal by making health care more patient-centered, reliable, accessible, and safe. This is attributed to the fact that the regimen is shorter and more likely to be taken than those currently used.

Challenges:
Tarrant County Public Health TB Division currently maintains a database to follow those diagnosed with LTBI and follow those on treatment. From 2007-2011, completion rates for contacts to active TB cases was 46% and for homeless shelter residents 28%. Treatment with rifapentine not only shortens the duration by 258 doses, but by administering via directly observed therapy (DOT), patients are more likely to comply with treatment. Completion of LTBI treatment will result in prevention of TB.

5-Year Expected Outcome for Provider and Patients:
By the end of DY5, 60% of those offered rifapentine treatment will accept. In addition to the number of people accepting treatment increasing; so will the number of those completing LTBI treatment.

Starting Point/Baseline:
According to the LTBI database maintained by Tarrant County Public Health-TB Division from 2007-2011,treatment completion rates for contacts to active TB cases is 46% and homeless shelter residents 28%.

In 2011, the refugee program changed from administering TB skin tests on their patients to conducting QuantiFERON Gold testing. This change decreased the number of refugees diagnosed with LTBI greatly, but treatment completion rates still remained poor (54%).

Rationale:
Current poor LTBI treatment completion rates among groups of people who are at high risk of developing active TB can most often be attributed to the length of current treatments offered. A recent study conducted and published by the CDC shows an improvement in LTBI treatment completion rates with a program that involves the drug rifapentine. This treatment regimen is 12 once-a-week doses under observation; instead of the current nine-month (270 doses) self-administered treatment. Healthy People 2020 also addresses poor LTBI completion rates and shows the current LTBI treatment completion average for contacts to active TB is 68.1% with a 2020 goal of 79%.

Project Components:
This project does not have core components.

The milestones and metrics selected are essential in creating and maintaining a rifapentine LTBI treatment program. Once policies and procedures are completed and staff hired/trained, enrollment can begin. The milestones selected not only promote an increase in the number patients completing LTBI treatment, but also decrease the number who refuse treatment or are lost before their regimen is completed.

The process milestone in DY3 will create a database that not only tracks those completing and refusing treatment, but it will allow for staff to identify patients missing multiple doses. This will help prevent them from being lost as a patient, and will also serve as the CQI for the program because these patients can be interviewed to find areas for improvement and identify issues patients may have taking the regimen.

Increasing the number of patients willing to take treatment and decreasing those who do not complete treatment will result in a lower rate of active TB.

Unique community need identification numbers the project addresses: CN.21High TB Prevalence
As described above, current LTBI treatment completion rates are poor. Without treatment, the three groups of people targeted have a greater risk of TB development. Two of the groups are mostly underinsured or Medicaid/Medicare (homeless and refugees) and are not likely to complete treatment. The third group is comprised of many in the lower socioeconomic category. TB generally affects those from a lower economic status who pass the disease on to those they

are around. However, the disease can be transmitted anywhere in the county where people are in contact with someone who has active TB.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project enhances the Tarrant County Public Health-TB Division's LTBI treatment program because it will not only increases the number of individuals willing to take treatment, but will also increase completion rates. Currently LTBI treatment is not conducted with rifapentine and no regimen offered to patients is completed in 12 weeks.

Related Category 3 Outcome Measures:

Outcome Measures
IT-12.6- Other Outcome Improvement Target

- 022817305.3.9- Primary Care and Primary Prevention-Primary Prevention for Active TB (treating with rifapentine)

Reasons/ Rationale for Selecting the Outcome Measures:

- DY3 IT-12.6- LTBI treatment completion rates for contacts, homeless shelter residents and refugees will improve by 20% compared to baseline established in DY2.
- DY4 IT-12.6- LTBI treatment completion rates will improve by 25% compared to DY2.
- DY5 IT-12.6- LTBI treatment completion rates will improve by 30% for contacts, homeless shelter residents and refugees combined compared to DY2.

Outcome Measures

IT-2.14- Other Admission Rate

- 022817305.3.17- Potentially Preventable Admissions- Undiagnosed Active Tuberculosis hospital admissions (treating LTBI with Rifapentine to prevent Active TB development)

Reasons/ Rationale for Selecting the Outcome Measures:

- DY3 IT-2.14- Undiagnosed, Active TB cases (Tarrant County residents) admitted to hospitals within the County will decrease 1% over the baseline established in DY2.
- DY3 IT-2.14- Undiagnosed, Active TB cases (Tarrant County residents) admitted to hospitals within the County will decrease by 2% over the baseline established in DY2.
- DY3 IT-2.14- Undiagnosed, Active TB cases (Tarrant County residents) admitted to hospitals within the County will decrease by 3% over the baseline established in DY2.

LTBI treatment completion and a decrease in the number of active TB cases should be a goal of the RHP because it is a goal for Healthy People 2020. Without the creation of a rifapentine treatment program both of these goals will be difficult for any TB program to achieve.

The CDC has conducted studies addressing poor LTBI treatment completion rates and has found that with rifapentine adherence to therapy improves. Following all of the studies conducted, in December 2011 the CDC released its recommendations for treating LTBI with rifapentine. The recommendation released also highlighted areas where rifapentine would be a benefit; two of these were patient willingness to take treatment and improving treatment completion rates.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**
  - 022817305.1.2- This project also focuses on LTBI treatment completion rates, but focuses on clinic hours. The TB Medication Management (Rifapentine) Program uses a new LTBI treatment regimen that will increase completion rates. The other difference between the two groups is target population. The TB Clinic Expansion project involves all patients diagnosed as LTBI, but the Rifapentine Project focuses on contacts to active TB cases, homeless shelter residents and refugees.

- **Related Category 4 population-focused improvements**: None

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Tarrant County Public Health defined the population that will be directly impacted by the project as individuals indentified as the number of LTBI clients receiving rifapentine. The percentage of

the population expected to be positively impacted by the project is 30%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.27% of the total project valuation was allocated to Category 1 and 2. The goal by the end of DY5 is potentially preventable TB hospital admissions for the 3% decrease in hospital reported TB cases (among Tarrant County residents). **Outcome Measure 1: 3.IT-5.1 –** The cost savings for the 174 additional LTBI clients that complete their LTBI medication treatment is the cost to the medical system to restart the medication treatment after the failure of $1,092 per client (174 X $1,092 = $190,008). This total value of $190,008 is multiplied by individual impact of 3 and community impact of 3 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the actual total outcome valuation of IT-5.1 of $2,717,114. **Outcome Measure 2: 3.IT-2.14** Based on a 10 year average 59 TB cases per year are hospital reported cases. There is a savings of $20,100 per potentially preventable TB hospital admissions for the 3% decrease in hospital reported TB cases ($20,100 X 2 = $40,200). $40,200 is then multiplied by the individual impact of 3 and the community impact of 3 to determine the value per year. The total value is multiplied by 5 years and a halo effect of 1.3 to determine the IT-2.14 actual total outcome valuation of $574,860. The TB medication project actual total project valuation is $3,291,974 but due to Public Health DSRIP funding availability the project was discounted 60.9% for a total project valuation of $1,287,314. The completion of LTBI medication treatment provides the client with a lifelong health benefit with the prevention of the conversion to an active case of TB. Without the LTBI medication completion a conversion to active TB could occur anytime within the individuals lifetime. In addition to the clients health benefits LTBI medication treatment completion also protects and provides benefits to the clients family members and other close connect individuals.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person is does not successfully complete the medication treatment, it is possible for the latent TB to convert to a case of active TB. Once converted to active TB the individual health is affected. If the medication treatment was partially completed, there is an enhanced chance of developing drug-resistant TB. This type of TB is usually treated with IV therapy. Drug-resistant TB is more serious and costly.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person does not successfully complete the medication treatment, it is possible for the latent TB to convert to a case of active TB. Once converted to an active TB case it is possible for the individual to transmit TB to others.

Outcome Measure 1: 3.IT-5.1 –Valuation Reference
$1,092 cost to the system to restart medication treatment after failure
Baylor Specialty Care

Outcome Measure 2: 3.IT-2.14
$20,100 TB case hospital cost
"Tuberculosis Stays in US Hospitals, 2006", Laurel Homquist, M.S., C. Allison Russo M.P.H., and Anne Elixhaurser PhD

022817305.2.5	***2.7.6***	***N/A***	***IMPLEMENT EVIDENCE-BASED DISEASE PREVENTION PROGRAMS (TB MEDICATION MANAGEMENT)***	
Tarrant County/dba Tarrant County Public Health				*022817305*
Related Category 3 Outcome Measure(s):	*-022817305.3.9* *022817305.3.17*	*IT-12.6* *.IT-2.14*	*Other Outcome Improvement Target* *Other Admissions Rate*	
Milestone 1 [P-1]: Development of innovative evidence-based project for targeted population. Rationale/Evidence: From 2007-2011 LTBI Treatment completion rates for contacts was 46% and 28% for homeless shelter residents. The rates above will be the baseline for DY2. In Dec 2011 a new LTBI treatment regimen was recommended by the CDC after studies showed an increase in treatment completion rates. Instead of 270 daily doses the regimen is 12 once weekly. Metric 1 [P-1.1]: Document innovational strategy and plan. Baseline/Goal: Create policies and procedures based upon CDC recommendations for LTBI rifapentine treatment program. Hire/train staff to conduct LTBI program. Data Source: TCHD- TB Division Policy and Procedure Manual; HR Records Milestone 1 Estimated Incentive	**Milestone 2** [P-X]: Create rifapentine Treatment Database or those patients diagnosed as LTBI and offered rifapentine to track the number enrolled, completing treatment, monitoring for those missing multiple doses and the number refusing treatment. Follow-up will be done with those who are noted to miss multiple doses to identify areas of possible improvement. Metric 1 [P-X.1]: 100% of patients offered rifapentine will be input and followed in database. Baseline/Goal: Create database to follow patients. Data Source: rifapentine LTBI Database Milestone 2 Estimated Incentive Payment: $141,454 **Milestone 3 [I-5]:** Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model.	**Milestone 4** [I-5]: Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Patients offered and accepting rifapentine treatment. Numerator: # of patients accepting treatment. Denominator: # of patients offered treatment. Rationale/Evidence: CDC study conducted shows that the shorter duration offers patients a practical advantage for completing their LTBI treatment in short period of time. Goal: 50% of patients offered rifapentine treatment will accept. Data Source: rifapentine Treatment Database will have an area to note if treatment offered but patient refused. Milestone 4 Estimated Incentive Payment: $302,645	**Milestone 5** [I-5]: Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Patients offered and accepting rifapentine treatment. Numerator: # of patients accepting treatment. Denominator: # of patients offered treatment. Rationale/Evidence: CDC study conducted shows that the shorter duration offers patients a practical advantage for completing their LTBI treatment in short period of time. Goal: 60% of patients offered rifapentine treatment will accept. Data Source: rifapentine Treatment Database will have an area to note if treatment offered but patient refused. Milestone 5 Estimated Incentive Payment: $292,411

022817305.2.5	***2.7.6***	***N/A***	***IMPLEMENT EVIDENCE-BASED DISEASE PREVENTION PROGRAMS (TB MEDICATION MANAGEMENT)***	
Tarrant County/dba Tarrant County Public Health				*022817305*
Related Category 3 Outcome Measure(s):	*-022817305.3.9* *022817305.3.17*	*IT-12.6* *.IT-2.14*	*Other Outcome Improvement Target* *Other Admissions Rate*	
Payment *(maximum amount):* $271,187		Metric 1 [I-5.1]: Patients offered and accepting Rifapentine treatment. Numerator: # of patients accepting treatment. Denominator: # of patients offered treatment. Rationale/Evidence: CDC study conducted shows that the shorter duration offers patients a practical advantage for completing their LTBI treatment in short period of time. Goal: 45% of the patients offered rifapentine will accept. Data Source: rifapentine Treatment Database will have an area to note if treatment offered but patient refused. Milestone 3 Estimated Incentive Payment: $141,454		
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $271,187		Year 3 Estimated Milestone Bundle Amount: $282,907	Year 4 Estimated Milestone Bundle Amount: $302,645	Year 5 Estimated Milestone Bundle Amount: $292,411
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$1,149,150				

Project Summary

Project Option 2.7.2 -Implement innovative evidence-based strategies to reduce tobacco use

Unique Project ID: 022817305.2.8 (Pass 3)
Performing Provider Name: Tarrant County/dba Tarrant County Public Health/022817305

Provider: Tarrant County Public Health has 420 FTEs, 20 sites, and provides public health services to 1.9 million in Tarrant County. Tarrant County Public Health is the county's public health department and provides health educational programming support for healthcare providers to include hospitals and PCPs.

Intervention: Project option 2.7.2 will use the American Lung Association's evidence-based Freedom From Smoking curriculum to decrease tobacco use in Tarrant County. This program has demonstrated smoking cessation success. This program is new in Tarrant County. Tarrant County does not have any organized, ongoing tobacco cessation programming for the citizens who are interested in tobacco cessation.

Need for the project: Tarrant County has more than 243,000 self-identified smokers in the county. Tarrant County does not have any organized, ongoing tobacco cessation programming for the citizens who are interested in tobacco cessation. Research shows us that tobacco use is a preventable cause of death and exacerbation of cardiovascular and respiratory diseases as well as causes some cancers.

Target population: Medicaid, un-insured and under-insured county residents who are tobacco users. Estimated 2,400 individuals will be impacted over the period of the waiver.

Expected patient benefits: Tarrant County does not currently have any widespread tobacco cessation programming available. This program would lead to a reduction in the dollars spent on tobacco related illnesses, or exacerbation of chronic illnesses related to tobacco use such as cardiovascular and respiratory illnesses for tobacco users and those who are in contact with the users. Evidence indicates that smokers have a lower Health Related Quality of Life as compared to those who have never smoked and those who have quit.[4] Evidence also shows us that ex-smokers have a significantly higher quality of life score than current smokers.[5]

Category 1 or 2 expected patient benefits/category 3 outcomes: Tobacco cessation and improved results on the Health Related Quality of Life score for at least one year for program participants. The goal is to develop, implement and track evidence-based tobacco intervention project and enroll 2,400 tobacco users into project and follow up to verify % remaining smoke free.

Project Option 2.7.2 -Implement innovative evidence-based strategies to reduce tobacco use

Unique Project ID: 022817305.2.8 (Pass 3)
Performing Provider Name: Tarrant County/dba Tarrant County Public Health/022817305

Project Description:
Implement Evidence-Based Disease Prevention Programs
Tarrant County Public Health will implement project option 2.7.2 by combining the evidence-based, American Lung Association Freedom From Smoking (FFS)[1] program and the evidence-based use of community health workers to teach Tarrant County residents how to stop smoking. The project area indicates that our program should be innovative in its use of evidence-based disease prevention programming. The project will use a combination of face-to-face interventions along with telephone and Internet support as did the Texas Tobacco Cessation Pilot Program in 2009.[2] We will launch a communications campaign to introduce the program to Medicaid enrollees to improve cessation treatment program use.[7]

Goals and Relationship to Regional Goals:
Project Goals:
The goals of project option 2.7.2 are to reduce tobacco use among Tarrant County residents and to improve quality of life of Tarrant County residents as tobacco users decide to learn and implement tobacco cessation. According to the 2009/2010 Tarrant County Behavioral Risk Factor Surveillance System, 18% of Tarrant County adults were classified as current smokers; well above the Healthy People 2020 target of 12%, but just under the current baseline of 20.6%.[3] Our project will be similar to the Texas Tobacco Cessation Pilot Program implemented by the HHSC in 2009, which demonstrated that participants who received face-to-face counseling or telephone intervention had much higher one-year tobacco-cessation rates than did those who were not offered any cessation support.[2] At the end of one year, the face-to-face intervention group went from 97.2% tobacco users to 56.0%, the telephone intervention group went from 96.9% to 66.7% tobacco users and the control group went from 100% to 83.3% tobacco users, which demonstrates a significant reduction in the percentage of tobacco users who participated in an intervention.[2]

Challenges:
Tarrant County has limited face-to-face tobacco-cessation programming. According to the 2009/2010 Tarrant County Behavioral Risk Factor Surveillance System, 18% of Tarrant County adults were classified as current smokers; well above the Healthy People 2020 target of 12%, but just under the current baseline of 20.6%.[3] Evidence indicates that smokers have a lower Health Related Quality of Life as compared to those who have never smoked and those who have quit.[4] Evidence also shows us that ex-smokers have a significantly higher quality of life score than current smokers.[5]

5-Year Expected Outcome for Provider and Patients:

The five-year expected outcomes are: (1) A one-year 25% decrease in tobacco use among program participants and, (2) 60% of the intervention population will experience improvement in the postevaluation of Health Related Quality of Life survey.

Texas Medicaid has begun to step up its actions to help Medicaid recipients stop smoking by offering tobacco-cessation counseling for pregnant clients and certain medications to assist with tobacco cessation at a reduced co-pay or at no cost.[6] Tarrant County Public Health currently works in collaboration with Tobacco Free North Texas and other North Texas agencies that are trying to ensure that tobacco-free legislation becomes a standard practice in the area.

Starting Point/Baseline:
This is a new project. The baseline data will be collected from health care providers who care for Medicaid recipients identified as smokers. The clients will be referred to the program and will complete the HRQOL survey prior to program implementation. A postprogram HRQOL survey will be conducted at 30 days postprogram. A comparison between pre- and post-HRQOL will be conducted using an item-by-item comparison for each participant. The baseline data will be established in DY2.

Rationale:
Tarrant County has limited face-to-face tobacco-cessation programming. According to the 2009/2010 Tarrant County Behavioral Risk Factor Surveillance System, 18% of Tarrant County adults were classified as current smokers; well above the Healthy People 2020 target of 12%, but just under the current baseline of 20.6%.[3] Evidence indicates that smokers have a lower Health Related Quality of Life as compared to those who have never smoked and those who have quit.[4] Evidence also shows us that ex-smokers have a significantly higher quality of life score than current smokers.[5]

Project Components:
Our project does not have any core components.

Project Milestones and Rationale
Milestone 1: development of innovative evidence-based project for target population. We selected this milestone because we are combining two evidence-based programs, Freedom From Smoking and Community Health Workers, to create one project. Therefore, it is imperative to fully develop the program and include any additional elements that may be desired by stakeholders and community partners.

Milestone 3: Execution of learning and diffusion strategy for testing, spread and sustainability will be a method of fulfilling part of the CQI requirements. We selected this milestone to ensure that the program is developed appropriately so that it is conducive to enrollment and completion by the target population. A key factor in closing the gap between best practice (such as FFS) and common practice is the ability of the health care providers and public health to spread innovations and new ideas such as program option 2.7.2.

Milestone 3: Identifying the percentage of patients in defined population. We selected this milestone to ensure that we create a sample of program participants large enough to have a

positive impact on the expenditures of medical needs related to tobacco use by decreasing the number of Medicaid tobacco users in Tarrant County, and large enough to ensure valid results.

Milestones 4, 5 & 7: Identify a percent of patients in defined population receiving innovative intervention consistent with evidence-based model. This milestone will help us to ensure that we are identifying and enrolling at an incremental rate that will allow us to implement CQI outcomes to keep the program evolving in the direction that will yield at least a one year smoking cessation rate and an improvement in HRQOL survey scores among program participants.

Milestone 6: Increase access to disease prevention programs using innovative project option. In an effort to ensure that we are reaching the Medicaid and uninsured residents who are in need of tobacco cessation education we will use screening venues, health events and collaborations with community partners to reach a larger sample of our target population.

Unique community need identification number the project addresses:
CN.15 Need for more education, resources and promotion of healthy lifestyles (free and safe places to exercise, health screenings, health education, healthy environments, etc.).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Medicaid has begun to allow its recipients to access medical tobacco-cessation products for low co-pays and provides counseling services to pregnant women at no cost.[6] We believe that our program will provide another alternative for Medicaid recipients to participate in tobacco-cessation programming.

Related Category 3 Outcome Measures:
Outcome Measures Reasons/Rationale for Selecting the Outcome Measure:

IT. 10.1: Quality Of Life/Functional Status:
Evidence indicates that smokers have a lower Health Related Quality of Life as compared to those who have never smoked and those who have quit.[4] Evidence also shows us that ex-smokers have a significantly higher quality of life score than current smokers.[5] Elements of quality of life include good health status, healthy relationships, personal happiness, socioeconomic stability, all of which we want for Tarrant County citizens.

Relationship to Other Projects:
Related to Category 1 and 2 projects
TCPH#022817305.2.1 Fetal Infant Mortality Review (tobacco cessations helps promote healthy pregnancy outcomes)

Category 4 population-focused improvements: N/A

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

Tarrant County Public Health is unaware of any other similar projects, but UNTHSC is proposing a program, Asthma 411, that could benefit by referring the tobacco-dependent adult relatives of the target population children in their program. Evidence indicates that children with asthma have better health outcomes when they are not in contact with environmental toxins such as smoke, dust and other environmental triggers.[8].= This program could also be a beneficial referral for the Tarrant County TB and STD programs in that tobacco-cessation can improve quality of life across the board.[5]
(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the Region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Tarrant County Public Health computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Tarrant County Public Health defined the population that will be directly impacted by the project as individuals identified as Tarrant County smokers with Medicaid who participate in Tarrant County Public Health smoking-cessation classes. The total number of the Tarrant County population expected to be positively impacted by the end of DY5 is approximately 2,400 cessation class participants. The goal by the end of DY5 is 25% of DY4 participants, or approximately 200, will remain smoke-free for one year. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.26% of the total project valuation was allocated to Category 1 and 2. 60% or approximately 600, will have an improved HRQOL survey result upon program completion. The 600 participants with improved quality of life times two quality of life values (productivity of $3,961.88 and medical cost of $2,342.56) or 600 X $6,304 equals $3,782,664. This amount is multiplied by individual impact of 5 and community impact of 4 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total project valuation. The actual Tobacco Intervention total project valuation for 5 years equals $68,844,485. However, due to the DSRIP Public Health funding available and the project valuation maximum the Tobacco Intervention project was discounted by 67.5% to a total project valuation of $22,405,703.
We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Dollar valuations for the expected impact are from Penn State, "Potential costs and benefits of smoking cessation for Texas," Tables 2 and 3, April 30, 2010.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 5**.** We believe this to be the correct number because upon being tobacco free for one year it is assumed the participant will remain smoke free for life. This has great impact on the health improvement, increase in productivity and the reduction in medical cost for a nonsmoker/ex-smoker. We believe this to be the correct number because as the FDA warnings on cigarette packages and advertising state, "cigarettes causes fatal lung disease," "cigarettes cause cancer," and "cigarettes cause strokes and heart disease."

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4**.** We believe this to be the correct number because reducing the number of smokers also reduces the harm to nonsmokers in the community from secondhand smoke. The FDA warnings on cigarette packages and advertising state, "tobacco smoke can harm your children" and "smoking during pregnancy can harm your baby." In addition, it will save community resources and medical costs by reducing smoke-related medical services for both the new non-smokers and those with health issues as a result of the second hand smoke.

Outcome Measure : IT.10.1: Quality of Life –Valuation Reference
Productivity cost per smoker $3,961.88
Medical cost per smoker $2,342.56
Penn State, "Potential costs and benefits of smoking cessation for Texas", Tables 2 and 3, April 30, 2010.

022817305.2.8	2.7.2		*IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO REDUCE TOBACCO USE (TARRANT COUNTY TOBACCO INTERVENTION PROGRAM)*	
Tarrant County/dba Tarrant County Public Health				**022817305**
Related Category 3 Outcome Measure(s):	**022817305.3.16**	**3.IT-10.1**	**25% DY4 participants remain smoke free for 1 year**	
Milestone 1 [P-1]: Development of innovative evidence-based project (tobacco cessation) for target population (Clients seen by Texas Health Resource Providers). Metric 1 [P-1.1]: Document innovational strategy and plan. Baseline/Goal: Finalize the Tobacco Cessation program to be rolled out to clinics Data Source: Program description and protocols Milestone 1 Estimated Incentive Payment: $2,357,666 **Milestone 2 [P-2]:** Implement evidence-based innovational project for targeted population. Metric 1 [P-1.2]: Document implementation strategy and testing outcomes. Baseline/Goal: 30% of eligible program participants with 40% having an increase in HRQOL scores 250 participant estimate Data Source: Program Records and Referral listings. Milestone 2 Estimated Incentive Payment :$2,357,666		**Milestone 3 [P-3]:**Execution of learning and diffusion strategy for testing, spread and sustainability. Metric 1 [P-3.1]: Document learning and diffusion strategy for testing, spread and sustainability. Baseline/Goal: Plan for implementation of the program into community locations Data Source: Program description and protocols Milestone 3 Estimated Incentive Payment: $ 2,459,856 **Milestone 4 [I-5]:** Identify 40% of eligible targeted patients in defined population receiving innovative intervention consistent with evidence-based model Metric 1 [I-5.1]: Evidenced contact with 50% of DY2 participants Goal: 15% of DY2 clients are still tobacco free 600 participant estimate Data Source: Program participant records and participant surveys Milestone 4 Estimated Incentive Payment: $2,459,857	**Milestone 5 [I-5]:** Identify 50% of eligible patients in defined population receiving innovative intervention consistent with evidence-based Metric 1 [I-5.1]: Evidence contact with 50% of DY3 program participants Goal: 20% total of DY2 and DY3 program participants have a one-year cessation rate. 800 participant estimate Data Source: Program participant records and participant surveys. Milestone 5 Estimated Incentive Payment: $2,635,805 **Milestone 6 [I-7]:** Increase access to disease prevention program using innovative project option. Metric 1 [I-7.1]: Increase number of encounters as defined by intervention (e.g. screenings, education, outreach, etc.) 800 participant estimate Goal: Identify potential program participants through screenings and outreach conducted by CHW. Data Source: Program records and protocols Milestone 6 Estimated Incentive	**Milestone 7 [I-5]:** Identify 60% of patients in defined population receiving innovative intervention consistent with evidence-based model.-1000 participant estimate Metric 1 [I-5.1]: Evidenced contact with 10% of DY-2 program participants Goal: 40% of DY2, DY3, DY4 program participants have a one year cessation rate 1000 participant estimate Data Source: Program participant records and participant survey Milestone 7 Estimated Incentive Payment: $**5,093,343**

022817305.2.8	**2.7.2**		***IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO REDUCE TOBACCO USE (TARRANT COUNTY TOBACCO INTERVENTION PROGRAM)***
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 3 Outcome Measure(s):	**022817305.3.16**	**3.IT-10.1**	**25% DY4 participants remain smoke free for 1 year**
			Payment: $2,635,805
Year 2 Estimated Milestone Bundle Amount: $4,715,332	**Year 3 Estimated Milestone Bundle Amount: $4,919,713**	**Year 4 Estimated Milestone Bundle Amount: $5,271,610**	**Year 5 Estimated Milestone Bundle Amount: $5,093,343**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $19,999,998			

Project Option 2.13.2 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.) – Detoxification Unit and Service Expansion Project.

Unique Project ID: 081599501.2.1
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501

Provider: MHMRTC is the Local Mental Health Authority (LMHA) providing mental health, early childhood, addiction and intellectual developmental disabilities services, serving an 897 square mile area and a population of approximately 1.8 million residents. MHMR of Tarrant County is a Contractor funded by DSHS to provide substance abuse services. We are the only state authorized detoxification unit for medically indigent and Medicaid clients in Region 10. Hospitals and other treatment providers in our 11 county region refer medically indigent and Medicaid clients to the Billy Gregory Center for these specialized services.

Intervention: The intervention is set to expand our medically supervised Detoxification unit from 12 to 20 beds. The project will also implement new strategies for post-discharge activities for all of the patients who enter the detoxification unit. Currently, at discharge counselors recommend post-discharge services, but there is no follow up to encourage participation in further services. MHMRTC plans to hire peer specialists charged with helping patients move into services to continue treatment and to stay sober and to continue to work with patients to encourage them to participate. We also plan to hire an APN to provide more and better access to physical health assessments during the patient's time in the unit.

Need for Project: Inpatient detoxification is a critical element of the continuum of care for chemically dependent individuals. For the uninsured, economically disadvantaged population, "access to this continuum of care within a comprehensive service system is essential to prevent them from 'falling through the cracks,' as they tend to be revolving-door" (i.e., repeating), high utilizers of publicly-funded services with high morbidity and mortality rates."[138] "Facilitating linkage to follow-up treatment after detoxification to ensure continuity of care was a key element [of the project studied for the article], as research has shown that detoxification alone has limited long-term value."[139] This project will expand encounters to a significant portion of SUD clients in Tarrant County who are currently on the waiting list for services or are currently being admitted to emergency room services with related conditions. The inpatient wait list fluctuates from 20 to over 45 Medicaid eligible and uninsured individuals. Further capacity will also be needed as UNTHSC and Wise Regional Medical center have projects that will result in additional referrals of patients to our detoxification unit.

[138] "Closing the Gaps: The Impact of Inpatient Detoxification and Continuity of Care on Client Outcomes", Journal Of Psychoactive Drugs, SARC Supplement 6, September 2010. http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=359390af-460e-4be4-9310-1046dc8b8c72%40sessionmgr4&vid=2&hid=25

[139] Id

Target Population: Region 10 substance using consumers who are experiencing withdrawal or intoxication. The population will consist primarily of uninsured and Medicaid eligible consumers.

Category 1 or 2 milestones expected benefit: The project seeks to provide care to 250 additional patients in DY4 and 300 in DY5 in addition to significantly enhancing services within the continuum of care offered to patients in existing beds (500 per year).

Category 3 outcomes:
IT 9.2 Our goal is a 20% reduction in ED visits for patients enrolled in the program.
IT-6.1 Our goal is to have 10% improvement over the baseline of patient satisfaction scores.

Project Option 2.13.2 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.) – Detoxification Expansion Project.

Unique Project ID: 081599501.2.1
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501

Project Description:

We propose an expansion of our medically supervised detoxification unit from 12 beds to 20. The project will also implement new strategies for post-discharge activities for all of the patients who enter the detoxification unit. Currently, at discharge counselors recommend post-discharge services, but there is no follow up to encourage participation in further services. MHMRTC plans to hire peer specialists charged with helping patients move into services to continue treatment and to stay sober and to continue to work with patients to encourage them to participate. We also plan to hire an APN to provide more and better access to physical health assessments during the patient's time in the unit.

-The team will focus on issues which disproportionally affect this population, including legal issues, mental illness, tobacco use and health conditions directly related to SUD and MH. This provision of care and coordination for Substance Abuse Disorder (SUD) clients in a specialized detoxification unit will improve health quality, reduce health care costs and costs incurred through the legal system in Tarrant County and RHP 10.

During and upon completion of detoxification services, consumers will be referred to the following services, among others:

- Peer recovery coaches will -assist clients -in accessing needed services currently available (addiction step-down services – intensive residential treatment and outpatient addiction treatment services)
- Transformation waiver project -081599501.2.2 Integrate Primary and BH Care Services by our organization,
- Transformation waiver project -081599501.2.3 Enhance Service Availability of Appropriate Levels of BH Care) in the treatment continuum by our organization, and
- -Back to the organization that referred them to our facility, when appropriate.

Goals and Relationship to Regional Goals:

Project Goals:
-To increase MHMRTC'S ability to provide the right care at the right time in the right setting, resulting in more patients being treated in the behavioral health setting rather than emergency departments, inpatient units or ending up incarcerated. Specifically this will increase the number of people receiving detoxification treatment services by 50% in Region 10.

-This project meets the following Regional goals:
A -goal of the Region is to provide improved access to ongoing preventive primary and behavior health care. This project will contribute to achieving that goal by focusing on a key behavior health populations and increasing the gateway to further treatment and long term wellness.

Challenges:
In order to determine whether we have met our goal of reducing ED visits, we will need data not in our control. Because JPS is a primary provider of ED services to our client base, we will work with them to gather data necessary to establish baselines and to track process.

We also recognize a challenge in following up with patients regarding patient satisfaction scores. Working with our peer recovery coaches, we will develop incentives and methodologies for engagement.

-5-Year Expected Outcome for Provider and Patients:
The expected outcome for MHMRTC is the ability to provide additional services to our target population which is historically underserved. Our goal for patients is that the services they receive result in long term sobriety and an improved quality of life.

Starting Point/Baseline:
The detoxification unit currently serves 500 clients annually, none of whom receive post-discharge services as proposed in this project. The total number of clients served in the detoxification unit with the funded expansion will increase from 500 clients annually to 800 clients served annually which equates to an additional 300 clients.

Rationale:
Inpatient detoxification is a critical element of the continuum of care for chemically dependent individuals. For the uninsured, economically disadvantaged population, "access to this continuum of care within a comprehensive service system is essential to prevent them from 'falling through the cracks,' as they tend to be revolving-door" (i.e., repeating), high utilizers of publicly-funded services with high morbidity and mortality rates."[140] "Facilitating linkage to follow-up treatment after detoxification to ensure continuity of care was a key element [of the project studied for the article], as research has shown that detoxification alone has limited long-term value."[141]

[140] "Closing the Gaps: The Impact of Inpatient Detoxification and Continuity of Care on Client Outcomes", Journal Of Psychoactive Drugs, SARC Supplement 6, September 2010. http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=359390af-460e-4be4-9310-1046dc8b8c72%40sessionmgr4&vid=2&hid=25

[141] Id

Consumers find difficulty in navigating the system and in finding a provider, particularly indigent detoxification care providers. Region 10 has no other state-funded detoxification unit available and the wait list is currently at 45 persons whom have put their name on the list. These numbers do not include the clients who should be admitted to the unit or were on the wait list but due to lack of capacity and time delays end up in less appropriate settings.

-**Project Components:**

a. Expansion of the detoxification unit by adding a minimum of eight additional beds
b. Identify the demographics, diagnoses, housing status, functional status, medical utilization and ED utilization of intended demographic through conducting a needs assessment
c. Implement revised care model for detoxification services
d. -U-se -detoxification substance-specific protocols in treatment
e. -Hire and train- peer support staff who -model and coach successful health and mental health behaviors

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.10 – Demand for ED visits is on the rise and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow

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

This is an enhancement of an existing project funded through the Department of State Health Services in Texas. During the last legislative session, SUD treatment was included as a Medicaid benefit to low-income individuals in Texas. This project will significantly enhance an existing delivery system reform initiative, focused on treating individuals in the most appropriate level of care at the most cost-effective and efficient manner. Diverting consumers with SUD from hospitals-, legal institutions and mental health hospitals is a part of delivery systems reform in Texas.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/ Rationale for Selecting the Outcome Measures:

IT-6.1 Percent improvement over baseline of patient satisfaction scores.

Ford and Zarate indicate in their article, "Closing the Gaps: The Impact of Inpatient Detoxification and Continuity of Care on Client Outcomes," that psychosocial areas will

improve when treatment services are provided.[142] Client outcomes were positive, particularly outcomes of clients who completed detoxification treatment services and received follow-up care. Their functioning relative to sobriety, employment, homelessness improved and arrests and days incarcerated decreased as compared to measures prior to clients participating in treatment services. The quality of life improvements resulting from enhanced detoxification services should be reflected in patient satisfaction scores.

IT- 9.2ED appropriate utilization

The study about which Ford and Zarate's article was written resulted in an approximate 19% decrease in ED visits post-discharge from the detoxification unit.

Relationship to Other Projects:

The expansion of detoxification beds in Region 10 is directly related to the expansion of behavioral health capacity (RPH Project 081599501.1.1). Consumers in Region 10 with behavioral health diagnosis of mental illness and or primary health care problems will be served in the appropriate level of care that is cost efficient and effective for both behavioral and primary health- This project is also related to R.N. care management (RHP 081599501.2.3), as it allows more access to specialized services that case managers can utilize for a targeted population, thus preventing the use of services in an inappropriate setting. Essentially, consumers will be able to access a full continuum of care to meet their primary health and behavior health needs.

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

The Detoxification Expansion Project participants who reside in Wise County will be referred to the Wise Regional Health System Intensive Outpatient Program (IOP) 130606006.2.3 – as a step-down option to continue substance use disorder services/recovery treatment. Wise Regional Health System proposes to establish a substance abuse division in Wise County for patients requiring substance abuse services.

Upon completion of detoxification services, we will also refer previously homeless dually diagnosed consumers to the University of North Texas Health Science Center (UNTHSC) 138980111.2.2 – Health Navigation and Incentives for Dual Diagnosis Patients project. Conversely, both Wise Regional Health System and UNTHSC will refer clients needing detoxification services, a higher level of care, to our Detoxification Expansion project.

[142] http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=359390af-460e-4be4-9310-1046dc8b8c72%40sessionmgr4&vid=2&hid=25

At least twice a year, we will participate in learning collaboratives at the regional level. The collaboratives will identify "raise the floor" initiatives which we will implement. We will also participate by bringing our best practices identified through the project.

Project Valuation:

Approach:

Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time.

Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system.

In order to set an appropriate incentive RHP 10 agreed that a multiplier of 5 should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the annual value of a single successful intervention at full implementation and multiplying that value by 5. The multiplier of 5 was decided with much discussion by performing providers. The rationale was that to overcome resistance to change, both in the delivery system and the payment system, 5 years of benefits were needed. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

The incentive element of the Region 10 valuation methodology is relevant to all Texas transformation efforts. However, it is particularly relevant to transformation of the mental health care system, where patient experience, population health and costs have previously not received any focus, and where services tend to be provided primarily in emergency situations. Texas ranks 50th in the country in per capita funding for mental health services. Only one-third of the more than 480,000 adults in Texas with serious and persistent mental illness received services through the community mental health

system. Therefore, the most important transformation that can occur in mental health is increased access to services. Until the advent of the waiver, the system has not had funds to experiment with the types of interventions that are being made possible through waiver funding. Incentives for effective implementation and outcomes are important to allow for the identification of successful interventions and the ultimate sustained transformation of the system.

Rationale:

We will be serving 1900 people throughout the waiver period. The full value of this additional capacity will not be limited to the interventions delivered during the waiver period since we intend to permanently operate at the higher capacity as we move to transform the system rather than make temporary changes for the sake of the waiver.

For this project, cost measures from studies identified reductions from baseline in medical status, psychiatric status, employment, criminal activity, and in treatment. Medicare/Medicaid savings were identified to identify the total value for one successful intervention. At full implementation we will be serving 800 unique patients annually, so the value per successful intervention was computed. We then applied the incentive multiplier of 5 deriving at the full valuation

081599501.2.1	***2.13.2***	***2.13.2***	**Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.).Other (*DETOXIFICATION UNIT AND SERVICE EXPANSION*)**	
Mental Health Mental Retardation of Tarrant County (MHMRTC)				*081599501*
Related Category 3 Outcome Measure(s):	*U-nique Category 3 IT identifier(s)* – 081599501.3.12 081599501.3.2	***IT 9.2*** ***IT-6.1***	*ED Appropriate Utilization* *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)**

081599501.2.1	*2.13.2*	*2.13.2*	**Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.).Other (*DETOXIFICATION UNIT AND SERVICE EXPANSION*)**
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Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. Metric [P-1.1]: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization -Goal:-Complete Needs Assessment Data Source: Project documentation; Inpatient, discharge and ED records; survey of stakeholders (inpatient providers, mental health providers, social services and forensics); literature review. Milestone 1 Estimated Incentive Payment-: $1,423,683 **Milestone 2** [P-2]**:** Design community-based specialized interventions for target populations. Interventions may include substance abuse services (specialized for individuals who have experienced prolonged or repeated institutionalization), 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 Metric [P-2.1]: Project plans which are based on evidence / experience and which address the project goals	**Milestone 3**[P-3]: Enroll and serve individuals with targeted complex needs (Substance use diagnosis and homelessness, MH and/or legal issues). Metric [P-3.1]: Number of targeted individuals enrolled/ served in the project. -Goal: Current population of 500 receive enhanced services. Data Source: Registry, EHR, claims Milestone 3 Estimated Incentive Payment: $1,485,211 **Milestone 4** [P-7]: 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 Metric [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Metric [P-7.2]: Implement the "raise the floor" improvement initiatives established	**Milestone 5** [I-X]: Serve additional patients needing detoxification services, to include enhanced services. Metric 1 [I-X.1]**:** Target population reached. Goal: 250 additional patients over number of patients served in DY3 Data Source: Registry, EHR, claims Milestone 5 Estimated Incentive Payment: $1,588,830 **Milestone** [P-7]: 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 Metric [P7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Metric [P-7.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting. Data Source: Documentation of	**Milestone 7** [I-X]: Serve additional patients needing detoxification services, to include enhanced services. Metric [I-X.1]: Target population reached. -Goal: 300 additional patients over number of patients served in DY3 Data Source: Registry, EHR, claims Milestone 7 Estimated Incentive Payment: $1,535,101 **Milestone 8** [P-7]: 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 Metric [P7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Metric [P-7.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives

081599501.2.1	***2.13.2***	***2.13.2***	**Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.).Other (*DETOXIFICATION UNIT AND SERVICE EXPANSION*)**	
Mental Health Mental Retardation of Tarrant County (MHMRTC)				*081599501*
Related Category 3 Outcome Measure(s):	*U-nique Category 3 IT identifier(s) –* 081599501.3.12 081599501.3.2	***IT 9.2*** ***IT-6.1***	*ED Appropriate Utilization* *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)**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ 2,847,366		Year 3 Estimated Milestone Bundle Amount: $2,970,422	Year 4 Estimated Milestone Bundle Amount: $3,177,660	Year 5 Estimated Milestone Bundle Amount: $3,070,203
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$12,065,652				

Project Option 2.15.1 – Integrate Primary and Behavioral Health Care Services – MHMR of Tarrant County and Fort Worth North-side Community Health Center (Federally Qualified Health Center) co-located at MHMRTC Homeless/Crisis Services located at: 1350 East Lancaster, Fort Worth, Texas 76102

Unique Project ID: 081599501.2.2
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501

Provider: MHMRTC is the Local Mental Health Authority (LMHA) providing mental health, early childhood, addiction and intellectual developmental disabilities services, serving an 897 square mile area and a population of approximately 1.8 million residents. As the Texas Department of State Health Services (DSHS) designated Local Mental Health Authority, MHMRTC functions as a safety net and is mandated to plan, develop policy, coordinate, and allocate and develop resources for mental health services in Tarrant County particularly for persons receiving Medicaid, Medicare, or who are indigent and uninsured.

Intervention: MHMRTC will subcontract with the FQHC system to co-locate primary care and behavioral health services at MHMRTC's homeless/crisis services center located at 1350 East Lancaster, Fort Worth, Texas. The location is in the heart of the homeless/emergency shelter district in Tarrant County. This project will provide access to primary care services for the target population.

Need for Project: Texans with severe mental illness who receive services in the state's public mental health system die 29 years earlier than the general population. Nearly two-thirds of these deaths are caused by treatable physical illness. -Approximately 40%, or over 2,800, of the individuals currently served by MHMRTC receive no primary care services from any other source

Target Population: Individuals with severe mental, developmental, and addictions disorders who may also be homeless, and who are not otherwise able to access primary care services. The population will consist primarily of uninsured patients with a small number of Medicaid and other patients.

Category 1 or 2 milestones expected benefit: The project seeks to provide integrated primary care and behavioral health treatment to 250 patients in DY4 and 500 in DY5.
Category 3 outcomes:
IT-1.7 Our goal is to reduce by 10% of the baseline the number of impacted patients with high blood pressure.
IT-1.10 Our goal is to reduce by 10% the number of diabetic patients in the target population with HbA1c >9.0%.

IT-9.2 Our goal is to reduce ED utilization in the served population by 9%.

Project Option 2.15.1 – Integrate Primary and Behavioral Health Care Services – MHMR of Tarrant County and Fort Worth North-side Community Health Center (Federally Qualified Health Center) co-located at MHMRTC Homeless/Crisis Services located at: 1350 East Lancaster, Fort Worth, Texas 76102

Unique Project ID: 081599501.2.2
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501

Project Description:
We propose an integrated primary care and behavioral health model which will provide greater access and efficiency in the delivery of primary care services to individuals with severe mental, developmental and addictions disorders and who may also be homeless. This integrated primary care and behavioral health model will co-locate primary care and behavioral health professionals, providing a greater level of efficiency and access as a whole to Tarrant County area Region 10. Utilizing the FQHC system (which will NOT entail the FQHC contributing any federal funding to this project) will result in a greater level of continuity and care coordination between primary

care and behavioral health providers. Space and equipment will be provided for the FQHC by MHMRTC with 1115 Waiver funds. The FQHC will provide staffing and services.

This program located at the MHMRTC East Lancaster location will address the gaps in primary care for individuals with severe mental, developmental and addictions disorders and who may also be homeless. Diabetes and hypertensive patients who are not receiving primary care or behavioral health care through the JPS Health Network (JPS) Network will be identified-for needed primary care and behavioral health services at the East Lancaster site, which is in the heart of the homeless/emergency shelter district in Tarrant County. Patients throughout the MHMRTC system, in general and homeless patients, in particular, as well as patients receiving services at the FQHC (not affiliated with JPS) will have access through this site for their primary care and behavioral health needs. MHMRTC currently serves approximately 6,000 individuals with severe mental, developmental and addictions disorders and who may also be homeless. Approximately 40% of the individuals currently served by MHMRTC receive no primary care services from any other source.

This project will be completed by the ongoing community-based case management services provided by qualified mental health professionals and LCDCs. MHMRTC is the only entity in Tarrant County authorized by the Department of State Health Services (DSHS) to provide community-/field-based case management and rehabilitation services, which are crucial in supporting such a vulnerable population with their primary care and behavioral health needs. In addition to providing supportive services and psychosocial rehabilitation for these patients, the case managers (PATH[143] and Addictions Services Outreach Team) will also engage potential patients from the homeless campsites and shelters providing outreach and referral services, as well as arranging transportation for patients needing to access the 1350 East Lancaster site. This integrated primary care and behavioral health project will be based on the National Council for Community Behavioral Health's (NCCBH) Four Quadrant Clinical Integration Model.[144]

Goals and Relationship to Regional Goals:

- Greater compliance in overall preventive health care
- Reduced avoidable emergency department and hospital admissions and
- Improved outcomes related to overall functionality and health status. This will take place through collaboration with a Federally Qualified Health Center (FQHC) and the local mental health authority.

[143] Projects for Assistance in Transition from Homelessness http://pathprogram.samhsa.gov./
[144]National Council for Community Behavioral Healthcare. Revised 2006. Behavioral health/primary care integration: the four quadrant model and evidence-based practices. http://www.thenationalcouncil.org/galleries/business-practice%20files/4%20Quadrant.pdf

The project goal is to function at minimum Level 4 collaborative level[145] wherein providers will share the same facility and share operations (scheduling appointments, medical records, etc.); regular face-to-face communication; sense of being part of a team to a maximum Level 5 collaborative level wherein providers are part of the same team and system; the patient experiences mental health treatment as part of their regular primary care or vice versa.[146]

This project meets the following Regional goals:
Region 10 goals are to improve quality and access to care for persons requiring multiple subspecialties (e.g., behavioral health, cardiac, geriatric, etc.). This integrated primary care and behavioral health project seeks to remove gaps in care and maximize quality for the highest number of consumers possible through onsite co-location of primary care and behavior health as well as through providing these same services via telemedicine.

Challenges:
- The most significant challenge we will address during the course of the waiver will be our need to rely on other parties for data. This waiver was designed to impact the cost and quality of care by engaging non-hospital providers. We will need to work with hospitals (and potentially other entities) to identify the data needed to support our outcomes and to develop reporting mechanisms. The final challenge related to other parties is the need to contract and share data with the FQHC.

5-Year Expected Outcome for Provider and Patients:
The goal of the project is to provide primary care services for patients with serious mental illness. The expected outcome for the provider is that the total health of patients will be managed, resulting in better outcomes. Since physical problems often exacerbate mental health problems, the provider hopes to realize less need on behalf of these patients. The expected outcome for patients is increased functionality and quality of life.

Starting Point/Baseline:
MHMR of Tarrant County (MHMRTC) will conduct a needs assessment in order to establish baseline data of the number of people who have physical/behavioral health needs in DY2. Currently, there are 2,824 MHMRTC patients without health insurance. MHMRTC will initiate agreement(s) with Fort Worth Northside Community Health Center (FQHC, not affiliated with JPS) in order to develop primary care and behavioral health services.
Rationale:

[145] See pg. 318, *RHP Category 2 Planning Protocol*, p. 318. Levels of interaction between physical and behavioral health providers.
[146] Doherty WJ., McDonald, SH & Baird MA. 1996. Five levels of primary care/behavioral health care collaboration. *Behavioral Healthcare Tomorrow.* Oct. 25-26.

Our target population experiences significant medical issues such as obesity, diabetes, high blood pressure, and thyroid conditions, which often go untreated due to unavailable primary care providers. Physical conditions often exacerbate mental health conditions and lead to poor outcomes and prognosis. For example, -as many as 75% of individuals with schizophrenia have been found to have high rates of serious physical illnesses, such as diabetes, respiratory, heart and/or bowel problems and high blood pressure (Bazelon Center for Health Law 2004). According to a recent SAMSHA news release, adults with a serious mental illness have higher rates (21.69%) of high blood pressure than those without a mental illness.[147]

Project Components:

a) Identify sites for integrated care projects, which will benefit a significant number of patients in the community. Examples of selection criteria include proximity/accessibility to target population, physical plant conducive to provider interaction; ability/willingness to integrate and share data electronically; receptivity to integrated team approach. We have determined to co-locate with the FQHC at 1350 East Lancaster, Fort Worth, Tx.
b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers will be facilitated. This will be accomplished in DY2.
c) Establish protocols and process for communication, data sharing, and referral between behavioral and physical health providers. Project milestones include this component in DY3.
d) Recruit a number of specialty providers (physical health, mental health, substance abuse), to provide services in the specified locations. 10 FTEs will be added.
e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include: (1) Regular consultative meetings between physical health and behavioral health practitioners; (2) Case conferences on individualized as-needed basis to discuss individuals served by both types of practitioners; and/or (3) Shared treatment plans co-developed by both physical health and behavioral health practitioners. This will be accomplished as professionals are added.
f) Acquire data reporting, communication and collection tools (equipment) be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange—depending on the size and scope of the local project. The project anticipates using the data system available to the FQHC. However, we may need to develop a separate system. This need will be identified and a plan developed during DY2. We will also need to negotiate with JPS to track ED usage.
g) Explore the need for and develop any necessary legal agreements that may be required in a collaborative practice. To be accomplished in DY2.

[147]Substance Abuse and Mental Health Administration. 2012. Adults experiencing mental illness have higher rates of certain chronic illnesses. *SAMHSA New Release*.

h) Arrange for utilities and building services for these settings. The project will be implemented in existing facilities. To the extent that additional space is needed, this will be done as the space is acquired.
i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individuals treated in these integrated service settings. The project anticipates using the data system available to the FQHC. However, we may need to develop a separate system. This need will be identified and a plan developed during DY2. We will also need to negotiate with JPS to track ED usage. Data elements will need to be defined and reports will need to be developed.
j) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying lessons learned, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. We will be working through our State association to identify best practices and will implement appropriate changes to our project.

The selected milestones and metrics were chosen to allow for assessment mechanisms to determine the scope of primary care needs in our area. Developing a set of standards and best practices will ensure program operations are built upon a solid infrastructure for the best service delivery. The milestones and metrics were also chosen to identify a concrete target percentage number to allow for ongoing performance measures. In DYs 3-5, face-to-face learning meetings/seminars will be attended, at least twice per year, for the purpose of continuous quality improvement. Integration of services and coordination of care will commence in DY3-5.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.5 – Insufficient integration of mental health care in the primary care medical care system
- CN.10 – Overuse of emergency department (ED) services
- CN.11 – Need for more care coordination
- CN.13 – Necessity of patient education programs

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

This project represents a new initiative to integrate primary care and behavioral health services for the impacted population

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/ Rationale for Selecting the Outcome Measures:

IT-1.7 Controlling high blood pressure (NCQU-HEDIS 2012, NQF 0018)[148]*– stand-alone measure.*
Nationally, 21.6% of -individuals 18 or older with serious mental illness have high blood pressure, compared to 17.7% of the population that does not have a similar illness[149] Control of high blood pressure in the target population will be an indication that the integration of primary care services has been successful
IT-1.10 Diabetes Care; HbA1c poor control (>9.0%) – NQF 0059.
Individuals with severe mental illnesses suffer a higher incidence of diabetes. Moreover, drugs used to treat mental illness are often associated with significant increases in fasting glucose concentrations.[9] Control of HbA1c in the target population will be an indication that the integration of primary care and behavioral health services has been successful.
IT-9.2 ED Appropriate Utilization
Individuals with serious mental illness have at least one ED visit during a year far exceeds use by those without serious mental illness. (47.6% vs. 30.5% nationally)[10] Reductions in ED visits will be an indication that the integration of primary care and behavioral health services has been successful.

Relationship to Other Projects:
All of MHMRTC's project address the expansion of behavioral health services and/or the integration of services to better serve a co-morbid population. It is expected that as the projects progress, we will refine each of the projects to better serve populations. It is also expected that efficiencies will be identified that will enhance our ability to serve a larger percentage of the population that currently is unable to find appropriate care. In particular, the projects that will have an impact on this project are:
-(1) 081599501.1.1 Expand Behavioral Health Capacity
(2) 081599501.2.1 Expand Detox Capacity-(3) 081599501.2.3 RN Care Management.

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

-JPS and MHMR are both planning to implement integrated health projects; each will -serve distinct client populations. The MHMRTC project will serve only those clients receiving services

[148] http: qualitymeasures.ahrq.gov/content.aspx?id=34655
[149] http://www.samhsa.gov/data/2k12/NSDUH103/SR103AdultsAMI2012.pdf

[9] http://clinical.diabetesjournals.org/content/24/1/18.full
[10] http://www.samhsa.gov/data/2k12/NSDUH103/SR103AdultsAMI2012.pdf

with MHMRTC while partnering with the FQHC to offer primary care treatment at the East Lancaster site. The JPS project will serve clients receiving primary care or behavioral health services at current JPS sites. Each entity offers a distinct array of mutually exclusive services for the project. MHMRTC is focused on serving individuals with severe mental, developmental, and addiction disorders who may be homeless. MHMRTC has engaged in planning efforts with JPS to assure we are not duplicating efforts and adequately coordinating treatment and patient continuity. MHMRTC currently has staff co-located at JPS who may be utilized to verify patient medical home to assure seamless unduplicated services. Patients with more complicated medical needs will be referred to JPS as deemed clinically appropriate. We also plan to conduct a needs assessment in DY2 in order to further develop a process for patient identification, coordination and to assure that patients receive seamless integrated care.
This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) MHMR of Tarrant County will also be working with other Community Centers in learning collaborative to select a small amount of outcome measures for category 3, based on the valuation studies conducted by health care economists at the UT Austin and UT 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.

Project Valuation:

Approach:
Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system.

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rationale was that to overcome resistance to change, both in the delivery system and the payment system, 5 years of benefits were needed. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

The incentive element of the Region 10 valuation methodology is relevant to all Texas transformation efforts. However, it is particularly relevant to transformation of the mental health care system, where patient experience, population health and costs have previously not received any focus, and where services tend to be provided primarily in emergency situations. Texas ranks 50th in the country in per capita funding for mental health services.[11] Only one-third of the more than 480,000 adults in Texas with serious and persistent mental illness received services through the community mental health system. Therefore, the most important transformation that can occur in mental health is increased access to services. Until the advent of the waiver, the system has not had funds to experiment with the types of interventions that are being made possible through waiver funding. Incentives for effective implementation and outcomes are important to allow for the identification of successful interventions and the ultimate sustained transformation of the system.

Rationale:
The calculation of the value of successful interventions was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses cost-utility analysis (CUA) to measure the cost of the program in dollars and the health consequences in utility-weighted units satisfying all of our valuation factors regarding patient experience, community benefit, and savings to the health care system. This valuation uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The QALY value results in significant values related to mental health interventions. These patients are intensive users of the health care system and are most often not functional in society. Incremental improvements in their status have an enormous impact on all three elements of the triple aim.

[11] Hogg Foundation for Mental Health, presentation at Waiver summit on August 8, 2012

081599501.2.2	*2.15.1*	*2.15.1(A-J)*	*INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES.* **Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.**	
MHMR of Tarrant County				***081599501***
Related Category 3 Outcome Measure(s):	***081599501.3.3*** ***081599501.3.7*** ***081599501.3.8***	***IT-1.7*** ***IT-1.10*** ***IT-9.2***	***Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)*** ***Diabetes Care; HbA1c poor control (>9.0%) – NQF 0059*** ***ED Appropriate Utilization – All ED Visits***	
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]: Establish baseline data of number of people who have physical/behavioral health needs. Metric 1 [P-X.1]: Baseline/Goal: The number of persons identified who have physical/behavioral health needs; conduct a census of the current MHMRTC clients/patients who have both primary and behavioral health needs Data Source: Primary/Behavioral Health Record, Medicaid Claims Milestone 1 Estimated Incentive Payment: $2,359,894 **Milestone 2** [P-5]: Develop integrated sites reflected in the number of locations and providers participating in the integration project. Metric 1 [P-5.1]: Number of agreements signed for the provision of integrated services Baseline/Goal: 1 Agreement signed for the provision of integrated services Data Source: Project Data	**Milestone 3** [P-3]**:** Develop and Implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa Metric 1 [P-3.1]: Numbers and types of referrals that are made between providers at the location Baseline/Goal: 100 referrals that are made between providers at the location Data Sources**:** Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results Milestone 3 Estimated Incentive Payment: $1,641,255 **Milestone 4** [P-6]: Develop Integrated behavioral health and primary care services within co-located sites. Metric 1 [P-6.1]: Numbers of providers achieving Level 4 of		**Milestone 6** [I-8]: Integrated Services Metric 1 [I-8.1]: X% of Individuals receiving both physical and behavioral health care at the established locations Goal: 250 individuals receiving both physical and behavioral health care in project sites -Data Source: Project data; claims and encounter data; medical records Milestone 6 Estimated Incentive Payment: $1,755,761 **Milestone 7** [I-9]: Coordination of Care Metric 1 [I-9.1]: X% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Goal: 200 individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Data Source: Project data; claims and encounter data; medical records	**Milestone 9** [I-8]: Integrated Services Metric 1 [I-8.1]: X% of Individuals receiving both physical and behavioral health care at the established locations Goal: 500 - individuals receiving both physical and behavioral health care in project sites Data Source: Project data; claims and encounter data; medical records Milestone 9 Estimated Incentive Payment: $1,696,388 **Milestone 10** [I-9]: Coordination of Care Metric 1 [I-9.1]: X% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Goal: 400 - individuals with treatment plan developed Data Source: Project data; claims and encounter data; medical records Milestone 10 Estimated Incentive

081599501.2.2	*2.15.1*	*2.15.1(A-J)*	*INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES.* **Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.**	
MHMR of Tarrant County				***081599501***
Related Category 3 Outcome Measure(s):	***081599501.3.3*** ***081599501.3.7*** ***081599501.3.8***	***IT-1.7*** ***IT-1.10*** ***IT-9.2***	***Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)*** ***Diabetes Care; HbA1c poor control (>9.0%) – NQF 0059*** ***ED Appropriate Utilization – All ED Visits***	
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 2 Estimated Incentive Payment: $2,359,894	interaction (close collaboration in a partially integrated system) Baseline/Goal: 2 providers achieving Level 4 of interaction (close collaboration in a partially integrated system) Data Source: Project Data Milestone 4 Estimated Incentive Payment: $1,641,255 **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 Metric 1 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.		Milestone 7 Estimated Incentive Payment: $1,755,761 **Milestone 8** [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 Metric 1 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Metric 2 [P-10.2]: Implement the	Payment: $1,696,388 **Milestone 11** [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 Metric 1 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Metric 2 [P-10.2]: Implement the "raise the floor" improvement

081599501.2.2	***2.15.1***	***2.15.1(A-J)***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES.* Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.**	
MHMR of Tarrant County				***081599501***
Related Category 3 Outcome Measure(s):	***081599501.3.3*** ***081599501.3.7*** ***081599501.3.8***	***IT-1.7*** ***IT-1.10*** ***IT-9.2***	***Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)*** ***Diabetes Care; HbA1c poor control (>9.0%) – NQF 0059*** ***ED Appropriate Utilization – All ED Visits***	
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)**
	Goal: 2 meetings Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Metric 2 [P-10.2]: Implement the "raise the floor" improvement initiatives established at the semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semi-annual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semi-annual meeting. Milestone 5 Estimated Incentive Payment: $1,641,255		"raise the floor" improvement initiatives established at the semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semi-annual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semi-annual meeting. Milestone 8 Estimated Incentive Payment: $1,755,762	initiatives established at the semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semi-annual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semi-annual meeting. Milestone 11 Estimated Incentive Payment: $1,696,387

081599501.2.2	***2.15.1***	***2.15.1(A-J)***	***INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES.*** **Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.**	
MHMR of Tarrant County				***081599501***
Related Category 3 Outcome Measure(s):	***081599501.3.3*** ***081599501.3.7*** ***081599501.3.8***	***IT-1.7*** ***IT-1.10*** ***IT-9.2***	***Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)*** ***Diabetes Care; HbA1c poor control (>9.0%) – NQF 0059*** ***ED Appropriate Utilization – All ED Visits***	
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)**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $4,719,788	Year 3 Estimated Milestone Bundle Amount: $4,923,765		Year 4 Estimated Milestone Bundle Amount: $5,267,284	Year 5 Estimated Milestone Bundle Amount: $5,089,163
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$20,000,000				

Project Option 2.19.1 – Develop care management function that integrates primary and behavioral health needs of individuals (RN Care Management)

Unique Project ID: 081599501.2.1
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501

Provider: MHMRTC is the Local Mental Health Authority (LMHA) providing mental health, early childhood, addiction and intellectual developmental disabilities (IDD) services, serving an 897 square mile area and a population of approximately 1.8 million residents. As the Department of Aging and Disability Services (DADS) designated local Intellectual and Developmental Disability (IDD) authority for the local service area (LSA) consisting of Tarrant County, MHMRTC is delegated by DADS to function as a safety net and be responsible for planning, policy development, coordination, including coordination with criminal justice entities, resource allocation, and resource development for and oversight of IDD services in the most appropriate and available setting to meet individual needs in the LSA.

Intervention: Implement a RN care coordination model for IDD consumers with chronic disease. RNs will provide the needed link to assist patients and caregivers with understanding and follow-through related to chronic disease management. Activities will include:

- Consulting with health care providers
- Aid in communication between the health care provider and the patient
- Assistance with linking to preventive services
- Care coordination teams will provide a variety of disease management guidelines and techniques to engage the patient and family.
- Community based interventions, including home visits and telehealth
- Behavioral supports for caregivers
- Development and maintenance of a chronic disease registry data base

Need for Project: IDD patients are 4 times as likely to have a chronic disease than the rest of the population, have a shorter life expectancy and experience persistent problems in accessing health services.[150] All chronically ill patients must deal with the deficiencies in the health care system's management of chronic disease including:

- Rushed practitioners not following established practice guidlelines
- Lack of care coordination
- Lack of active follow up to ensure the best outcomes
- Patients inadequately trained to manage their illness

These problems are exacerbated in the IDD population because of communication problems and problems with understanding what is needed to manage disease. Without proper understanding, chronic conditions are likely to become acute episodes resulting in hospitalization, disability and premature death.

Target Population: IDD patients with chronic disease. MHMRTC currently services 1,100 IDD clients. We will need to determine the number of IDD clients with chronic disease. However,

[150] http://onlinelibrary.wiley.com/doi/10.1111/j.1752-9824.2011.01105.x/abstract

we expect to serve 480 clients during the waiver period. Currently 80% of people served by MHMRTC have Medicaid and the 20% without Medicaid are typically children (eligibility is based on parent income) or people who do not qualify for Medicaid because of citizenship status.

Category 1 or 2 milestones expected benefit:
In DY4, we will provide RN care coordination to 300 patients.
In DY5 we will add 180 patients to that population for a total annual population beginning in DY5 of 480.

Category 3 outcomes:
IT-10.1 Quality of Life. Our goal is to achieve 10% improvement over baseline of quality of life scores as measured by the AQoL or another validated quality of life assessment tool for the IDD population.
IT-9.2 ED Appropriate Utilization. Our goal is to reduce ED visits by 15%
IT-2.13 Other admissions rate (inpatient admissions for IDD clients in RN care management). Our goal is to reduce inpatient admissions by 40%.

Project Option 2.19.1 – Develop care management function that integrates primary and behavioral health needs of individuals (RN Care Management)

Unique Project ID: 081599501.2.3
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501

Project Description:
Our team of RNs will use a care management model, such as Wagner's chronic care model, to develop the project and select criteria to identify the intellectual and developmental disability (IDD) patients who benefit from disease management. We plan to use a team care coordination model with RNs and behaviorists to provide a variety of disease management guidelines and techniques to engage the patient and family.[151] Community-based interventions, including home visits and telehealth, have been found to be effective in improving treatment adherence and reducing psychiatric hospitalizations.[152] This leads to increased patient engagement and allows RNs to measure stages of patient activation, enabling intervention and teaching with IDD patients who lack the skills to self-manage. We propose to bolster care management by providing behavioral supports to caregivers of the IDD patients to help reduce their levels of stress.[153]
Research shows the following barriers are particularly problematic within the developmental disability population with primary care providers: communication difficulties between patients, families and health care professionals; problems in obtaining patient histories; difficulties in problem determination; no continuity of care; lack of understanding of medications or self-care; and primary care providers' lack of skills, knowledge, training and expertise with the IDD population.[154]
The RN ensures the health care provider understands the issues of the IDD patient, assists with linking the patient for preventive services, and consults with the health care providers.[155] RN care coordination provides the needed link to assist the patient with understanding and follow-through related to chronic disease management.

Goals and Relationship to Regional Goals:

Project Goals:
Developing and implementing a RN care management project allows MHMRTC to meet several goals.

- Better care for our IDD patients through increased primary and specialist care referrals and access, which results in increased preventive care as well as better care coordination

[151] Craig C, Eby D, & Whittington J. (2011(). IHI white paper: care coordination model: better care at lower cost for people with multiple health and social needs. http://www.ihi.org/knowledge/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx
[152] Kolbasovsky A, Reich L, & Meyerkopf N. (2010). Reducing six-month inpatient psychiatric recidivism and costs through case management. *Care Management Journals*. 2-10.
[153] Hastings R, & Beck A. (2008). Stress intervention for parents of individuals with intellectual disabilities. *Journal of Child Psychology and Psychiatry*. 1338-1349.
[154] Jansen, ibid.
[155] Craig, ibid.

among providers. A Region 10 stakeholder survey shows providers do not feel there is strong care coordination among primary care, specialty care and hospitals.

- Decrease emergency department (ED) utilization and decrease psychiatric hospitalization by expanding access to behaviorists at our psychiatric clinic. This leads to better health in Tarrant County because the entire IDD community in the area uses our specialty IDD psychiatric clinic. RN care management addresses a need cited by community stakeholders to achieve better integration of primary care and mental health care services through models for mental health integration.
- Disease management, which leads to decreased costs in use of the ED and medical hospitalization, improved functionality and better quality of life.
  The purpose of the project is to ensure IDD patients see their doctors, understand their medical conditions and get help with their behaviors. This leads to reduced cost of care, improved health and increased patient satisfaction.[156]

This project meets the following Regional goals:
This project addresses goals of Region 10 and the triple aim by improving health of the IDD patient by enabling the health care provider to understand the issues of the IDD patient, assisting with linking the patient for preventive services, addressing chronic medical and psychiatric issues through disease management, decreases costs for the Region due to fewer hospitalizations and ED use and improves quality of life for the IDD patient and family.

Challenges:
The most significant challenge for this project will be hiring enough RNs with the skills to address their special needs. We are in the process of developing a RN care management recruitment brochure, and have contemplated a tuition assistance program.

5-Year Expected Outcome for Provider and Patients:
The outcomes will lead to increased referrals and access to primary and specialty care, reduced ED use and hospitalizations related to psychiatric issues as well as chronic medical conditions, as recorded in our chronic disease registry data base and claims data.

Starting Point/Baseline:
Currently MHMRTC does not utilize an RN care management program for the 1,100 IDD clients we serve. The project requires a needs assessment to determine baseline number of IDD clients with chronic disease to be targeted for disease and care management. A health risk screening tool, such as HRSTonline.com, will be utilized to prioritize need and gather baseline data on primary care referral needs. The baseline time period is DY2. This project will target a minimum of 43% of the IDD population identified by DY5.

[156] Hassiotis, A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disability Management and Health Outcomes*, 409-417.

Rationale:

IDD patients have unique needs related to their behaviors and potential lack of understanding of the care needed for their chronic health conditions. Without understanding of the care ordered, and regular follow-up of the primary and behavioral care, these chronic conditions are likely to become acute episodes resulting in hospitalization, disability and premature death[157] IDD patients often have multiple chronic conditions. Medical Expenditures Panel Survey (2012)[158] shows a higher rate for chronic disease in developmental disabilities:

Chronic condition	No disability %	IDD%
Arthritis	9.7	26.7
Asthma	7.6	17.0
Cardiovascular Disease	5.1	13.0
Diabetes	3.7	18.0
High blood pressure	16.1	27.5
High cholesterol	16.7	22.4
Stroke	0.7	14.2

In Tarrant County the prevalence rates for these conditions is increased based on data from Texas Price Point (Texas Hospital Association, 2012).[159] Lack of understanding related to the care ordered and lack of follow up with primary care leads to a large cost for our community in IDD hospitalizations related to chronic conditions.

IDD numbers July 2010 to July 2011 in Tarrant County

Chronic conditions	Hospital discharges % of # D/C in Tarrant related to IDD	LOS % of LOS days in Tarrant related to IDD	Charge % of average charge cost in Tarrant related to IDD	Charge/day % of average charge/day cost in Tarrant related to IDD
Arthritis	58.86	3.71	$18,624	$2,333
Asthma	64.20	.20	$1,189	$354
Cardio/ Vascular diseases	363.03	2.49	$20,484	$5,225
Diabetes	74.88	.40	$2,537	$570
High B/P	23.13	.21	$1,582	$448
Stroke	102.03	1.37	$12,204	$2,105

[157] Jansen, ibid.

[158] Agency for Health care Research Quality. Medical expenditure panel survey. (2006). Medical Expenditure Panel Survey Home MEPS. http://meps.ahrq.gov/mepsweb/index.jsp.

[159] Texas Hospital Association. (2012). Texas Price Point. Retrieved August 2012, from http://txpricepoint.org/Report.aspx

Review of this data shows without regular care, these IDD patients' health issues escalate to acute episodes and poorer health status, including hospitalization, and decreased quality of life. This is a challenge for MHMRTC and our community.

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-**Project Components:**

a. Conduct data matching to identify individuals with co-occurring disorders who are:
    1. Not receiving primary care
    2. Not receiving specialty care according to professionally accepted practice guidelines
    3. Over-utilizing ER services based on analysis of comparative data on other populations
    4. Over-utilizing crisis response services
    5. Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms
b. Review chronic care management best practices such as Wagner's Chronic Care Model and select practices compatible with organization readiness for adoption and implementation
c. Identification of BH case managers and disease care managers to receive assignment of these individuals
d. Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders
e. Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression, asthma
f. Train staff in protocols and guidelines
g. Develop registries to track client outcomes
h. Review the intervention(s) impact on quality of care and integration of care 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.

All of the core components of this project are addressed by process milestones in DY2 and 3. This includes working with Region 10 agencies for data matching, as well as protocol development, disease management guidelines, staff hiring and training, and particularly choosing how to use a chronic disease registry. We need to understand if our EHR will work or if we need to implement elements in another type of registry.- We plan to have Wagner's chronic care model guide our project development.

-We plan to hire 12 FTE nursing personnel to be trained in care management protocols; two FTE board certified behavior analysts, as well as four FTE staff to manage the project and implement

use of disease management software. The RN care manager caseload ratio will start at 1:25, based on acuity and need of the client.[160] Clients just discharged from the hospital require intensive coordination; once they have received ongoing care coordination may need less intensive care.

-Continuous quality improvement will be ongoing, identifying gaps and sharing lessons learned in best practice treatment through the disease registry. We have included milestones in DY4 and DY5 to track our CQI efforts. As a result, in DY5 we will measure an increased use of routine preventive and primary care by 50% as well as measuring 480 patients who receive disease-specific training instructions.

Unique community need identification numbers the project addresses:

- CN. 5 – Insufficient integration of mental health care in the primary care medical care system
- CN. 11 – Need for more care coordination
- CN. 13 – Necessity of patient education programs

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome measures:
IT-10.1 Quality of Life (stand alone measure)

By the end of the Waiver, MHMRTC will show a 10% improvement in quality of life scores as measured by the AQoL or another validated quality of life assessment tool for the IDD population. -The RN care management project is designed to help improve symptoms and function, two essential components of quality of life. According to the National Quality Forum, care coordination is foundational to quality health services, including quality of life.[161] When symptoms and function are improved, the patient will have decreased ED visits and decreased hospitalizations. A "feet to the street" integrated care management model has been used, which showed improved health outcomes and patient satisfaction as well as reduction in inpatient and ED services.[162] They also demonstrated a decrease in homelessness, an increase in medical home assignment and very high patient satisfaction.

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[160] Craig, ibid.
[161] National Quality Forum. (2010, October). Quality connections: care Coordination. http://www.qualityforum.org/Publications/2010/10/Quality_Connections__Care_Coordination.aspx.
[162] Leonard M, McGlone S, & Boardman A. (2012). Operation: we care. *CMSA Today*, 12-16.

IT-9.2 ED appropriate utilization. IDD patients with chronic disease experience all of the deficiencies of the health care system with respect to chronic disease management. Those deficiencies are exacerbated in this population due to communication problems, leading to unnecessary acute episodes. Our goal is to reduce ED utilization by 15%

IT-2.13 Other admissions rate. IDD patients with chronic disease experience all of the deficiencies of the health care system with respect to chronic disease management. Those deficiencies are exacerbated in this population due to communication problems, leading to unnecessary acute episodes. Our goal is to reduce inpatient hospitalizations in this population by 40%.

Relationship to Other Projects:

081599501.1.2 Crisis stabilization services for IDD population with co-occurring mental illness. Both projects address an IDD population that has co-occurring complications. Because many individuals with chronic diseases also have mental illness, there may be duplications in the populations that will be addressed as they are identified.

Projects 081599501.1.1 Expand behavioral health. This project adds capacity with respect to mental health professionals and will provide a resource as needed.

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

The Baylor, JPS and MHMR care coordination projects serve distinct client populations in Tarrant County. Baylor and JPS projects focus on primary care patients, registered in their clinics, with mental health (MH) needs and MH patients with primary care needs. The MHMR project focuses on MHMR intellectual developmental disabilities patients with chronic disease, who benefit from disease management. We will link these patients into a primary care system.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) MHMR of Tarrant County will also be working with other Community Centers in learning collaboratives to select a small amount of outcome measures for category 3, based on the valuation studies conducted by health care economists at the UT Austin and UT 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.

Project Valuation:

Approach:

Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation

of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing our the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:
The calculation of the value of successful interventions for this project was based on an extensive literature review utilizing studies in which similar interventions were implemented and the impacts to the healthcare system were recorded.

Our target population of 1,100 clients will be impacted by this project as RN care coordination services will be available to all. Of that population, 480 are expected to come into services during the waiver period. The full value of these intensive supports will not be limited to the interventions delivered during the waiver period since we intend to permanently operate a RN Care Coordination model as we move to transform the system rather than make temporary changes for the sake of the waiver.

For this project, cost savings have been identified in several areas including $9,964 savings versus the inpatient setting, savings with regard to the level of claims expenditures in the amount of $6,359, and $483 of net Medicare/Medicaid savings totaling $16,806 for each consumer. At full implementation we will be serving 480 additional people annually, yielding a value of $8,066,880. We then applied the incentive multiplier of 5 deriving a full valuation of $40,334,400. Due to our funding limitation in Pass 1, we had to discount each of our Pass 1 projects. The discounted value of this project is $21,521,621, of which $19,224,968 has been spread to Category 2 and $2,299,653 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

The performing provider has determined that tracking quality of life , ED utilization, and inpatient admissions with the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

081599501.2.3			2.19.1	2.19.1(A-H)	DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVORIAL HEALTH NEEDS OF INDIVIDUALS (RN CARE MANAGEMENT)
MHMR of Tarrant County					081599501
Related Category 3 Outcome Measure(s):	081599501.3.4 081599501.3.15 081599501.3.16	*IT-10.1* *IT-9.2* *IT-2.13*	*Quality of Life/Functional Status* *ED Appropriate Utilization* *Other 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-2]. Identify community agencies that have the relevant data to identify the service utilization patterns of persons with co-occurring disorders Metric [P-2.1]: Listing of relevant agencies and the data elements each has available. Baseline/Goal: find out what data community agencies have for these utilization patterns/list agencies that have available data. Data Source: Records of MHMR of Tarrant county Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,512,296 **Milestone 2** [P-6]. Care coordination protocols are developed. Metric [P-6.1]: Written protocols are easily available to staff. Baseline/Goal: no current written protocols at MHMRTC/develop protocols Data Source**:** Written protocols Milestone 2 Estimated Incentive	**Milestone 4** [P-5]. BH case managers and disease care managers are identified. Metric [P-5.1]: Number of staff identified with the capacity to support the targeted population. (BH case managers not necessary) Baseline/Goal: Do not currently have any staff in a RN care management department/hire 12 FTE RNs, 2 FTE BCBA, 4 FTE management and support staff Data Source**:** Staff rosters Milestone 4 Estimated Incentive Payment: $2,366,480 **Milestone 5** [I-24]: Go-live: Enter patient information in the disease registry for target patient population with chronic disease. Metric [I-24.1]: Identify gaps, via a review of the identified registry elements above in treatments as identified Best Practices for the target patient population with a chronic disease Goal: train on disease registry and Begin entering patients in disease	**Milestone 6** [P-8]: Staff members are trained in care coordination protocols and practice guidelines for disorders identified in the data matching. Metric [P-8.1]: Percent of staff receiving training Baseline/Goal: Goal to have all new hires trained. -Data Source: S-taff- training records Milestone 6 Estimated Incentive Payment: $1,687,723 -**Milestone 7** [I-25]: Identify patients with chronic disease entered into registry who receive instructions appropriate for their chronic disease such as: activity level, diet, medication management, etc. Metric [I-25.1]: patients with chronic disease who receive appropriate disease-specific instructions. Goal: -300 patients entered in disease registry given instruction and assess reasons for gaps of when appropriate instruction given. Data Source: Chronic disease	-**Milestone 9** [I-25]: Identify patients with chronic disease entered into registry who receive instructions appropriate for their chronic disease such as: activity level, diet, medication management, etc. Metric [I-25.1]: patients with chronic disease who receive appropriate disease-specific instructions. Baseline/Goal: additional 180 patients entered/480 patients entered in disease registry given instruction and assess reasons for gaps of when appropriate instruction given. Improvement over DY4 data Data Source: Chronic disease registry/EHR Milestone 9 Estimated Incentive Payment: $2,445,975 **Milestone 10** [I-X]: Evaluate and continuously improve care management services. Metric [I-X.1]: Project planning and implementation documentation

081599501.2.3			***2.19.1***	***2.19.1(A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVORIAL HEALTH NEEDS OF INDIVIDUALS (RN CARE MANAGEMENT)***
MHMR of Tarrant County					081599501
Related Category 3 Outcome Measure(s):	081599501.3.4 081599501.3.15 081599501.3.16	*IT-10.1* *IT-9.2* *IT-2.13*	*Quality of Life/Functional Status* *ED Appropriate Utilization* *Other 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)**
Payment: $1,512,296 **Milestone 3** [P-16]: Develop an implementation plan for a chronic disease registry Metric [P-16.1]: Development of implementation plan Baseline/Goal: no current disease registry at MHMRTC/identification of disease registry Data Source: Documentation of plan. Can we use our EHR or develop aspects of what must be accomplished in the plan. Milestone 3 Estimated Incentive Payment: $1,512,297	registry/ complete implementation of disease registry training, enter at least 120 patients in registry. Data Source: Documentation of patients entered and gaps identified. Milestone 5 Estimated Incentive Payment: $2,366,481	registry/EHR Milestone 7 Estimated Incentive Payment-1,687,723 **Milestone 8** [I-X]: Evaluate and continuously improve care management services. Metric [I-X.1]: Project planning and implementation documentation demonstrates plan,do,study, act quality improvement cycles. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 8 Estimated Incentive Payment: $**1,687,722**	demonstrates plan,do,study, act quality improvement cycles. Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement. Milestone 10 Estimated Incentive Payment: $**2,445,975**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $4,536,889	Year 3 Estimated Milestone Bundle Amount: $4,732,961	Year 4 Estimated Milestone Bundle Amount: $5,063,168	Year 5 Estimated Milestone Bundle Amount $4,891,950

081599501.2.3			***2.19.1***	***2.19.1(A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVORIAL HEALTH NEEDS OF INDIVIDUALS (RN CARE MANAGEMENT)***
MHMR of Tarrant County					081599501
Related Category 3 Outcome Measure(s):	081599501.3.4 081599501.3.15 081599501.3.16	*IT-10.1* *IT-9.2* *IT-2.13*	*Quality of Life/Functional Status* *ED Appropriate Utilization* *Other 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$19,224,968					

Project Option 2.13.2 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.) – Substance Use Disorder (SUD) Outpatient Integration.

Unique Project ID: 081599501.2.4 (Pass 2)
Performing Provider Name/TPI: MHMR of Tarrant County/081599501

Provider: MHMRTC is the Local Mental Health Authority (LMHA) providing mental health, early childhood, addiction and intellectual developmental disabilities services, serving an 897 square mile area and a population of approximately 1.8 million residents. MHMRTC is a contractor funded by the Department of State Health Services (DSHS) to provide substance abuse services. Hospitals, physicians, and other providers from an 11 county region refer medically indigent and Medicaid clients to Addiction Services (AdS). Activities undertaken to address any substance-related disorder as well as prevention activities include the provision of screening, assessment, referral and treatment for chemical dependency and chemical dependency counseling.

Intervention: This project provides for the integration of substance abuse services and mental health services. The intervention is a 6 – 12 month program that includes SUD screening, assessment, individual and group counseling, and peer support services within our existing adult mental health outpatient clinics. The purpose of this project is to implement the recently developed MHMRTC SUD outpatient program at our 11 mental health clinic locations. -. It will also expand the services currently provided to include peer support services.

Need for project: Approximately 50% of the mentally ill, medically indigent population served at MHMRTC sites has SUD. Many mentally ill individuals go untreated and undiagnosed for co-occurring substance use disorders due to the lack of substance abuse treatment professionals in mental health and primary care clinics. As a result, these patients suffer many health and legal crises, particularly when mental health medications are combined with street drugs and/or alcohol.

Target population: Mentally ill, medically indigent consumers who are served at our mental health locations and who also suffer with SUD-. Estimated number to be served over the course of the waiver period is 1,350-. Approximately 100% of our consumers are either Medicaid eligible or indigent

Category 1 or 2 milestones expected benefit: The project seeks to provide 250- unique patients encountered in DY3, 375- in DY4 and 725 in DY5, for a total of 1,350 during the waiver period.

Category 3 outcomes: -IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. Our goal is to decrease incarcerations by 10% in the population receiving treatment.
IT-9.2 ED appropriate utilization. Our goal is to decrease ED visits by 10% in the population receiving treatment.
IT-10.7 Functional status assessment for addiction severity: ASI. Our goal is to demonstrate improved functional status in 35% of the population discharged from treatment.

Project Option 2.13.2 – Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.) – Substance Use Disorder (SUD) Outpatient Integration.

Unique Project ID: 081599501.2.4 (Pass 2)
Performing Provider Name/TPI: MHMR of Tarrant County/081599501

Project Description:
Expansion of the existing MHMRTC substance use disorder (SUD) outpatient program currently available at only two substance abuse clinics to approximately 11 mental health sites in the MHMRTC network. MHMRTC will add licensed chemical dependency counselors (includes LCDC, LPC and LCSW) and peer support staff at each of these locations.
Goals and Relationship to Regional Goals:

Project Goals:
The goal of this project is to increase MHMRTC outpatient sites' ability to provide the right care, at the right time, in the right setting. Through the proposed project, consumers with SUD will have access to a more efficient preventive and proactive care through the increased

availability of outpatient substance abuse services within existing mental health settings. The five-year target goal is to substantially improve MHMRTC addiction services care capacity as evidenced by a 50% increase in SUD assessments and outpatient service utilization in Tarrant and surrounding counties

This project meets the following Regional goals:
The goal of this project is to avert -ED visits (and resulting inpatient admissions); to avert disruptive and deleterious events such as criminal justice system involvement; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community. This can be done by providing community-based interventions for individuals to prevent them from cycling through multiple systems, such as the criminal justice system; the general acute and specialty psychiatric inpatient system; and the mental health system.

Challenges:
Through the Addiction Severity Index (ASI), we will be able to measure the effectiveness of the project at increasing functional status and reducing incarcerations. However, -in order to establish the success of this project with respect to ED visits, we will need to coordinate our data needs with hospitals. Because the majority of the patients that will be included in this project receive services at JPS, we will negotiate with that hospital to obtain data.

5-Year Expected Outcome for Provider and Patients:
The goal of the project is to provide integrated care for patients suffering with both mental health problems and SUD. The expected outcome for the provider is that there will be less physical and mental health crises involving these patients, allowing resources to be committed to prevention and treatment. The expected outcome for patients is increased functionality and quality of life through less time spent in acute care, emergency care, and life-restricted settings (e.g. jail and nursing homes).

Starting Point/Baseline:

MHMRTC Addiction Services (AdS) outpatient clinics currently serve 1,500 consumers annually. The total number of consumers served across treatment services with the funding expansion will increase the number served by approximately 90-% (1,350-) by the end of project period.

Rationale:
Approximately 50% of the mentally ill, medically indigent population served at MHMR of Tarrant County's Mental Health division (6,000 actively enrolled into services) have SUD and would benefit from/need substance abuse treatment services.

-A significant number of mental health consumers use street drugs to treat psychiatric symptoms. Many crises occur when mental health medications are combined with street drugs and or alcohol. Many mentally ill individuals go untreated and undiagnosed for co-occurring substance

use disorders due to the lack of substance abuse treatment professionals in mental health and primary care clinics. Currently, patients with co-occurring psychiatric and SUD in Tarrant County have to go to one of two locations for substance abuse assessment and treatment. Expansion of the proposed services will allow mental health consumers with co-occurring psychiatric and substance abuse issues to receive behavioral health services in one location that they are familiar with instead of traveling to two separate locations.

Project Components:

a) -Cognitive behavioral therapy intervention, 12-step recovery, motivational interviewing techniques, Matrix model and Seeking Safety are interventions that will be utilized.[163] These are evidence-based models used successfully with adults with co-occurring substance abuse and mental disorders. The Addiction Severity Index (ASI) is also an evidence-based assessment tool[164] used nationwide to assess the level of substance abuse and chemical dependence- in consumers.[165] It will be administered at intake, six-month update/reassessment and when clients exit treatment programming. The ASI will be completed electronically in our electronic documenting system – Clinical Management for Behavioral Health Services (CMBHS). Functional status outcomes will be aggregated from ASI indicators.

b) Peer support services will be provided. The goal is to model successful behaviors. Services will be provided by certified peer specialists who are in recovery from mental illness and/or substance abuse disorders and are supervised by mental health professionals.

c) Finally, the Four Quadrant model[166] will be utilized to identify the population. It is based on the 1998 consensus document on mental health and substance abuse/addiction integration service. The severity for each disorder is divided into Four Quadrants: (1) Low mental health-low substance abuse, served in primary care; (2) High mental health-low substance abuse, served in the mental health system by staff who have substance abuse competency; (3) Low mental health-high substance abuse, served in the substance abuse system by staff who have mental health competency; and (4) High mental health-high substance abuse, served by fully integrated mental health and substance abuse program. The targeted population is that group that falls into quadrants 2 and 4.

Unique community need identification numbers the project addresses:

CN.1 – Lack of provider capacity

[163] (Najavits, Seeking Safety: An Evidence-Based Model for Substance Abuse and Trauma/PTSD, 2002)
[164] (Najavits, For Debate Studies of the reliability and validity of the Addiction Severity Index, 2002)
[165] (Paul M.G. Emmelkamp, 2006)
[166] (Mauer, 2006)

CN.10 – Demand for ED visits is on the rise and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is an enhancement of an existing project funded through the Department of State Health Services (DSHS) in Texas. During the last legislative session, substance abuse treatment was included as a Medicaid benefit to low-income individuals in Texas. This project will significantly enhance an existing delivery system reform initiative, focused on treating individuals in the most appropriate level of care at the most cost effective and efficient manner. Diverting consumers with SUD from emergency rooms, legal institutions and mental health hospitals is a part of delivery systems reform in Texas.

Related Category 3 Outcome Measures:
-Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. A study conducted by the National Center on Addiction and Substance Abuse at Columbia University found that 24.4% of prison and jail inmates have both mental illness and substance abuse problems.[167]
IT-9.2 ED appropriate utilization. In a report to Congress, SAMHSA reported that the combination of mental illness and substance abuse disorder can result in poor response to traditional treatments and increases the risk for other serious medical problems. As a result, individuals with co-occurring disorders often require high-cost services such as inpatient and emergency room care.[168] In 2007, 1 in 8 emergency room visits was related to mental health or substance abuse. Almost 12% of those visits were for co-occurring disorders.[169]
IT-10.7 Functional status assessment for addiction severity: ASI. The ASI is an indicator of the severity of a patient's SUD. If the program reduces that severity, the resulting impacts on the individual, the health care system and the community will also be reduced.

Relationship to Other Projects:

All of MHMRTC's projects address the expansion of behavioral health services and/or the integration of services to better serve a co-morbid population. It is expected that as the projects progress, we will refine each of the projects to better serve populations. It is also expected that efficiencies will be identified that will enhance our ability to serve a larger percentage of the population that currently is unable to find appropriate care. In particular, the projects that will have an impact on this project are:

[167] http://www.casacolumbia.org/articlefiles/575-report2010behindbars2.pdf
[168] http://www.nasmhpd.org/docs/Policy/Behavioral%20Health%20Primary_CoOccurringRTC.pdf
[169] http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp

(1) 081599501.1.1 Expand Behavioral Health Capacity
(2) 081599501.2.1 Expand Detox Capacity
(3) 081599501.2.3 RN Care Management.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
The Detoxification Expansion Project participants will be referred to the proposed substance use disorder (SUD) outpatient integration project 081599501.2.4 and the Wise Regional Health System Intensive Outpatient Program (IOP) 130606006.2.3, as a stepdown option to continue substance use disorder services/recovery treatment.

-This project will participate in the Region's learning collaborative. Please refer to Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of all participating provider projects for each collaborative. MHMR of Tarrant County will also be working with other Community Centers in learning collaborative to select a small amount of outcome measures for category 3, based on the valuation studies conducted by health care economists at the UT Austin and UT 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.

Project Valuation:
Approach:
Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system.

In order to set an appropriate incentive RHP 10 agreed that a multiplier of 5 should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the

annual value of a single successful intervention at full implementation and multiplying that value by 5. The multiplier of 5 was decided with much discussion by performing providers. The rationale was that to overcome resistance to change, both in the delivery system and the payment system, 5 years of benefits were needed. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

The incentive element of the Region 10 valuation methodology is relevant to all Texas transformation efforts. However, it is particularly relevant to transformation of the mental health care system, where patient experience, population health and costs have previously not received any focus, and where services tend to be provided primarily in emergency situations. Texas ranks 50th in the country in per capita funding for mental health services. Only one-third of the more than 480,000 adults in Texas with serious and persistent mental illness received services through the community mental health system. Therefore, the most important transformation that can occur in mental health is increased access to services. Until the advent of the waiver, the system has not had funds to experiment with the types of interventions that are being made possible through waiver funding. Incentives for effective implementation and outcomes are important to allow for the identification of successful interventions and the ultimate sustained transformation of the system.

Rationale:
The calculation of the value of successful interventions for this project used an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses cost-utility analysis (CUA) to measure the cost of the program in dollars and the health consequences in utility-weighted units satisfying our valuation factors regarding patient experience, community benefit, and savings to the health care system. This valuation uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The QALY value results in significant values related to mental health interventions. These patients are intensive users of the health care system and are most often not functional in society. Incremental improvements in their status have an enormous impact on all three elements of the triple aim.

081599501.2.4	*2.13.2*	*2.13.2*	**Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.).Other (**Substance Use Disorder (SUD) Outpatient Integration project**)**
Mental Health Mental Retardation of Tarrant County (MHMRTC)			*081599501*
Related Category 3 Outcome Measure(s):	*unique Category 3 IT identifier(s) –* -081599501.3.9 081599501.3.10 081599501.3.11	***IT-9.1*** ***IT-9.2*** ***IT-10.7***	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. ED appropriate utilization Functional status assessment for addiction severity

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 frequent users of community public health resources. Metric 1 [P-1.1]: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization Baseline/Goal: 0/ Complete Needs Assessment Data Source: Project documentation; Inpatient, discharge and ED records; State psychiatric facility records; survey of stakeholders (inpatient providers, mental health providers, social services and forensics); literature review. Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,022,729 **Milestone 2** [P-2]**:** Design community-based specialized interventions for target populations. Interventions may include substance abuse services	**Milestone 3**[I-X]: Improvement milestone of target population reached Metric 1 [I-X-]: Number of targeted individuals enrolled/ served in the project. -Goal: Total number of unique patients encountered in the clinic for reporting period 250 Data Source: Clinical Management for Behavioral Health Services (CMBHS) Assessment (ASI). Milestone 3 Estimated Incentive Payment: $2,110,331 **Milestone 4** [P-7]: 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	**Milestone 5**- [I-X]: Improvement milestone of target population reached.-]: Metric 1 [I-X-1]**:** Number of targeted individuals enrolled/ served in the project. -Goal: Total number of unique patients encountered in the clinic for reporting period 375-. Data Source: Registry, EHR, claims or other Performing Provider source Milestone 5 Estimated Incentive Payment: $2,260,253 **Milestone 6** [P-7]: 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	**Milestone 7** [I-X]: Improvement milestone of target population reached. -Metric 1 [I-X-1]: Number of targeted individuals enrolled/ served in the project. -Goal: Total number of unique patients encountered in the clinic for reporting period 725-. Data Source: Registry, EHR, claims or other Performing Provider source Milestone 7 Estimated Incentive Payment: $2,183,820 **Milestone 8** [P-7]: 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

081599501.2.4	*2.13.2*	*2.13.2*	**Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.).Other (**Substance Use Disorder (SUD) Outpatient Integration project***)***
Mental Health Mental Retardation of Tarrant County (MHMRTC)			*081599501*
Related Category 3 Outcome Measure(s):	*unique Category 3 IT identifier(s) –* -081599501.3.9 081599501.3.10 081599501.3.11	***IT-9.1*** ***IT-9.2*** ***IT-10.7***	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. ED appropriate utilization Functional status assessment for addiction severity

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)
(specialized for individuals who have experienced prolonged or repeated institutionalization), and peer support services – A service that models successful health and mental health behaviors. These services will be-provided by certified peer specialists who are in recovery from mental illness and/or substance use disorders and are supervised by mental health professionals Metric 1 [P-2.1]: Project plans which are based on evidence/experience and which address the project goals Baseline: 0 Date Source; SAMHSA Resource Data Bank; AHRQ, NQF Goal: Design Community-based specialized intervention Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,022,729	participating provider should publicly commit to implementing these improvements Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings 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 semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semi-annual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semi-annual meeting. Milestone 4 Estimated Incentive Payment: $2,110,331	publicly commit to implementing these improvements Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings 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 semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semi-annual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semi-annual meeting. Milestone 6 Estimated Incentive Payment: $2,260,253	these improvements Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: 2 meetings 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 semi-annual meeting. Data Source: Documentation of "raise the floor" improvement initiatives agreed upon at each semi-annual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semi-annual meeting. Milestone 8 Estimated Incentive Payment: $2,183,820

081599501.2.4	***2.13.2***	***2.13.2***	**Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting (i.e., the criminal justice system, ED, urgent care etc.).Other (**Substance Use Disorder (SUD) Outpatient Integration project***)***
Mental Health Mental Retardation of Tarrant County (MHMRTC)			*081599501*
Related Category 3 Outcome Measure(s):	*unique Category 3 IT identifier(s) –* -081599501.3.9 081599501.3.10 081599501.3.11	***IT-9.1*** ***IT-9.2*** ***IT-10.7***	Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. ED appropriate utilization Functional status assessment for addiction severity

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)
Year 2 Estimated Milestone Bundle Amount: ***(add incentive payments amounts from each milestone):*** **$4,045,458**	**Year 3 Estimated Milestone Bundle Amount: $4,220,662**	**Year 4 Estimated Milestone Bundle Amount: $4,520,506**	**Year 5 Estimated Milestone Bundle Amount: $4,367,639**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$17,154,265			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.8.11– Apply Process Improvement Methodology to Improve Quality/Efficiency (Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications)

Unique Project ID: 094105602.2.1
Performing Provider Name/TPI: North Hills Hospital /094105602

Provider: North Hills Hospital is a 176 bed acute care hospital in Tarrant County Texas serving a primary and secondary service are of 540,000. North Hills Hospital serves 16% inpatient Medicaid and Uninsured and 48 % ED patients are Medicaid and uninsured.
Intervention: This project will implement process improvement methodologies in a sepsis evidenced based care program to reduce sepsis complications. Sepsis Resuscitation and Management Bundle program was kicked off in 2012 as a hospital specific program. Process improvement would be an expansion/enhancement.
Need for the project: Mortality for sepsis nationally is >30%. Regional readmissions for sepsis are was 22% in 2011 with mortality for readmission at 10.5%. Sepsis was also top 50% of reasons patients readmitted for each of the 10 index conditions and a higher mortality rate for readmission than all other conditions. Readmission for sepsis can occur due to early discharge, improper antibiotic treatment and lack of continuation of medication .(DFW Hospital Council data)
Target population: The target population is patients presenting to ED and all patients diagnosed with sepsis shock, severe sepsis. Approximately 40% of patients to be screened are Medicaid and indigent. It is estimated currently 11% of our patients treated for sepsis are Medicaid eligible or indigent. Estimated number of patients to be served over course of waiver period: With improvement in diagnosis a key element of the program, this number is expected to increase to estimated 689. Patients who are Medicaid eligible or uninsured will benefit as they more often use the ED and their illness is farther progressed when presenting to ED along with greater complexity of co-morbid diseases. Due to lack of access to medical care patients tend to delay seeking care which can lead to harmful results. The quicker diagnosis of sepsis and evidence-based care will prevent greater mortality and disability from sepsis.
Category 1 or 2 expected patient benefits: The project seeks to increase the timeliness of correctly diagnosing sepsis in order the begin evidence-based care with improved the compliance with Sepsis Bundle and Resuscitation for patients diagnosed with severe sepsis and septic shock. We expect to diagnose and treat 689 sepsis patients (estimated at DY 1- 126 DY2-131, DY 3-137, DY 4- 144 DY 5-151). 125 patients were diagnosed in DY 1 with the implementation of the sepsis program. However only 6 patients were properly treated with the evidence based care plan from the program. Patients that may not diagnosed/diagnosed timely or not receive evidence based treatment may have resulted in death or disability. The program will have great benefit to

patients to reduce harm from lack of proper and timely diagnosis and/or lack of evidence based treatment.

Category 3 outcomes: The outcomes selected reflect the effectiveness of implementing evidence-based care such as reduction in mortality and decreased length of stay.

IT-4.8 Our goal is to reduce the Sepsis Mortality of patients diagnosed with sepsis , estimated DY 1 mortality was 27% and improvement of 25% by DY 5, morality would be 20%.

IT -4.9 Our goal is the reduce the Average length of stay of patients with sepsis . Estimated DY 1 ALOS was 7.3, a reduction goal by DY 5 of 2 days to ALOS of 5.3.

Project Option 2.8.11– Apply Process Improvement Methodology to Improve Quality/Efficiency (Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications)

Unique Project ID: 094105602.2.1
Performing Provider Name/TPI: North Hills Hospital /094105602

Project Description:
The project will design and implement a process improvement plan to increase the utilization and compliance with sepsis resuscitation and management bundles to improve patient outcomes.

North Hills Hospital is committed to continuous quality improvement so all our patients receive the safest and highest quality health care possible. We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis. Our processes and interventions are based upon evidence-based care models, which include a sepsis resuscitation bundle for emergency department (ED) patients and a sepsis management bundle for ongoing care. Rapid diagnosis and management are cornerstones to successful outcomes.

The ICU and ED plans for improvements in sepsis identification and treatment includes revising the electronic nurse sepsis screening at triage, implementing an electronic nurse sepsis screen to aid in early detection of inpatients, staff education regarding sepsis screening, and refining the Rapid Response Team (RRT) processes to include sepsis screening and initial resuscitation. This allows the RRT to begin fluid resuscitation on the in-house patient who screens positive for severe sepsis or septic shock and is hypotensive.

North Hills Hospital will also track primary endpoints of mortality and ICU LOS. Process and other measures will be tracked that include percentage of patients initiated on vasopressors and mean days of vasopressor use, percentage of patients initiated on the mechanical ventilator and mean ventilator days, and initiation of hemodialysis or continuous renal replacement therapy. Our target population is any patient diagnosis of severe sepsis, septic shock, and/or lactate > 4 mmol/L (36 mg/dl).

Although great work has been done to implement protocols and interventions, utilization and compliance of sepsis resuscitations and management bundles remains a challenge. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Goals and Relationship to Regional Goals:
Project Goals:

The goal of this project is to implement process improvement plan to improve safety and quality for those patients with sepsis. We will:

1. Achieve 90% compliance with the sepsis resuscitation and management bundles in patients admitted to the ICU.
2. Substantially improve early sepsis identification, reduce sepsis-related mortality by 25% from baseline.
3. Develop effective and fully implemented measurement and reporting system supporting compliance with the sepsis resuscitation and management bundles.
4. Continue to work with Emergency Medical Services to improve the delivery of care provided to patients with suspected infection.
5. Improve identification of sepsis patients housewide by implementing nursing admission screening and shift assessments for sepsis screening.
6. Improve identification of sepsis, compliance with current sepsis resuscitation and management bundles in the emergency department.

This project meets the following Regional goals:
This project supports the Regional goals to improve the patient care experience, health outcomes for the population and the per capita cost of care. Specifically, this project will improve the early diagnosis of patients with severe sepsis and septic shock so that evidence-based care can be delivered. Improved recovery of patients with severe sepsis and septic shock will reduce unnecessary death and harm and reduce cost of posthospital care in addition to quality-adjusted life gained.

Challenges:
According to CDC 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis each year, which includes diagnoses of severe sepsis and septic shock, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Proactive analysis of the contributing factors contributing to the design of evidence-based standardized care sets and subsequent adoption of those tools will contribute greatly to reducing variation and associated cost. Early recognition and management of sepsis results in lives saved.

5-Year Expected Outcome for Provider and Patients:

We expect to reach 100% compliance in identification/diagnosing of patients with severe sepsis, septic shock, and/or lactate >4mmol/L (36 mg/dl). We also expect to be 90% compliant with application of the sepsis bundles for patients who meet specified criteria.

Starting Point/Baseline:
The number of patients with severe sepsis, septic shock and/or lactate>4mmol/L (36mg/dl) that would qualify for sepsis resuscitation and management bundles based on expected sepsis claims from similar size hospital and mature sepsis programs would average 125 per year for a total of 689 patient over course of the waiver. Active implementation of sepsis resuscitation and management bundles and data collection is beginning in 2012. However, the number of patients with severe sepsis, septic shock and/or lactate>4mmol/L (36mg/dl) that would qualify for sepsis resuscitation and management bundles has not been determined. In DY 1 the hospital diagnosed 126 patients with sepsis protocol. Although the number of patients diagnosed looks on target for similar size hospitals, the program implementation is not in compliance with evidence based treatment. Early data collection indicates compliance with sepsis bundles is a low as 3%.

Rationale:
According to CDC 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis each year, which includes diagnoses of severe sepsis and septic shock, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Our internal data shows a mortality rate as high as 60%. Identification and treatment protocols have been developed and implemented to impact mortality and ICU LOS, which has improved. We are in the early stages of implementation of the program components and we still face the challenge of successful implementation. Also, additional interventions will be implemented in the future (e.g., shift assessments on all in-house patients). To be successful we need to eliminate/correct processes that create time delays, non-adherence to order set and failure to identify/diagnose sepsis. We have been as low as 10% in compliance in implementing sepsis bundles. We believe in order to continue to see improvement from initial implementation, continuous quality improvement through data collection, analysis and review will accelerate change through our multidisciplinary teams.

Project Components:

The project components to report metrics number of patient's diagnosis correctly and for sepsis bundle compliance are necessary to measure the success of implementing the sepsis improvement plan.

A sepsis improvement plan must have key elements to be successful. A project plan is necessary to identify and engage all stakeholders (ED, inpatient units, EMS), understand current status, resources, baselines, roles and responsibilities, expectations of individuals and outcomes. In order to have an impact on reduction in mortality and average length of stay, compliance with sepsis diagnosis and protocols for sepsis bundles are critical. In implementation, it is necessary to examine the plan, understand what is working and what is not, identify barriers and make corrective action. Continuous quality improvement (CQI) activities will be conducted to ensure successful implementation. In DY2 and DY 3, milestones to implement a program to improve efficiencies and/or reduce program variation are essential to the success of sepsis program. The practice strategy for PDSA and CQI will be a Lean Six Sigma DMAIC approach. A Value Stream Mapping will allow us to document the current state of the program implemented in 2012. The Value Stream Mapping and metric results will determine where variation exits and which processes are constraints to the success of the program. This will help us identify the priority for processes improvement events to be conducted. The team will conduct events utilizing tools to find root causes of variations or process delays. Changes will be implemented with appropriate tools to update the program process. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Each year a Value Stream Mapping can be utilized to validate change, document current state and continue the cycle of process improvement.

Unique community need identification numbers the project addresses:

- CN 11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Sepsis resuscitation and management bundle program kicked off in 2012 as a hospital-specific program. Applying process improvement methodologies to the sepsis program will greatly enhance the chances of success in implementing the plan and reducing mortality and average length of stay.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and

harm attributable to sepsis. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

IT-4.8 Sepsis mortality (Stand-alone measure)

By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early treatment and decrease length of stay, reduce health care cost and mortality. Institute for Healthcare Improvement; Surviving Sepsis Campaign; Society of Critical Care Medicine; IDSA Guidelines for appropriate antibiotic selection.

IT-4.9 Average length of stay (Non-stand-alone measure)

By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early treatment and decrease complications with resulting length of stay in ICU and overall LOS.

Relationship to Other Projects:
This project supports the population-focused improvements 094105602.4.4, RD-3 Potentially Preventable Complications (PPCs). Improved quality with evidence-based care for sepsis increases education, training, and screening that will reduce preventable complications in the hospital setting.

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

1. The following providers are also proposing projects to address sepsis resuscitation and management improvement:
   - JPS
   - Plaza Medical Center Fort Worth
   - Medical Center of Arlington
   - Huguley Memorial Medical Center
   - Texas Health Harris Methodist HEB

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and

outcomes by computing the total value of the Category 3 outcomes connected to each project. North Hills Hospital has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. (See Section V.B. for a full explanation of the model.)

North Hills Hospital defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The percentage of the population expected to be positively impacted by the project for mortality is 4%, which was determined based on outcome target for reduction in mortality by 25% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 21. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $218,700 for 5 years.
The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 7.3 days per patient. This was estimated at total of reduced in patient days by DY 5 of 650. The estimated cost per day for a sepsis patient is $828. This totaled approximately $544,000.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $218,700.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 3. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $326,000.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $210,700.
To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $326,000.

The total value of the project then was estimated at $1,844,000. Approximately 79% of the total value was assigned to Category 2 project and the remaining 9% of value assigned to Category 3 outcome for Sepsis Mortality and 11.8% assigned to Category 3 outcome for reduced Average Length of Stay.

094105602.2.1	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE-BASED INTERVENTION THAT WILL LEAD TO REDUCTIONS IN SEPSIS COMPLICATIONS***	
North Hills Hospital				*094105602*
Related Category 3 Outcome Measure(s):	*094105602.3.1* *094105602.3.2*	*3.IT-4.8* *3.IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
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.1]: Documentation of Sepsis Improvement Plan Baseline/Goal: Plan Data Source: Sepsis Improvement Plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $90,664 **Milestone 2** [P-6.]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events Baseline/Goal: Implement events Data Source: Plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $90,664 **Milestone 3** [P-X]: Participate in a	**Milestone 5** [P-6]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events (Documentation of all steps conducted in the PDSA) Baseline/Goal: Develop a sepsis improvement plan Data Source: Plan Milestone 5 Estimated Incentive Payment: $123,637 **Milestone 6** [I-13.1]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal: Improve compliance from 50%, 68 cases on bundle Data Source: EHR Milestone 6 Estimated Incentive Payment: $123,637 **Milestone 7** [I-13]: Progress toward target/goal (Compliance with correct		**Milestone 8** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1] Number or percent of all clinical cases that meet target/goal Goal: Improve compliance from 70%, 100 cases on bundle Data Source: EHR Milestone 8 Estimated Incentive Payment: $198,395 **Milestone 9** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance by 20% from baseline Data Source: EHR Milestone 9 Estimated Incentive Payment: $198,394	**Milestone 10** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal : Improve compliance to 90% 135 cases on bundle Data Source: EHR Milestone 10 Estimated Incentive Payment: $163,891 **Milestone 11** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal : Improve Sepsis Diagnosis Compliance by 25%from baseline Data Source: EHR Milestone 11 Estimated Incentive Payment: $163,892

094105602.2.1	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE-BASED INTERVENTION THAT WILL LEAD TO REDUCTIONS IN SEPSIS COMPLICATIONS***	
North Hills Hospital				*094105602*
Related Category 3 Outcome Measure(s):	*094105602.3.1* *094105602.3.2*	*3.IT-4.8* *3.IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
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)**
learning collaborative Metric 1 [P-X.1]: Submit report for Sepsis Improvement Plan findings Baseline/Goal: Annual conference Data source: Conference meeting attendance and minutes Milestone 3 Estimated Incentive Payment *(maximum amount):* $90,664 **Milestone 4[P-X]:** Establish baseline, in order to measure improvement over self (for correct timely diagnosis of sepsis and bundle compliance) Metric 1 [P-X]: Conduct assessment of targeted population Baseline/Goal: Percent compliance with correct timely diagnosis of sepsis Data source: EHR Metric 2 [P-X]: Conduct assessment of targeted population Baseline/Goal: 2011 Sepsis Bundle compliance 18.5 % Data source :EHR	timely diagnosis of Sepsis) Metric 1 [I-13.1.2]: Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance by 15% from baseline Data Source: EHR Milestone 7 Estimated Incentive Payment: $123,637			

094105602.2.1	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE-BASED INTERVENTION THAT WILL LEAD TO REDUCTIONS IN SEPSIS COMPLICATIONS***
North Hills Hospital			*094105602*
Related Category 3 Outcome Measure(s):	*094105602.3.1* *094105602.3.2*	*3.IT-4.8* *3.IT-4.9*	*Sepsis Mortality* *Average Length of Stay*

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 4 Estimated Incentive Payment *(maximum amount):* $90,664			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $362,656	Year 3 Estimated Milestone Bundle Amount: $370,911	Year 4 Estimated Milestone Bundle Amount: $396,789	Year 5 Estimated Milestone Bundle Amount: $327,783
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,458,139			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.4.1– Implement a strategic improvement program for patient satisfaction (Redesign to Improve Patient Experience)

Unique Project ID: 094193202.2.1
Performing Provider Name/TPI: Plaza Medical Center Fort Worth /094193202

Provider: Plaza Medical Center Fort Worth is a bed acute care hospital. 11% of inpatients are Medicaid and uninsured, while 42 % ED patients are Medicaid and uninsured.
Intervention: The goal of the project is to implement process improvement plans that target specific patient experiences. The purpose is to change the organizational culture and impact patient safety and quality with improved patient experience. This is would be a new intervention.
Need for the project: Patient experience scores reflect a deficiency in key areas that are critical for patient safety and quality of care. These include communication with physicians and nurses, communication regarding medications and discharge process. Patients who are Medicaid eligible or uninsured are most vulnerable to communication matters due to greater language and cultural barriers. These patients also face greater obstacles for discharge planning with lack of resources and support in post-acute care. Underserved and Medicaid patients will benefit to greater degree with improvement in processes that make for a better patient experience.
Target population: Target population is all patients served by hospital. Estimated number of patients to be served over course of waiver period: This would be difficult to quantify since the all patients are targeted priority on Inpatients, we would estimate 8500 a year or 34,000 patients over the course of the waiver will be impacted. We do actively survey 100 patients a month/1200 a year. Patients who are Medicaid eligible or uninsured are most vulnerable to communication matters due to greater language and cultural barriers. These patients also face greater obstacles for discharge planning with lack of resources and support in post-acute care. Underserved and Medicaid patients will benefit to greater degree with improvement in processes that make for a better patient experience.
Category 1 or 2 expected patient benefits: The project seeks to improvement in patient satisfaction scores as measured by HCAHPS Grand Composite. This will be a benefit to patients from better communication with nurses and doctors , better medication management, pain management and discharge planning. Studies have shown with improved patient experience, the quality of care patients experience also improves. This will result in reduce preventable complications such as infections, less readmissions and reduced medication errors . It is estimated patients impacted will be DY 2-8500, DY 3-8670, DY 4-9100, DY5-9560.
Category 3 outcomes: IT-6.1 Our goal is to improve Percent Improvement over baseline of patient satisfaction scores from 64% currently to 75% by DY5. Yes improvement in scores is part of the purposed of project.

Project Option 2.4.1– Implement a strategic improvement program for patient satisfaction (Redesign to Improve Patient Experience)

Unique Project ID: 094193202.2.1
Performing Provider Name/TPI: Plaza Medical Center Fort Worth /094193202

Project Description:
Plaza Medical Center Fort Worth is proposing a project to establish baseline HCAHPS scores and implement a patient/family experience strategic plan.

A steering committee will be formed and workgroups of the committee will work on process improvements for patient experience targets. Evaluation will be performed and documented to measure implementation progress, results and make adjustments to improvement plans. As part of the strategic plan, patient experience will be an integral part of employee orientation. A communication plan on work being done to improve the patient experience will be developed and implemented to ensure all employees and physicians are included on progress and initiatives. Studies have shown that improved patient experience can improve patient health outcome and quality.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of the project is to implement process improvement plans that target specific patient experiences. The purpose of performing this project is the engage all stakeholder such as leader and employees that can be the high level role to drive the patient experience improvement across the hospital for a cultural change at the organizational level.

This project meets the following Regional goals:
A major goal of the Region is to pursue the triple aim of health care by improving patient experience of care, improve health of populations and reduce the cost of health care. Redesigning the patient experience in the Region will impact the health of our community by keeping patients engaged in the health care system.

Challenges:
The hospital has been participating in HCAHPS to measure patient experience in hospital setting. Implemented training plans have not improved scores. Plaza Medical Center Fort Worth has achieved grand composite score of 70% for 2010Q3-2011Q2 and 70% for 2010Q4-2011Q3, which is consistently been below the CMS national average. The scores summarize:

- How well nurses and doctors communicate with patients
- How responsive hospital staff are to patients' needs

- How well hospital staff help patients manage pain
- How well the staff communicates with patients about medicines, and whether key information is provided at discharge
- Cleanliness and quietness of patients' rooms
- Patients'' overall rating of the hospital and whether patients would recommend the hospital to family and friends

The project will address targeted patient experiences with that have not been improved by other initiatives.

5-Year Expected Outcome for Provider and Patients:
We expected at end of Waiver period we will be > 75th percentile on grand composite scores for CMS HCAHPS.

Starting Point/Baseline:
Plaza Medical Center Fort Worth has achieved grand composite score of 70% in 2010Q3-2011Q2 and 70% 2010Q4-2011Q3, which has consistently been below the CMS national average.

Rationale:
Patient experience scores are measured internally and reported quarterly from a Gallup Survey. These scores are shared with senior leaders and staff in various manners, including Dashboards and reports. Various committees work on departmental and process issues but a coordinated, systemwide approach is lacking. A patient/family experience strategic plan will eliminate duplication of time and effort and provide a roadmap for improvement and best practice. Engaging patients and families in the process will strengthen the organization's resolve to get better and stay better.

The overall approach to redesigning patient experience will be centered on cultural change at the organizational level. This will involve clinicians, patients and their families or caregivers. An organizational strategy will be developed so that we manage patient experience and create avenues to implement the strategic plan/vision. This project option is best for organizational integration, which is critical to successful patient experiences.

Project Components:
All core components will be implemented.

a) Organizational integration and prioritization of patient experience
b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and

Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;

c) Implementing processes to improve patients' experience in getting through to the clinical practice;
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

Establishing a steering committee with high-level leadership is necessary to drive cultural change to impact patient experiences. . A communication plan will be developed to inform all employees and physicians of the work of the steering committee and results to better integrate the process and changes into the culture. Process improvements needed will be identified and analyzed with Lean Six Sigma tools. The work groups will be empowered to implement changes identified and report back to the steering committee. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event Evaluation, control and sustain activities are necessary for continuous quality improvements . Evaluation of the implemented improvements and testing are necessary for continuous quality improvements. We will measure the impact of the improvements implemented from CMS HCAHPS scores.

Unique community need identification numbers the project addresses:

- CN.10 – Overuse of the emergency department services
- CN.11 – Need for more care coordination
- CN.12 – Need for more culturally competent care to address unmet needs

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative. This is a new initiative for Plaza Medical Center Fort Worth; it currently does not have structure or feedback.
Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
IT-6.1 Percent improvement over baseline of patient satisfaction scores

An organizational strategy will be developed so that the hospital will manage patient experience and create avenues to implement the strategic plan/vision. Performance will be measured, among other factors, by the extent to which patient experience improves systematically.

In October 2005, the Joint Commission's Journal on Quality and Patient Safety published a series of case studies of health care institutions' efforts to improve both quality and safety. One of these was from Lehigh Valley Hospital in Allentown, Penn., which used active engagement of patients and families in attempting to improve patient safety.[170]

Weingart and colleagues (2006) examined inpatients' reports of service incidents — deficiencies in service quality such as waits/delays, poor communication, poor care coordination, lack of respect for personal preferences, or environmental issues. They found that roughly 40% of patients reported at least one incident and that reporting of incidents was associated with diminished patient satisfaction.[171]

Also, Kaldenberg and Trucano (2007) examined facility-level relationships between hospital-acquired infection (HAI) rates and patient perceptions of specific aspects of hospital quality in the State of Pennsylvania. Specifically, they chose three questions from an inpatient survey thought to measure practices that, when poorly executed, could create a more infection-prone environment: ratings of cleanliness; of the skill of the person who took the patient's blood; and of nurses' response to the call button. All three were found to be significantly, negatively correlated with HAI rates.[172]

Relationship to Other Projects:

This project supports 094193202.4.5 RD-4 Patient-centered health care. The project will implement training and improvement work on experience targets aimed to increasing patient satisfaction with the hospital, nurses and physicians that will result in a better patient experience

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

The other providers proposing similar projects:

- JPS
- Medical Center of Arlington
- Glen Rose Medical Center

[170] Anthony R, Ritter M, Davis R, Hitchings K, Capuano TA & Mawji Z. (2005). Lehigh Valley Hospital: engaging patients and families. *Joint Commission Journal on Quality and Patient Safety.* 31(10), 566-572.

[171] Weingart SDN, Pagoviceh O, Sands DZ, Li JM, Aronson ,MD, Davis RB, Phillips, RS & Bates DW. (2006). Patient-reported service quality on a medicine unit. *International Journal of Quality in Health Care*, 18(2), 95-101.

[172] Kaldenberg D. & Trucano M. (2007). The relationship between patient perceptions of hospital practices and facility infection rates: Evidence from Pennsylvania hospitals. *Patient Safety and Quality Health Care.*

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Plaza Medical Center Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Plaza Medical Center Fort Worth defined the population that will be directly impacted by the project as patients with Medicare who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 4 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The rate per Medicare case of $11,759 was used to calculate the estimated loss of revenues using these penalty % for DY 2- 0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.05% . This totaled $2,161,220.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $1,396,542. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $1,294,779.

The total value of the project was calculated at $4,852,541. Approximately 79% of the project value was assigned to the Category 2 project, $3,836,901 and 21% to the Category 3 project, $1,015,640.

094193202.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Plaza Medical Center Fort Worth				*094193202*
Related Category 3 Outcome Measure(s):	*094193202.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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)**	**-(10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee should meet at least twice a month. Metric 1 [P-3.1]**:** Documentation of committee proceedings and list of committee Members. Baseline/Goal: Establish committee and meeting schedule Data Source: Meeting minutes, agendas, participant lists, and/or list of steering committee members Milestone 1 Estimated Incentive Payment *(maximum amount):* $477,141 Milestone 2 [P-2]: Write and disseminate a patient/family experience strategic plan Metric 1 [P-2.1]: Submission of a	**Milestone 3** [P-11]: Orchestrate improvement work on identified experience targets (IP and Ambulatory strategies for improved caregiver communication (i.e. nurse and physician communication), responsiveness of staff and pain management). Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup. Metric 1 [P-11.1]: Submission of implementation plan. Baseline/Goal: Work plan write up and implementation of phase 1 Data Source: Implementation plans Milestone 3 Estimated Incentive Payment *(maximum amount):* $325,335 **Milestone 4 [**P-13]: Perform a		-. **Milestone 6** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 20 displays Data Source: Verification of displays, methodology and CEO report to employees, physicians and steering committee	

094193202.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Plaza Medical Center Fort Worth				*094193202*
Related Category 3 Outcome Measure(s):	*094193202.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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)**	**-(10/1/2015 – 9/30/2016)**
strategic plan and documentation of the dissemination of that plan throughout the organization Baseline/Goal: Documented patient experience plan and communication strategies well defined Data Source: Completed patient experience plan, verification of communication throughout the organization. Milestone 2 Estimated Incentive Payment *(maximum amount):* $477,141	mid-course evaluation of the results of improvement projects / Make necessary adjustments and continue with implementation Metric 1 [P-13.1]*:* Submission of evaluation results. Baseline/Goal: Evaluate 100% of improvement projects Data Source: Evaluation write –up Milestone 4 Estimated Incentive Payment: $325,335 **Milestone 5** [P-4]: Integrate patient experience into employee training. Metric 1 [P-4.1]: 100 % of new employees who received patient experience training as part of their new employee orientation. Baseline/Goal: Develop training Data Source: Implementation plans Milestone 5 Estimated Incentive		Milestone 6 Estimated Incentive Payment *(maximum amount):* $1,044,098	

094193202.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	***IMPLEMENT A STRATEGIC IMPROVEMENT PROGRAM FOR PATIENT SATISFACTION (REDESIGN TO IMPROVE PATIENT EXPERIENCE)***	
Plaza Medical Center Fort Worth				*094193202*
Related Category 3 Outcome Measure(s):	*094193202.3.1*	*3 IT 6.1*	*Percent Improvement over baseline of patient satisfaction scores (all 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)**	**-(10/1/2015 – 9/30/2016)**
	Payment *(maximum amount):* $325,335			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $954,282	Year 3 Estimated Milestone Bundle Amount: $976,005		Year 4 Estimated Milestone Bundle Amount: $1,044,098	Year 5 Estimated Milestone Bundle Amount: $862,516
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $3,836,901				

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.8.11– Apply Process Improvement Methodology to Improve Quality/Efficiency (Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications)

Unique Project ID: 094193202.2.2
Performing Provider Name/TPI: Plaza Medical Center Fort Worth /094193202

Provider: Plaza Medical Center is a 217 bed acute care hospital in Fort Worth Texas serving a primary and secondary service area population of 1.1million. Plaza Medical Center serves 11% inpatient Medicaid and Uninsured and 42 % ED patients are Medicaid and uninsured.
Intervention: This project will implement process improvement methodologies in a sepsis evidenced based care program to reduce sepsis complications. Sepsis Resuscitation and Management Bundle program was kicked off in 2012 as a hospital specific program. Process improvement would be an expansion/enhancement.
Need for the project: Mortality for sepsis nationally is >30%. Regional readmissions for sepsis are was 22% in 2011 with mortality for readmission at 10.5%. Sepsis was also top 50% of reasons patients readmitted for each of the 10 index conditions and a higher mortality rate for readmission than all other conditions. Readmission for sepsis can occur due to early discharge, improper antibiotic treatment and lack of continuation of medication .(DFW Hospital Council data)
Target population: The target population is patients presenting to ED and all patients diagnosed with sepsis shock, severe sepsis. Approximately 40% of patients to be screened are Medicaid and indigent. It is estimated currently 5% of our patients treated for sepsis are Medicaid eligible or indigent. However with improvement in diagnosis a key element of the program, this number is expected to increase. Estimated number of patients to be served over course of waiver period: Based on current processes over only 580 patients (116 patients per year). However with improved diagnosis this is expected to increase to 850 patients (average 198 patients per year). Patients who are Medicaid eligible or uninsured will benefit as they more often use the ED and their illness is farther progressed when presenting to ED along with greater complexity of co-morbid diseases. Due to lack of access to medical care patients tend to delay seeking care which can lead to harmful results. The quicker diagnosis of sepsis and evidence-based care will prevent greater mortality and disability from sepsis.
Category 1 or 2 expected patient benefits: The project seeks to increase the timeliness of correctly diagnosing sepsis in order the begin evidence-based care with improved the compliance with Sepsis Bundle and Resuscitation for patients diagnosed with severe sepsis and septic shock. We expect to diagnose and treat 837 sepsis patients (estimated at DY 1- 58 DY2-180, DY 3-189, DY 4- 200 DY 5-210) Only 58 patients were diagnosed and treated in DY 1 with the implementation of the sepsis program. That means up to 120 patients a year may not diagnosed or diagnosed timely and may have resulted in death or disability. The program will have great benefit to patients to reduce harm from lack of proper and timely diagnosis and/or lack of evidence based treatment.

Category 3 outcomes: The outcomes selected reflect the effectiveness of implementing evidence-based care such as reduction in mortality and decreased length of stay.
IT-4.8 Our goal is to reduce the Sepsis Mortality of patients diagnosed with sepsis.Estimated DY 1 mortality was 48% however a baseline rate with appropriate sample size will be measured in DY 2 .We estimate an improvement of 25% by DY 5, morality would be 24%.

IT -4.9 Our goal is the reduce the Average length of stay of patients with sepsis. Estimated DY 1 ALOS was 8.7, a reduction goal by DY 5 of 2 days to ALOS of 6.7.

Project Option 2.8.11– Apply Process Improvement Methodology to Improve Quality/Efficiency (Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications)

Unique Project ID: 094193202.2.2
Performing Provider Name/TPI: Plaza Medical Center Fort Worth /094193202

Project Description:
The project will design and implement a process improvement plan to increase the utilization and compliance with sepsis resuscitation and management bundles to improve patient outcomes.

Plaza Medical Center Fort Worth is committed to continuous quality improvement so all of our patients receive the safest and highest quality health care possible. We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis. Our processes and interventions are based upon evidence-based care models, which include a sepsis resuscitation bundle for emergency department (ED) patients and a sepsis management bundle for ongoing care. Rapid diagnosis and management are cornerstones to successful outcomes.

The ICU and ED plans for improvements in sepsis identification and treatment includes, revising the electronic nurse sepsis screening at triage, implementing an electronic nurse sepsis screen to aid in early detection of inpatients, staff education regarding sepsis screening, and refining the Rapid Response Team (RRT) processes to include sepsis screening and initial resuscitation. This allows the RRT to begin fluid resuscitation on the in-house patient who screens positive for severe sepsis or septic shock and is hypotensive.

Plaza Medical Center Fort Worth will also track primary endpoints of mortality and ICU LOS. Process and other measures will be tracked that include, percentage of patients initiated on vasopressors and mean days of vasopressor use, percentage of patients initiated on the mechanical ventilator and mean ventilator days, and initiation of hemodialysis or continuous renal replacement therapy.

Our target population is any patient diagnosis of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl).

Although great work has been done to implement protocols and interventions, utilization and compliance of sepsis resuscitations and management bundles still remains a challenge. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to implement process improvement plan to improve safety and quality for those patients with sepsis. We will:

1. Achieve 90% compliance with the sepsis resuscitation and management bundles in patients admitted to the ICU.
2. Substantially improve early sepsis identification, reduce sepsis-related mortality by 25% from baseline
3. Effective and fully implemented measurement and reporting system supporting compliance with the sepsis resuscitation and management bundles.
4. Continue to work with Emergency Medical Services to improve the delivery of care provided to patients with suspected infection
5. 5.Improve identification of sepsis patient's housewide by implementing nursing admission screening and shift assessments for sepsis screening
6. Improve identification of sepsis, compliance from TBD with current sepsis resuscitation and management bundles in the emergency department.

This project meets the following Regional goals:

This project supports the Regional goals to improve the patient care experience, health outcomes for the population and the per capita cost of care. Specifically, this project will improve the early diagnosis of patients with severe sepsis and septic shock so that evidence-based care can be delivered. Improved recovery of patients with severe sepsis and septic shock will reduce unnecessary death and harm and reduce cost of post hospital care in addition to quality-adjusted life gained.

Challenges:

According to 2007 CDC statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic

shock, each year, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Proactive analysis of the contributing factors contributing to the design of evidence-based standardized care sets and subsequent adoption of those tools will contribute greatly to reducing variation and associated cost. Early recognition and management of sepsis results in lives saved.

5-Year Expected outcome for Provider and Patients:
We expect to reach 100% compliance in identification/diagnosing of patients with severe sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl). We also expect to be 90% compliance with application of the sepsis bundles for patients who meet specified criteria.

Starting Point/Baseline:
The number of patients with severe sepsis, septic shock and/or lactate>4mmol/L (36mg/dl) that would qualify for sepsis resuscitation and management bundles based on expected sepsis claims from similar size hospital and mature sepsis programs would be 180 to 210 per year for a total of 837 patients over course of the waiver. Active implementation of sepsis resuscitation and management bundles and data collection is beginning in 2012 (DY 1). Only an estimate 58 patients were diagnosed and treated for sepsis with the initiation of the program in DY 1. However, the number of patients with severe sepsis, septic shock and/or lactate>4mmol/L (36mg/dl) that would qualify for sepsis resuscitation and management bundles has not been determined since hospital is not implementing with the program with much success . Early data collection indicates compliance with sepsis bundles is a low as 50%.

Rationale:
According to CDC 2007 statistics, septicemia is the 10th leading cause of death in the United States. The eighth leading cause of death is influenza and pneumonia combined, and pneumonia is a leading source of severe sepsis and septic shock. Septicemia, influenza, and pneumonia deaths in 2007 contributed to over 80,000 deaths. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. In the United States, there are approximately 750,000 new cases of sepsis, which includes diagnoses of severe sepsis and septic shock, each year, and mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Our internal data shows a mortality rate as high as 60%. Identification and treatment protocols have been developed and implemented to impact mortality and ICU LOS which has improved. We are in the early stages of implementation of the program components and we still face the challenge of successful implementation. Also, additional interventions will be implemented in the future (shift assessments on all in-house patients, etc.). To be successful we need to work on eliminating/correcting processes that create time delays, non adherence to order set and, failure

to identify/diagnose sepsis. We have been as low as 50% in compliance in implementing sepsis bundles. We believe in order to continue to see improvement from initial implementation, continuous quality improvement through data collection, analysis and review will accelerate change through our multidisciplinary teams.

Project Components:
The project components to report metrics number of patient's diagnosis correctly and for sepsis bundle compliance are necessary to measure the success of implementing the sepsis improvement plan.

A sepsis improvement plan must have key elements to be successful. A project plan is necessary to identify and engage all stakeholders (ED, inpatient units, EMS), understand current status, resources, baselines, roles and responsibilities, expectations of individuals and outcomes. In order to have an impact on reduction in mortality and average length of stay, compliance with sepsis diagnosis and protocols for sepsis bundles are critical. In implementation, it is necessary to examine the plan, understand what is working and what is not, identify barriers and make corrective action. Continuous quality improvement (CQI) activities will be conducted to ensure successful implementation. In DY2 and DY 3, milestones to implement a program to improve efficiencies and/or reduce program variation are essential to the success of sepsis program. The practice strategy for PDSA and CQI will be a Lean Six Sigma DMAIC approach. A Value Stream Mapping will allow us to document the current state of the program implemented in 2012. The Value Stream Mapping and metric results will determine where variation exits and which processes are constraints to the success of the program. This will help us identify the priority for processes improvement events to be conducted. The team will conduct events utilizing tools to find root causes of variations or process delays. Changes will be implemented with appropriate tools to update the program process. To sustain results of changes implemented, audits at 6 months and 12 months will be utilized for each process improvement event. Each year a Value Stream Mapping can be utilized to validate change, document current state and continue the cycle of process improvement.

Unique community need identification numbers the project addresses:

- CN 11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Sepsis resuscitation and management bundle program kicked off in 2012 as a hospital-specific program. Applying process improvement methodologies to the sepsis program will greatly enhance the chances of success in implementing the plan and seeing reduction in mortality and average length of stay.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/ Rationale for Selecting the Outcome Measures:
We are implementing a standardized, evidence-based program for early detection and resuscitation of patients with severe sepsis and septic shock to reduce unnecessary death and harm attributable to sepsis. Continuous quality improvement through data collection, analysis and review will be the basis for accelerating change through multidisciplinary teams.

IT-4.8 Sepsis mortality (Stand-alone measure)

By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early treatment and decrease length of stay, reduce health care cost and mortality. Institute for Healthcare Improvement; Surviving Sepsis Campaign; Society of Critical Care Medicine; IDSA Guidelines for appropriate antibiotic selection.

IT-4.9 Average length of stay (Non-stand-alone measure)

By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early treatment and decrease complications with resulting length of stay in ICU and overall LOS.

Relationship to Other Projects:
This project supports the population-focused improvements 094193202.4.4, RD-3 Potentially Preventable Complications (PPCs). Improved quality with evidence-based care for sepsis increases education, training, and screening that will reduce preventable complications in the hospital setting.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
The following providers are also proposing projects to address sepsis resuscitation and management improvement:

- JPS
- North Hills Hospital
- Medical Center of Arlington
- Huguley Memorial Medical Center
- Texas Health Harris Methodist HEB

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new

learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Plaza Medical Center Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Plaza Medical Center Fort Worth defined the population that will be directly impacted by the project as patients diagnosed with sepsis. . There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The percentage of the population expected to be positively impacted by the project for mortality is 3.5%, which was determined based on outcome target for reduction in mortality by 25% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 31. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $315,000 for 5 years.
The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 8.7 days per patient. This was estimated at total of reduced in patient days by DY 5 of 1017. The estimated cost per day for a sepsis patient is $750. This totaled approximately $763,000.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $315,000.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 1. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $152,685.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.

This value was estimated as a proportion of mortality reduction at $252.000.
To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $145,385.

The total value of the project then was estimated at $1,943,133. Approximately 79% of the total value was assigned to Category 2 project and the remaining 6.3% of value assigned to Category 3 outcome for Sepsis Mortality and 14.69% assigned to Category 3 outcome for reduced Average Length of Stay.

094193202.2.2	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE-BASED INTERVENTION THAT WILL LEAD TO REDUCTIONS IN SEPSIS COMPLICATIONS***	
Plaza Medical Center Fort Worth				*094193202*
Related Category 3 Outcome Measure(s):	*094193202.3.2* *094193202.3.3*	*3.IT-4.8* *3.IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
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.1]: Documentation of Sepsis Improvement Plan Baseline/Goal: Plan Data Source: Plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $95,537 **Milestone 2** [P-6.]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events Baseline/Goal: Implement Data Source: Plan Milestone 2 Estimated Incentive Payment *(maximum amount):* $95,537 **Milestone 3** [P-X]: Participate in a learning collaborative	**Milestone 5** [P-6]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events (Documentation of all steps conducted in the PDSA) Baseline/Goal: Develop a sepsis improvement plan Data Source: Plan Milestone 5 Estimated Incentive Payment: $130,283 **Milestone 6** [I-13.1]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal: Improve compliance to 50%, 95 cases on bundle Data Source: EHR Milestone 6 Estimated Incentive Payment: $130,283 **Milestone 7** [I-13]: Progress toward target/goal (Compliance with correct		**Milestone 8** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1] Number or percent of all clinical cases that meet target/goal Goal: Improve compliance to 70%, 140 cases on bundle Data Source: EHR Milestone 8 Estimated Incentive Payment: $209,058 **Milestone 9** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance by 20% from baseline Data Source: EHR Milestone 9 Estimated Incentive Payment: $209,058	**Milestone 10** [I-13]: Progress toward target/goal (Compliance with use of Sepsis Bundle) Metric 1 [I-13.1.1]: Number or percent of all clinical cases that meet target/goal Goal : Improve compliance to 90% , 190 cases on bundle Data Source: EHR Milestone 10 Estimated Incentive Payment: $172,700 **Milestone 11** [I-13]: Progress toward target/goal (Compliance with correct timely diagnosis of Sepsis) Metric 1 [I-13.1.2]:Number or percent of all clinical cases that meet target/goal Goal : Improve Sepsis Diagnosis Compliance by 25%from baseline Data Source: EHR Milestone 11 Estimated Incentive Payment: $172,700

094193202.2.2	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE-BASED INTERVENTION THAT WILL LEAD TO REDUCTIONS IN SEPSIS COMPLICATIONS***	
Plaza Medical Center Fort Worth				*094193202*
Related Category 3 Outcome Measure(s):	*094193202.3.2* *094193202.3.3*	*3.IT-4.8* *3.IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
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)**
Metric 1 [P-X.1]: Submit report for Sepsis Improvement Plan findings Baseline/Goal: Annual conference Data source: Conference meeting attendance and minutes Milestone 3 Estimated Incentive Payment *(maximum amount):* $95,537 **Milestone 4** [P-X]: Establish baseline, in order to measure improvement over self (for correct timely diagnosis of sepsis and bundle compliance) Metric 1 [P-X]: Conduct assessment of targeted population Baseline/Goal: Percent compliance with correct timely diagnosis of sepsis Data source: EHR Metric 2 [P-X]: Conduct assessment of targeted population Baseline/Goal: 2011 Sepsis Bundle compliance 0% Data source :EHR	timely diagnosis of Sepsis) Metric 1 [I-13.1.2]: Number or percent of all clinical cases that meet target/goal Goal: Improve Sepsis Diagnosis Compliance by 15% from baseline Data Source: EHR Milestone 7 Estimated Incentive Payment: $130,283			

094193202.2.2	*2.8.11*	***N/A***	***IMPLEMENT AN INNOVATIVE AND EVIDENCE-BASED INTERVENTION THAT WILL LEAD TO REDUCTIONS IN SEPSIS COMPLICATIONS***	
Plaza Medical Center Fort Worth				*094193202*
Related Category 3 Outcome Measure(s):	*094193202.3.2* *094193202.3.3*	*3.IT-4.8* *3.IT-4.9*	*Sepsis Mortality* *Average Length of Stay*	
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 4 Estimated Incentive Payment *(maximum amount):* $95,537				
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $382,148	Year 3 Estimated Milestone Bundle Amount: $390,849		Year 4 Estimated Milestone Bundle Amount: $418,116	Year 5 Estimated Milestone Bundle Amount: $345,400
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,536,513				

Project Summary
Project Option 2.8.4 – Reduction in 30-day Hospital Readmission Rates (Potentially Preventable Readmissions) [CHF Project]

Unique Project ID: 109574702.2.1
Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702

Huguley Memorial Medical Center is a 213 bed acute care hospital serving southern Tarrant and northern Johnson counties with two intensive care units, progressive care unit, open heart surgery center, behavioral health center and emergency department available 24 hours a day, seven days a week. More than 350 primary care and specialty care physicians provide a wide range of inpatient and outpatient services.

As a non-profit faith-based health care provider, we have a unique concern for the poor and vulnerable in our community. Of the patients we serve, 12% are uninsured and 15% have Medicaid coverage.

This CHF Project intervention is new and targets any patient with a primary or secondary diagnosis of heart failure. The project incorporates performance improvement methodologies and evidence-based interventions to decrease 30-day readmissions through medication management, weight monitoring and dietary education/management and appropriate primary care placement and follow-up.

For 2011 our CHF 30-day all cause readmission rate was 21% (350 inpatients with CHF diagnosis with 73 all cause readmissions). We expect to serve and impact 1,750 CHF patients with this project over the Waiver period, many of whom will be uninsured or have Medicaid coverage.

Many of the uninsured or Medicaid patients we serve are lacking in resources and awareness specific to how they can positively impact their health status. This involves engaging in follow-up activities to include filling and taking their prescriptions, following diet and weight management plans developed by the hospital dietitian, and engaging in follow up care with their primary care provider. Often, these critical components in restoring and maintaining good health are ignored due to financial or logistical limitations that for the time, may be beyond the patients control.
The CHF Project seeks to provide the above counseling, coaching, and intervention to 100 patients in DY4 and 200 patients in DY5.

Our goal is to reduce the 30-day potentially preventable all-cause readmission rate from 21% to 15% by DY5.

Project Option 2.8.4 – Reduction in 30-day Hospital Readmission Rates (Potentially Preventable Readmissions) [CHF Project]
Unique Project ID: 109574702.2.1
Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702

Project Description:
Project Area: Apply Process Improvement Methodology to Improve Quality/Efficiency
Project Intervention: Reduction in 30-Day Hospital Readmission Rates (Potentially Preventable Readmissions)

The CHF Project is the implementation of an innovative and evidence-based intervention that will lead to reductions in 30-day readmissions for our hospital.

The project will be initiated with a Plan Do Study Act (PDSA) initiative that will involve the following activities:

- Identify and prioritize areas and processes to be improved upon
- Identify the target and metrics for measuring the impact of the process improvements
- Comparing and analyzing data specific to the target area for improvement in outcomes
- Identification of operational procedures for improvement of overall efficiencies in care management
- Training of providers and staff
- Interaction with other RHP providers engaged in the same areas and interventions

Post-acute patient monitoring might include:

- Obtaining prescription medications for patients who cannot afford them
- Providing a scales to patients who may not own one to allow them to properly and consistently monitor their weight
- Engaging the assistance of a dietitian to provide education on the appropriate diet
- Assisting the patient with securing a primary care physician
- Assisting the patient with securing transportation to follow up appointments in the event transportation is a barrier
- Collaborating with the Area Agency on Aging (United Way) – helping fill gaps identified above

Goals and Relationship to Regional Goals:
Project Goals:
The goal of the project is to improve delivery of care to the underserved, including those with government-funded insurance, the uninsured and undocumented patient population that we serve from Southern Tarrant and Northern Johnson counties, resulting in improved management of their CHF with a corresponding reduction in readmissions to the hospital.

The Center for Medicare and Medicaid Services has identified readmission rates for CHF patients as an area of focus and we are required to monitor and report to CMS on this statistic.[viii] In addition, our corporate ownership has made reducing readmission rates for CHF a priority. This project meets the following Regional goals:

A major goal of Region 10 is to improve the quality and efficiency of care that is delivered to the uninsured, underinsured and economically disadvantaged population in our service area. This population is often less prepared and able to effectively combat the challenges associated with a disease such as CHF.

This project will focus on hospital care, discharge education and postdischarge follow-up in order to ensure this target patient population is well positioned to respond proactively to changes necessary to avoid readmission.

Challenges:
Many patients are affected by the following circumstances which create a unique challenge to implementing this project successfully:

- Lack of understanding and education specific to their disease and how they can play a role in self-managing it
- Lack of adequate financial resources to fully engage in the postacute follow-up activities prescribed by their physician
- General compliance – some of these patients enter the postacute environment and are clear and up-front in their resolve to ignore specifically prescribed postacute follow-up activities prescribed by their physician
- Owning a scale to weigh themselves
- Having adequate transportation to get to appointments or retrieve medications
- Affording prescription medication
- Having a consistent and continuous relationship with a primary care physician such that there is the opportunity for ongoing, consistent care coordination
- Lack of understanding and financial resources for basic quality nutrition habits that positively contribute to improvements in their disease

5-Year Expected Outcome for Provider and Patients:
Improved health of patients with CHF as evidenced by a 20% reduction in hospital 30-day, all-cause readmission rates by the end of the five year period.

Starting Point/Baseline:

For 2011 our CHF 30-day all-cause readmission rate is 20.96% (350 inpatients with CHF diagnosis with 73 all-cause readmissions.)

Rationale:

The target population includes individuals with a diagnosis of heart disease who are at risk for readmission due to inadequate monitoring or management of their chronic disease, specifically, CHF patients in our community who are underserved, , and/or beneficiaries of government-funded insurance .

In a 2011 report, patients admitted for congestive heart failure (CHF) had the highest number of readmissions of 22.6%. Heart failure was also the number one reason for readmission for both the Medicare and uninsured patient. There were 13,272 hospitalizations in North Texas of heart failure patients who were followed by readmissions in 2011.[ix]

Project Components:

- In 2004 alone, Medicare heart failure readmissions totaled 17.4 billion dollars and heart failure was the number one cause of readmissions for both medical and surgical discharges.[x]
- It is estimated that 1 million heart failure patients are re-hospitalized each year.[xi]
- Successful efforts to reduce preventable admission rates will improve quality of care and simultaneously decrease costs.[xii]
- Peer-reviewed evidence-based literature supports that post-discharge care – including pre-discharge planning, home based follow-up and patient education – has shown to lower heart failure readmission rates.[xiii xiv xv xvi xvii xviii]
- Our milestones measure an increased population receiving chronic care management through proven, effective model of care: (1) we are establishing a multidisciplinary team approach for identification of/intervention with patient at risk for readmission, patient education and post-acute monitoring and (2) we are improving quality of life while decreasing cost of care as evidenced by decreasing the number of patients requiring readmission to the hospital within 30 days of discharge. The metrics will look at those aspects in the care that best serves our population and prevents readmissions.
- Huguley will incorporate CQI by conducting Plan, Do, Study, Act (PDSA) cycles and process improvement evaluations.

Unique community need identification numbers the project addresses:

CN 11 – Need for more care coordination

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

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/ Rationale for Selecting the Outcome Measures:

IT-3.2 Congestive Heart Failure 30-day readmission rate (Stand-alone Measure)

- Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index heart failure admission. If an index admission has more than 1 readmission, only the first is counted as a readmission.
- Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of heart failure and with complete claims history for the 12 months prior to admissions.

Relationship to Other Projects:

- **Describe the related Category 1 and 2 projects** with the unique RHP project identification number based on the requirements above: n/a

- **Describe the related Category 4 population-focused improvements** with the unique RHP project identification number based on the requirements above: 4.2.1 Congestive Heart Failure (HF): 30-day readmissions

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $9,203 in cost is saved by the health care system.[173] The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).

[173] Texas Department of State Health Services with a 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.
- **Individual benefits** were calculated using lost wages, caretaker expense and extension of life (if applicable).

109574702.2.1	***2.8.4***		***REDUCTION IN 30-DAY HOSPITAL READMISSION RATES (POTENTIALLY PREVENTABLE READMISSIONS) [CHF]***	
Huguley Memorial Medical Center				*109574702*
Related Category 3 Outcome Measure(s):	***109574702.3.1***	*IT 3.2*	*Congestive Heart Failure 30-day readmission rate (Stand-alone 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]: 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. Baseline/Goal: Submission of Performing Provider Report Data Source: Program Description Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,677 **Milestone 2** [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 of metric and baseline. Baseline/Goal: Identify the target metric for measurement. Data Source: Performing Provider Plan and Program Description Milestone 2 Estimated Incentive Payment $12,677	**Milestone 7** [P-12]: Report findings and learnings Metric 1 [P-12.1]: Final report/report summary Baseline/Goal: Submission of report Data Source: All data sources used for the process improvement events Milestone 7 Estimated Incentive Payment *(maximum amount):* $24,549 **Milestone 8** [P-15]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At face-to-face meetings, 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-15.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.		**Milestone 10** [I-13]: Progress toward target/goal. Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal. Numerator: Number of relevant clinical cases at target Denominator: Total number of relevant clinical cases Baseline/Goal: 2% points improvement over prior year Data Source: Performing provider information systems Milestone 10 Estimated Incentive Payment: $77,677	**Milestone 11** [I-13]: Progress toward target/goal. Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal. Numerator: Number of relevant clinical cases at target Denominator: Total number of relevant clinical cases Baseline/Goal: 2% points improvement over prior year Data Source: Performing provider information systems Milestone 11 Estimated Incentive Payment: $62,720

109574702.2.1	*2.8.4*		*REDUCTION IN 30-DAY HOSPITAL READMISSION RATES (POTENTIALLY PREVENTABLE READMISSIONS) [CHF]*	
Huguley Memorial Medical Center				*109574702*
Related Category 3 Outcome Measure(s):	***109574702.3.1***	*IT 3.2*	*Congestive Heart Failure 30-day readmission rate (Stand-alone 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 3 [P-3]: Compare and analyze clinical/quality data, and identify at least one area for improvement. Metric 1 [P-3.1]: Analysis and identification of target area Baseline/Goal: Identification of specific target area for improvement Data Source: Analysis and Performing Provider Plan Milestone 3 Estimated Incentive Payment *(maximum amount):* $12,677 **Milestone 4** [P-4]: Define operational procedures needed to improve overall efficiencies in care management. Metric 1 [P-4.1]: Report on at least two new operational procedures needed to improve overall efficiencies in care management. Baseline/Goal: Submission of analysis findings/summary Data Source: Performing Provider Report Milestone 4 Estimated Incentive Payment *(maximum amount):$* 12,677	Baseline/Goal: 100% participation in face-to-face learning with other providers Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 8 Estimated Incentive Payment: $24,549 **Milestone 9** [I-13]: Progress toward target/goal. Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal. Numerator: Number of relevant clinical cases at target Denominator: Total number of relevant clinical cases Baseline/Goal: 2% points improvement over baseline Data Source: Performing provider information systems Milestone 9 Estimated Incentive Payment: $24,551			

109574702.2.1	*2.8.4*		*REDUCTION IN 30-DAY HOSPITAL READMISSION RATES (POTENTIALLY PREVENTABLE READMISSIONS) [CHF]*	
Huguley Memorial Medical Center				*109574702*
Related Category 3 Outcome Measure(s):	***109574702.3.1***	*IT 3.2*	*Congestive Heart Failure 30-day readmission rate (Stand-alone 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 5 [P-8]: Train providers/staff in process improvement Metric 1 [P-8.1]: Number of emergency department providers/staff trained Numerator: Number of providers/staff trained Denominator: Total number of providers/staff Baseline/Goal: 90% of Intensive Care Unit, Progressive Care Unit, and Unit 400 (CDU) staff trained Data Source: Performing Provider Training Records Milestone 5 Estimated Incentive Payment: $12,677 **Milestone 6** [P-15]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At face-to-face meetings, all providers should identify and agree upon several				

109574702.2.1	***2.8.4***		***REDUCTION IN 30-DAY HOSPITAL READMISSION RATES (POTENTIALLY PREVENTABLE READMISSIONS) [CHF]***	
Huguley Memorial Medical Center				*109574702*
Related Category 3 Outcome Measure(s):	***109574702.3.1***	*IT 3.2*	*Congestive Heart Failure 30-day readmission rate (Stand-alone 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)**
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-15.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: 100% participation in face-to-face learning with other providers Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting notes. Milestone 6 Estimated Incentive Payment: $12,681				
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $76,066	Year 3 Estimated Milestone Bundle Amount: $73,649		Year 4 Estimated Milestone Bundle Amount: $77,677	Year 5 Estimated Milestone Bundle Amount: $62,720
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $290,112				

Project Option 2.8.11– Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications (sepsis resuscitation bundle)

Unique Project ID: 109574702.2.2
Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702

Huguley Memorial Medical Center is a 213 bed acute care hospital serving southern Tarrant and northern Johnson counties with two intensive care units, progressive care unit, open heart surgery center, behavioral health center and emergency department available 24 hours a day, seven days a week. More than 350 primary care and specialty care physicians provide a wide range of inpatient and outpatient services.

As a non-profit faith-based health care provider, we have a unique concern for the poor and vulnerable in our community. Of the patients we serve, 12% are uninsured and 15% have Medicaid coverage.

The sepsis resuscitation bundle project is new and initially targets any patient who presents in our emergency department with sepsis, symptoms of sepsis, or a potential diagnosis of sepsis. By DY4, the sepsis resuscitation bundle will be implemented and applied to all patients who access care at our hospital with sepsis. The project incorporates performance improvement methodologies and evidence-based interventions to implement the sepsis resuscitation bundle earlier in the care and treatment of the patient and in so doing, reduce both mortality and length of stay for patients with sepsis.

We expect to serve at least 2,000 patients with this project over the Waiver period. In 2011 alone, 28% of our patients diagnosed with sepsis were self-pay. With the implementation of the sepsis resuscitation bundle, all sepsis patients will benefit; however, a large number of them will be uninsured or have Medicaid coverage.

The sepsis resuscitation bundle project focuses on early detection of sepsis or symptoms exhibited by septic patients, and then to implement the complete bundle within 6 hours of sepsis identification. This initiative is expected to positively impact 200 patients in DY3, 300 patients in DY4, and 400 patients in DY5.

Our goal is to implement the sepsis resuscitation bundle 85% of the time for all sepsis patients, and reduce the sepsis mortality rate by 15% by DY5.

Project Option 2.8.11– Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications (sepsis resuscitation bundle)

Unique Project ID: 109574702.2.2
Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702

Project Description:
This project incorporates the development and implementation of an evidence-based early detection and treatment plan for patients with sepsis (sepsis resuscitation bundle). Specific symptoms will be identified as target symptoms and when those are exhibited it triggers the use of the sepsis resuscitation bundle (bundle) for the patient. When sepsis remains undetected for a period of time, the likelihood of complications and increased risk of mortality increases rapidly.

The project will incorporate a sepsis team that will monitor results for the project and will report those results to key stakeholders including physicians, staff, governing board, the Learning Collaborative members, and the community

Goals and Relationship to Regional Goals:
Project Goals:
The goal of the project is to develop and implement an evidence-based bundle to ensure faster and more appropriate treatment of underserved patients including those with government-funded insurance, the uninsured and undocumented patients with identified sepsis in our hospital. This project will be initiated in the emergency department (ED) and will subsequently be incorporated in the treatment of inpatients.

We will initiate Plan Do Study Act (PDSA) in order to determine specific process opportunities and set the course for the project. We will employ continuous quality improvement through the comparing and analyzing clinical quality day and deploy action plans for improvement for identified issues.

The goal by DY5 is to achieve 90% compliance with the identification of sepsis and the application of the sepsis resuscitation bundle for our ED patients who meet the specified criteria thereby improving efficiency and reducing program variation.

The goal by DY5 is to achieve 80% compliance with the identification of sepsis and the application of the sepsis resuscitation bundle for our inpatients who meet the specified criteria thereby improving efficiency and reducing program variation.

Meeting this goal will improve the health outcomes of the patients we serve from Southern Tarrant and Northern Johnson counties, ultimately reducing sepsis-related complications and mortality.

This project meets the following Regional goals:

Region 10 is committed to improving the patient experience, reducing the cost of care and reducing mortality rates. Implementation of the sepsis resuscitation bundle will have a positive impact on all goals.

Challenges:

To effectively improve the health outcomes of the underserved, government-funded insurance and undocumented patient populations we serve through implementation of the sepsis resuscitation bundle, we must:

- Increase the speed and accuracy of early detection of the septic patient;
- Educate and train physicians and staff related to the early identification and treatment of sepsis;
- Change physician and clinician practice habits related to the treatment of sepsis;
- Work with all health care disciplines for a teamwork approach for the identification and treatment of this disease process;
- Educating the community on early detection and treatment of the infection process.

5-Year Expected Outcome for Provider and Patients:

Our five-year goal is to reduce the number of sepsis-related deaths by 15% and implement the early detection and sepsis resuscitation bundle 85% of the time housewide.

Starting Point/Baseline:

- Jan-Sept 2012 data shows Huguley had 44,189 encounters in our ED of which 244 were diagnosed with sepsis.

- Training will involve 500 clinical staff to include nurses, techs, and physicians.

Rationale:

Reasons for selecting this project option**:**

- Sepsis is the tenth leading cause of death in the U.S.[xix]
- 750,000 new cases of sepsis occur each year with 210,000 fatalities. [xx]
- Estimated $14.6B spent on hospitalization for septicemia in 2008.[2]
- Inflation adjusted cost for septicemia increased 11.9% annually from 1997-2008. [xxi]
- Hospitalizations for sepsis more than doubled from 2000-2008 yet overall hospitalizations remained flat during the period.[xxii]
- Sepsis patient ALOS is 75% longer than other hospital conditions

- Death is eight times more likely for septic patients versus patients with other conditions.[xxiii]
- Surviving septic patients are 50% less likely to be discharged home; 2 times more likely to be discharged to another short term acute care setting and three times more likely to be discharged to a long-term care setting.[5]

Project Components:

- In 2008, the Surviving Sepsis Campaign was initiated, focusing on early recognition and implementation of an early sepsis resuscitation bundle. The implementation of this sepsis resuscitation bundle has been proven to save lives in the U.S.[xxiv]

- The mortality rate of severe sepsis is equal to that of acute MI, is over four times greater than that of breast cancer and is more than five times greater that that of AIDS.

Unique community need identification numbers the project addresses:
CN 11 – Need for More Care Coordination
How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other Federal funding for it.
Related Category 3 Outcome Measures:
Outcome Measures and Reasons/ Rationale for Selecting the Outcome Measures:
IT 4.8 Sepsis Mortality (stand-alone measure)

- Numerator: Number of patients expiring during current month hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.
- Denominator: Number of patients identified that month with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.

Mortality rates from severe sepsis are on a similar scale to lung, breast, and colon cancer, and it is one of the leading causes of death in the intensive care unit. Due to its aggressive, multifactorial nature, sepsis is a rapid killer. Death is common among sepsis patients, with around 30% of patients dying within the first month of diagnosis and 50% dying within six months. The 28-day mortality rate in sepsis patients is comparable to the 1960s hospital mortality rate for patients of acute myocardial infarction (AMI).

The focus on reducing sepsis mortality could have an impact our entire patient population so the benefits are widespread. In 2011, 28% of our patients with a sepsis diagnosis were self-pay so there is a clear opportunity to improve the health of our low-income population.

Relationship to Other Projects:

Related Category 1 and 2 projects with the unique RHP project identification number based on the requirements above: n/a

Related Category 4 population-focused improvements with the unique RHP project identification number based on the requirements above: 4.3.35

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Decreased mortality rate does not bring any direct health care cost savings. Lives saved are utilized to calculate individual and community costs. The total valuation is calculated by summing up individual and community costs.

Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

109574702.2.2	*2.8.11*		*Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications (sepsis resuscitation bundle)*
Huguley Memorial Medical Center			*109574702*
Related Category 3 Outcome Measure(s):	*109574702.3.2* *109574702.3.3*	*IT-4.8* *IT-4.9*	*Apply Process Improvement Methodology to Improve Quality/Efficiency – Sepsis*

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. Baseline/Goal: Submission of Performing Provider Report Data Source: Computerized Physician Order Entry, Electronic Medical Record, PowerPlans Milestone 1 Estimated Incentive Payment *(maximum amount):* $34,976 **Milestone 2** [P-3]: Compare and analyze clinical/quality data, and identify at least one area for improvement. Metric 1 [P-3.1]: Analysis and identification of target area. Baseline/Goal: Submission of analysis findings/summary and identification of target area Data Source: Analysis Milestone 2 Estimated Incentive Payment *(maximum amount):* $34,976	**Milestone 6** [P-6]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events Baseline/Goal: Number of performance improvement events Date Source: Program Description Milestone 6 Estimated Incentive Payment: $42,331 **Milestone 7** [P-8]: Train providers/staff in process improvement Metric 1 [P-8.1]: Number of providers/staff trained Numerator: Number of providers/staff trained Denominator: Total number of providers/staff Baseline/Goal: 90% of Intensive Care, Rapid Response Team and Intensivists trained Data Source: Performing Provider Staff Roster Milestone 7 Estimated Incentive	**Milestone 10** [I-13]: Progress toward target/goal Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal Numerator: Number of relevant clinical cases at target Denominator: Total number of relevant clinical cases Baseline/Goal: 50% improvement in the number of patients utilizing the sepsis resuscitation bundle over baseline Data Source: Performing provider information systems Milestone 10 Estimated Incentive Payment: $178,585	**Milestone 11** [I-13]: Progress toward target/goal Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal Numerator: Number of relevant clinical cases at target Denominator: Total number of relevant clinical cases Baseline/Goal: 25% improvement in the number of patients utilizing the sepsis resuscitation bundle over prior year Data Source: Performing provider information systems Milestone 11 Estimated Incentive Payment: $144,199

109574702.2.2	*2.8.11*		*Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications (sepsis resuscitation bundle)*
Huguley Memorial Medical Center			*109574702*
Related Category 3 Outcome Measure(s):	*109574702.3.2* *109574702.3.3*	*IT-4.8* *IT-4.9*	*Apply Process Improvement Methodology to Improve Quality/Efficiency – Sepsis*

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 3 [P-4]: Define operational procedures needed to improve overall efficiencies in care management. Metric 1 [P-4.1]: Report on at least two new operational procedures needed to improve overall efficiencies in care management. Baseline/Goal: Submission of analysis findings/summary Data Source: Performing Provider Report Milestone 3 Estimated Incentive Payment *(maximum amount):* $34,976 **Milestone 4** [P-8]: Train providers/staff in process improvement Metric 1 [P-8.1]: Number of emergency department providers/staff trained Numerator: Number of providers/staff trained Denominator: Total number of providers/staff Baseline/Goal: 90% of Intensive Care, Rapid Response Team and Intensivists trained	Payment: $42,330 **Milestone 8** [P-12]: Report findings and learnings Metric 1 [P-12.1]: Final report/report summary Baseline/Goal: Submission of report Data Source: All data sources used for the process improvement events Milestone 8 Estimated Incentive Payment *(maximum amount):* $42,330 **Milestone 9** [P-3]: Compare and analyze clinical/quality data, and identify at least one area for improvement. Metric 1 [P-3.1]: Analysis and identification of target area. Baseline/Goal: Submission of analysis findings/summary and identification of target area Data Source: Analysis Milestone 9 Estimated Incentive Payment *(maximum amount):* $42,332		

109574702.2.2	*2.8.11*		*Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications (sepsis resuscitation bundle)*
Huguley Memorial Medical Center			*109574702*
Related Category 3 Outcome Measure(s):	*109574702.3.2* *109574702.3.3*	*IT-4.8* *IT-4.9*	*Apply Process Improvement Methodology to Improve Quality/Efficiency – Sepsis*

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)**
Data Source: Performing Provider Staff Roster Milestone 4 Estimated Incentive Payment: $34,976 **Milestone 5** [P-X] Establish baseline rates Metric 1: Determine baseline rate sepsis Numerator: number of sepsis mortality events Denominator: total number of sepsis cases/diagnosis (current patient volume approximately 290 sepsis patients) Baseline/Goal: Number of patients admitted through the ED with sepsis Data Source: Performing provider EMR Milestone 5 Estimated Incentive Payment: $34,977			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $174,881	Year 3 Estimated Milestone Bundle Amount: $169,323	Year 4 Estimated Milestone Bundle Amount: $178,585	Year 5 Estimated Milestone Bundle Amount: $144,199

109574702.2.2	*2.8.11*		*Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications (sepsis resuscitation bundle)*
Huguley Memorial Medical Center			*109574702*
Related Category 3 Outcome Measure(s):	*109574702.3.2* *109574702.3.3*	*IT-4.8* *IT-4.9*	*Apply Process Improvement Methodology to Improve Quality/Efficiency – Sepsis*

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)**

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $666,988

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.2.1 – Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)
Unique Project ID: 112677302.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302
Provider:
THFW is a 726 bed tertiary care medical center serving all of North Central Texas. THFW is the largest hospital and has the busiest ED in North Central Texas. In 2011, THFW admitted 26, 319 Medicaid patient days (3,976 discharges) and 12,468 Uninsured patient days (2,667 discharges).
Intervention: The goal of this project is to provide seamless care for low income and uninsured residents of Tarrant County living with diabetes to improve health outcomes and self-management competency, prevent unnecessarily reduced quality of life, and decrease inappropriately high reliance on acute and emergent care community resources. Linking diabetes patients that present to the ED or as inpatients to a primary care physician is a new initiative, and could significantly enhance the number of patients who have access to diabetes education and support.
Need of the project: The uninsured and Medicaid beneficiaries with chronic conditions are at the greatest risk of unnecessary disease-related complications and avoidable hospitalizations. Few, if any, of the hospital's low income / uninsured patients with diabetes enroll in available outpatient DSMT programs because the cost is prohibitive and programs require physician referral, pre-registration and payment of fees. Medicaid does not pay for outpatient Diabetes Self-Management training. THFW data indicates that of the patients readmitted within 30 day for diabetes, about 13% have Medicaid and an additional 6% are self-pay or uninsured.
Target population: Our target population is low income / uninsured community members with diabetes who are not currently being managed and are seen frequently in the ED and have multiple admissions. Our 5 year goal is to provide diabetes management resources and education to at least 500 unique patients.
Expected patient benefits: A major goal of the region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to that goal by linking low income / uninsured residents of Tarrant County to a medical home and available Diabetes Self-management Education / Support resources to actively engage them in their self-care and reduce the likelihood of an acute condition that would require ED care and / or inpatient admission.
Category 1 or 2 expected patient benefits: Development of a comprehensive care management program with a formalized multidisciplinary CARE team, combined with development / implementation of a program to assist patients to better self-manage their chronic condition will lead to improved access to care and an increased percentage of patients with self-management goals. These patients, linked to a medical home and actively engaged in their self-care, will experience improved health outcomes and rely less on acute and emergent care community resources. Anticipate serving approximately 100 patients in DY 3 and increasing by 5% annually.
Category 3 outcomes: Diabetes patients who benefit from this program will demonstrate improvement in HbA1c, compared to their initial or baseline value, thereby decreasing the percentage of patients age 18-75 with HbA1c >9%. By providing access to care and assistance in self-management of their disease, risk of admission and readmission is reduced, thereby improving the Diabetes 30 day readmission rate and saving an estimated $8,297 cost for every

inpatient admission avoided. Anticipate improvement in 30 patients in DY 3 and annual incremental growth.

Project Option 2.2.1 – Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)

Unique Project ID: 112677302.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Project Description:
A CARE team of clinical and support staff (such as nurse navigators, diabetes care managers, case managers) will link low-income and uninsured diabetes patients identified through the ED, inpatient stays, or community outreach partnerships to a medical home and diabetes management resources for ongoing coaching and education to help them learn to effectively manage their diabetes and take an active role in reducing the negative toll that diabetes would otherwise have on their lives.

Goals and Relationship to Regional Goals:
Project Goals:
The goal of this project is to provide seamless care for low-income and uninsured residents of Tarrant County living with diabetes to

- improve health outcomes and self-management competency,
- prevent unnecessarily reduced quality of life, and
- Decrease inappropriately high reliance on acute and emergent care community resources.

Our proposed intervention will improve access to diabetes care management support (i.e. a medical home for primary care, lab work, and medication management) and help these people with diabetes better self-manage their disease through education and peer support in an outpatient community-based setting.
This project meets the following Regional goals:
A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project will contribute to achieving that goal by linking low income, uninsured residents of Tarrant County to a medical home and improving access to diabetes self-management education and support in a community-based setting.

Challenges:
Higher than the national average of 8%, 9.7% adults 18 years and older in Texas are diagnosed with diabetes, i.e. (1.8 million adults). Among the elderly population (older than 65 years old), the rate is 23%, and among adults 45-64, the rate is 14%.[174] While chronic conditions are a growing concern for all U.S. populations, the uninsured and Medicaid beneficiaries with chronic conditions are at the greatest risk of unnecessary disease-related complications and avoidable

[174] Texas Behavioral Risk Factor Surveillance System, 2010. Center for Health Statistics, Texas Department of State Health Services.

hospitalizations. Those who are uninsured or without access to appropriate care have been widely reported in clinical research literature as having the greatest difficulty in managing chronic conditions due to lack of a medical home, minimal or no primary care access, limited or no access to medications necessary for disease management, and limited or no access to regular lab work.[175]

One out of 12 adult individuals in Tarrant County has been diagnosed with diabetes. In 2011, 1294 patients presented to the THFW ED with a principal diagnosis of diabetes, and 562 were admitted for inpatient management. In 2011, THFW had 9399 encounters for diabetes listed as a primary or secondary diagnosis. Of those, 1344 were readmitted within 30 days, a rate of 14.2%. Of these readmissions, 13.29% had Medicaid or managed care Medicaid and 5.05% were uninsured /self-pay. YTD 2012, 744 patients have presented to the THFW ED with a primary diagnosis of diabetes, and 326 have been admitted. So far in 2012, THFW has had 7208 encounters for diabetes, with 1010 readmissions within 30 days, a rate of 14.01%. Of these readmissions, 12.97% had Medicaid or managed care Medicaid and 6.63% were uninsured / self-pay. The missing link, coordinated access to resources and self-management education, perpetuates the cycle of avoidable hospitalizations and readmissions.

5-Year Expected Outcome for Provider and Patients:
Our five year goal is to provide diabetes management resources to at least 500 unique patients. Patients referred to our programs will self-select goals that will help them better manage their chronic condition(s) / diabetes.

Starting Point/Baseline:
Some components of this program already exist. THFW offers ADA-recognized diabetes self-management training (DSMT) programs at two sites. These programs are staffed by experienced certified diabetes educators (nurses and dietitians) skilled in facilitating behavior change. Unfortunately, few, if any, of the hospital's low-income, uninsured patients with diabetes enroll in the outpatient DSMT programs because the cost is prohibitive and programs require physician referral, pre-registration, and payment of fees. Medicaid does not pay for outpatient diabetes self-Management training. Additional resources such as the hospital's diabetes support group and the THR Ask-a-Diabetes Educator website are underutilized because both patients and providers are unaware of their existence. Preparation has begun for implementation of a chronic disease self-management program through the faith community. The THFW ambulatory outpatient clinic, staffed by a part-time nurse practitioner, RN, and PCT, provides interim care for low-income/uninsured patients until they can either be seen by their provider postdischarge or find a medical home. More than half of the patients seen in the clinic have diabetes.

[175] See Cardiovascular Disease Risk Among the Poor and Homeless – What We Know So Far by Charlotte A. Jones et. al. Curr. Cardio. Rev. 2009, January; 5(1):69-77; The Centers for Disease Control 2011 National Fact Sheet on Diabetes

Our CARE team will break through these barriers by coordinating access to resources and education. Collaboration with highly skilled nurse case managers in an expanded patient care navigation program will connect at-risk patients with diabetes to a medical home and available outpatient resources to actively engage them in their self-care, and reduce the likelihood of an acute condition requiring ED care and/or inpatient admission.

Rationale:
In the past, our system has focused on providing high-quality inpatient and emergency services. However, technological advances and recognition of the inadequacies of a reactive inpatient-centered system of care, particularly for those living with chronic illness, requires a system make-over in which primary care access is the basis for ensuring ongoing, coordinated care for patients. So that patients can stay healthy and out of the hospital, we have selected this project to link patients to a medical home. Additionally, we have focused this project on a population disproportionately affected by the lack of primary care – economically disadvantaged and underserved adults living with a chronic disease.

Project Components:
Our project includes all the components listed, including

- A clinically-led and mission-driven CARE team, including non-physician health professionals and diabetes care navigators who work together to provide seamless care until program participants are established in a medical home
- Access to team members in person, by phone, or electronically by email or the THR Ask-A-Diabetes Educator website
- Disease-specific education and self-management support designed to increase personal engagement and empower participants to make lifestyle changes to stay healthy and self-manage their chronic condition
- Peer support opportunities in addition to opportunities for participants to become auxiliary support resources for other participants, others within their communities, and members of their families.

These project targets low-income / uninsured community members with diabetes who are not currently being managed who are seen frequently in the ED and who have multiple inpatient admissions. Our milestones measure improvements in access to care resulting from a coordinated approach that links these patients to available resources and education to improve clinical outcomes and reduce avoidable hospital readmissions.

THFW will incorporate CQI by conducting Plan, Do, Study, Act (PDSA) cycles and process improvement evaluations.

Unique community need identification numbers the project addresses:

- CN 8 – Lack of access to health care due to financial barriers (i.e., lack of affordable care)
- CN 11 – Need for more care coordination
- CN 13 – Necessity of patient education programs

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

Linking diabetes patients who present to the ED or inpatients to a primary care physician is a new initiative. This project could significantly enhance the number of patients who have accessibility to diabetic education. This project has not received any other federal funding.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/ Rationale for Selecting the Outcome Measures:

IT-1.10 Diabetes Care: HbA1c poor control (>9%) NQF 0059 (Stand alone measure)

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

- Denominator: Members 18-75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

Data Source: EHR, Registry, Claims, Administrative clinical data

Rationale/Evidence:

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Complications from the disease cost the country nearly $100 billion annually. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

IT-3.3 Diabetes 30-day readmission rate

- Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than one readmission, only the first is counted as a readmission.

- Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Relationship to Other Projects:

- **Related Category 1 and 2 projects:** This project relates to project 2.9.1 Establish/Expand Patient Care Navigation Program. The patient navigation program assists with the identification of at-risk patients who might benefit from closer monitoring. The navigator would refer the patient to the Diabetes Clinic for management of their disease.

- **Related Category 4 Population-focused improvements:** RD.1: Potentially Preventable Admissions RD.1.2: Diabetes Admission Rate should improve for at-risk patients who would not otherwise be able to access care to manage their diabetes. Diabetics whose disease is managed will decrease their risk of developing complications from their disease that would result in hospital admissions. RD 2: 30 Readmission Rate – RD 2.2 Diabetes 30-day Readmissions are Category 3 Outcome Measures selected as an anticipated outcomes to measure the effectiveness of this project. By providing access to care and assistance in self-management of their disease, risk of admission and readmission are reduced

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology:** For every inpatient admission avoided, $8,297 in cost is saved by the health care system.[176] Health care costs are calculated by multiplying $8,297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification**: Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[176] Based on 2011 historical inpatient diabetes admissions data for Texas Health Fort Worth

112677302.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Redesign the Outpatient delivery system to coordinate care for patients with Diabetes*
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 3 Outcome Measure(s):	*130614405.3.4* *130614405.3.5*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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 a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Baseline/Goal: One established diabetes care management program Data Source: Program materials, Program Policies Milestone 1 Estimated Incentive Payment: $127,326 **Milestone 2 [**P-4]: Formalize multidisciplinary teams, pursuant to the chronic care model defined by Wagner, or similar Metric 2 **[**P-4.1]: Increase the number of multidisciplinary teams or number of sites with formalized teams. Baseline / Goal: Implement one	**Milestone 3** [P-11]: Develop and implement program to assist patients to better self-manage their chronic conditions. Metric 3 [P-11.1]**:** Increase the number of patients enrolled in a self-management program. Baseline/Goal: Provide affordable Diabetes Self-Management Programs for uninsured / low-income patients Establish baseline (anticipate 90-100 enrollees). Data Source: Registry Milestone 3 Estimated Incentive Payment: $246,558	**Milestone 4** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project Metric 4 [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: 5% increase in number of unique patients served by the Diabetes CARE team compared to baseline. Data Source: Registry Milestone 4 Estimated Incentive Payment: $130,022 **Milestone 5** [I-18]: Improve the percentage of patients with self-management goals Metric 5 [I-18.1]: Patients with self-management goals Numerator: Patients with self-management goals Denominator: # of patients enrolled in self-management program	**Milestone 6** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project Metric 6 [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: 5% increase in number of unique patients served by the Diabetes CARE team compared to DY4. Data Source: Registry Milestone 6 Estimated Incentive Payment: $104,987 **Milestone 7** [I-18]: Improve the percentage of patients with self-management goals Metric 7 [I-18.1] Percentage of Patients with self-management goals Numerator: Patients with self-management goals Denominator: # of patients enrolled in self-management program

112677302.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Redesign the Outpatient delivery system to coordinate care for patients with Diabetes*	
Texas Health Harris Methodist Hospital Fort Worth				*112677302*
Related Category 3 Outcome Measure(s):	*130614405.3.4* *130614405.3.5*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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)**
Diabetes CARE team @ THFW. Data Source: HR records (job descriptions) Milestone 2 Estimated Incentive Payment: $127,326			Goal: Establish baseline. Data Source: Registry Milestone 5 Estimated Incentive Payment: $130,022	Goal: 5% increase compared to DY4. Data Source: Registry Milestone 7 Estimated Incentive Payment: $104,987
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $254,652	Year 3 Estimated Milestone Bundle Amount: $246,558		Year 4 Estimated Milestone Bundle Amount: $260,044	Year 5 Estimated Milestone Bundle Amount: $209,974
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $971,228				

DSRIP Project Summary: Region 10 Category 2

Project Option 2.2.1 – Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases (Improving Management of Heart Failure (HF))

Unique Project ID: 112677302.2.2
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Provider: THFW is a 726 bed tertiary care medical center serving all of North Central Texas. THFW is the largest hospital and has the busiest Emergency Department in North Central Texas. In 2011, THFW admitted 3,976 Medicaid patient discharges and 2,667 Uninsured patient discharges.
Intervention: The project purpose is to decrease the rate of Heart Failure patient hospital admissions and readmissions. This project will increase the number of Medicaid and unfunded patients than the newly existing clinic is able to serve prior to this initiation of the DSRIP CHF project. It is the expansion of a new but existing initiative.
Need of the project: This project was chosen because at THFW there is a high volume of CHF inpatient admissions (historically between 950 and 1000 annually). It was also identified during care team rounds that a significant number of CHF readmits within 30 days have not been seen by a physician prior to returning. It is the intent of the project to increase the heart patients' ability to manage their own care in collaboration with their providers with a decrease in the rate of readmissions within 30 days and CHF admissions overall.
Target population: The uninsured and the underinsured, and those who do not have current access to a primary or appropriate specialty physician within a 1-2 week period following discharge. Patients will be served by at least 5000 clinic visits and contacts during the course of the waiver.
Expected patient benefits: The expected patient benefits are timely access to a physician post discharge, follow up regarding compliance with discharge medications, diet and other positive lifestyle behaviors, teaching and interventions to promote these behaviors, and post discharge clinic as a bridge to a stable healthcare home.
Category 1 or 2 expected patient benefits: Expand development of program and expand and document interaction types between patient and healthcare team beyond one-to-one visits to include such interactions as group visits, telephone visits, and other interaction types; Develop and implement programs to assist patients to better self-manage their Heart Failure; Increase hours of clinic to increase capacity for visits; Participate in face to face learning seminars at least twice per year with other providers and the RHP to promote collaborative learning and increased performance; Apply Chronic Care Model to Heart Failure (Wagner Chronic Care Model) ; Implement CHF specific or MCC (that includes CHF) Medical Home; Improvement in access to care of patients receiving CHF/chronic care management services using innovative project option; Apply the Chronic Care Model to Heart Failure populations which are prevalent locally.
Category 3 outcomes: Our project goal is to implement programs that will improve the health of patients with heart failure as evidenced at the conclusion of the 5 year time period by a

reduction in Heart Failure hospital admission rate by 5% and 30 day all cause hospital readmission rate by 15%.

Project Option 2.2.1 – Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases (Improving Management of Heart Failure (HF))

Unique Project ID: 112677302.2.2
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Project Description:
Prevention of potentially avoidable heart failure readmissions through improved identification of patients at high risk for readmission and decrease of total annual CHF readmissions, targeted interventions to address specific needs of the individual, and post-acute care monitoring of patient at high risk for readmission. Central to this process is a post-discharge CHF Clinic staffed by an advanced practice registered nurse (APRN). The clinic will also be staffed by an RN and nurse technician to promote optimal functioning. This clinic is not meant to provide long-term continuous care to these patients, but to bridge the gap between discharge and the first available appointment with their own physician or a newly assigned physician. The clinic and the processes in which the staff engage will also help bridge the gap between the inpatient and the outpatient experience and management of the continuum of care. Other areas that the APRN and RN may choose and be able to interact with are post-discharge telephonic assessments and/or some home visits with a care transition coach or clinician in ways that fit the entire spectrum of patient management. Patients released from the hospital setting who are deemed at high risk for not following up with a physician in a timely manner have been identified as a key population to see in this clinic. This is determined while the patient is still in the hospital as either an inpatient or outpatient (e.g., in the ED).

Goals and Relationship to Regional Goals:
Project Goals:
The primary project goal is to improve the health of low-income, underserved HF patients through more effective disease management along the continuum of care with particular emphasis on transitions through the post-acute phase. Goals are to (1) reduce overall need for HF patient hospital admission and (2) reduce HF patient hospital readmissions within 30 days of discharge. The process goals support the operation and expansion of the newly opened Post-discharge CHF Clinic. This area was chosen because at our facility (THFW) there is a high volume of CHF inpatients (historically between 950 and 1,000 a year). It was also identified during care team rounds that a significant number of CHF readmissions within 30 days have not been seen by a physician prior to returning. This is either due to physician offices not being set up to see patients in a timely manner or patients not having resources to access a physician. Both of these issues can be addressed when they come to the Post-discharge HF clinic.

This project meets the following Regional goals:
N/A

Challenges:
We must communicate with physicians to inform them that the purpose of seeing their current patients in the post-discharge CHF clinic is to bridge the gap between discharge and the patient's follow-up visit in the physician's office or clinic. There is no intent to take patients away from their practice. Another challenge is the prevention of missed appointments at the clinic. Some similar clinics in other settings have had as many as 60% of their patients not show up to their first appointment.[177].

5-Year Expected Outcome for Provider and Patients:
The five-year expected metric outcome will be at least a 5% decrease in 30-day readmits. Regional Goals were identified through The "Checkup for Tarrant County," prepared in 2009 from 2008 data, which showed the following demographics related to heart disease: Cardiovascular disease is identified in Tarrant County as having higher rates than in the state or the U.S. This data translates to a need to address high risk for readmit populations within the realm of heart disease, as evidenced by its early inclusion by CMS in disease outcome indicators, specifically congestive heart failure. This report provides further evidence of the need for interventions within the hospital's geographic area, showing areas of poverty within Central and South East Tarrant County, which are also adjacent to the area in which THFW Harris Methodist Hospital is located.

Starting Point/Baseline:
Currently the CHF 30-day readmission rate at Texas Health Fort Worth is 22%

Rationale:
The reasons for selecting the project was the large number of CHF patients seen in this inter-city, tertiary hospital located in an area with a population that has a higher percentage of cardiac disease than the state and national average. This area also has a significant population within the poverty level who are underserved and uninsured.[178]

Project Components:
This option was selected to meet the need for more timely post-discharge follow-up for heart failure patients, the majority of whom are unable to get appointments in less than two weeks or more, do not have medical follow-up due to ability to pay, , and are uninsured or underinsured. The post-discharge CHF Clinic also revisits and reinforces teaching done prior to inpatient discharge, and determines whether the patient and family understand discharge orders and

[177] http://www.the-hospitalist.org/details/article/1409011/Is_a_Post-ischarge_Clinic_in_Your_Hospitals_Future.html.
[178] Parkland Hospital District. Checkup 2008 Trends and Highlights, Prepared for Healthy Tarrant County (2009).

medications. Reinforcement post-discharge enhances retention of dietary and medication information that is so important for patient compliance with lifestyle changes to decrease readmissions.

Our project contains all of the required core components including:

1. Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system
2. Ensure that patients can access their care teams in person, by phone or email
3. Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources
4. Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
5. 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. THFW will incorporate CQI by conducting Plan, Do, Study, Act (PDSA) cycles and process improvement evaluations.

CMS has already identified readmissions of CHF patients within 30 days as an important metric, and it is one that our facility is familiar with regarding gathering data for reporting, tracking our successes and benchmarking ourselves against other facilities. The milestones will track the development and progression of the clinic as it expands to meet the needs of these patients. Our milestones were selected to advance the development of the chronic care management program designed to assist our target population. Milestones include (1) identifying/hiring and training a multidisciplinary team, (2) developing and implementing a plan for the HF clinic based on the Wagner's Chronic Care Model,[179] (3) establishing a multidisciplinary team approach to the identification of and intervention with patients at risk for ineffective management of their HF, (4) collaborating with area health care providers to assure effective management of the high-risk HF patient along the health care continuum, (5) increasing the number of at-risk patients in the program, and (6) implementing interventions key to improving the patient's health (weight monitoring, medication management, self-management), thus reducing risk for hospital admission or readmission. These milestones and metrics will measure the number of patients receiving ongoing chronic care management through an evidence-based, coordinated model (rather than not receiving care, or receiving fragmented care).

Unique community need identification numbers the project addresses:

[179] Wagner Chronic Care Model. http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2.

- CN.1 – Lack of provider capacity
- CN. 3 – Shortage of specialty care
- CN 8 – Lack of access to health care due to financial barriers

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

This plan will enhance our new start-up CHF Clinic initiative. Currently the clinic is open for patient visits three days a week for 4 hours each day. The APRN is part time and the backup staff is an RN and use technician with access to the hospital services and case managers.

Related Category 3 Outcome Measures:

Outcome Measures

- IT-3.2 Congestive Heart Failure 30-day readmission rate (Stand-alone measure)
- IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8 (Stand-alone measure)

Relationship to Other Projects:

- **Related Category 1 and 2 projects**

Related Project(s)	Description of Relationship
.1.21 Expand Primary Care Capacity – THFW Mobile Health Unit	The expanded primary care capacity provided by THFWs Mobile Health Unit Clinics will address issues of access due to health care professional shortage, insufficient or no health care insurance coverage and geography which takes them outside inner city health care facilities.
Diabetic Health Promotion and Management	A large number of heart patients, including CHF patients also have the diagnosis of diabetes, which puts them at greater risk for readmissions. Patients with better control and management of their diabetes will improve their overall health and could decrease readmits.
Establish and Expand Health Care Navigation Systems	The Post-discharge CHF clinic can liaison with this group to provide new medical homes and other services for patients who come in for appointments to this clinic. This may be an avenue to capture services for more patients who can use the navigation services within this related project.

- **Related Category 4 population-focused improvements**: RD.1: Potentially Preventable Admissions RD.1.1: Congestive Heart Failure Admission rate and RD 2: 30 Readmission Rate: RD 2.1 Congestive Heart Failure (HF) 30-day Readmissions is

Category 3 Outcome Measures selected to evaluate the effectiveness of this project. This project also impacts RD.4 Patient-centered Health care: RD.4.2 Medication Management as enhanced inpatient screening and discharge processes will verify completion of medication reconciliation and assist patient in understanding and/or obtaining necessary medications prior to discharge.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $9,203 in cost is saved by the health care system.[180] The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.

Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[180] Texas Department of State Health Services with a 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

112677302.2.2	***2.2.1***		*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*	
Texas Health Harris Methodist Fort Worth				*112677302*
Related Category 3 Outcome Measure(s):	*112677302.3.6* *112677302.3.7*	*3.IT-3.2* *3.IT-2.1*	*Congestive Heart Failure 30-day readmission rate* *Congestive Heart Failure Admission rate (CHF) - PQI #8*	
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-9]: Develop program to identify and manage chronic care HF patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of HF patients identified as needing screening test, preventive tests, or other clinical services Goal: Develop screening process to identify HF patients at high risk for readmission and process to engage them in program/provide necessary services Data source: Patient registry Milestone 1 Estimated Incentive Payment *(maximum amount):* $185,584 **Milestone 2** [P-10]: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits. **Metric 1** [P-10.1]:Implement group visits as part of program curriculum	**Milestone 3** [P-11] : Develop and implement program to assist patient to better self-manage their chronic conditions Metric 1 [P-11.1]: Increase the number of patients enrolled in a self-management program. Goal: 25% of CHF patients in the clinic enroll in the program Data source: Patient registry **Milestone** 3 Estimated Incentive Payment: $**119,790** **Milestone 4 [P-X]**: Increase hours of clinic to increase capacity for seeing patients to better assist them in managing conditions. Baseline/Goal: Increase operating hours by 75% Data source: Internal reports **Milestone** 4 Estimated Incentive		**Milestone 6** [I-17]: Apply the Chronic Care Model to targeted chronic diseases (Heart failure), which are prevalent locally Metric 1 [I-17.1]: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC (Heart Failure) Goal: 50 additional patients Data Source: Registry Milestone 6 Estimated Incentive Payment: $126,343 **Milestone 7** [I-19]: Implement disease-specific or MCC Medical Home Metric 1 [I-19.1]: Use of appropriate medication for specific disease (Heart Failure use of ACEI or ARB) a. Numerator: Number of individuals with heart failure and EF <40% who receive ACEI or ARB b. Denominator: Number of Heart Failure patients appropriate to receive an ACEI or ARB Goal: 80% Data Source: Clinic records	**Milestone 9** [I-17]: Apply the Chronic Care Model to targeted chronic diseases (Heart failure), which are prevalent locally Metric 1 [I-17.1]: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC (Heart Failure) Goal: 75 additional patients Data Source: Registry Milestone 9 Estimated Incentive Payment: $ **102,016** **Milestone 10**[I-19]: Implement disease-specific or MCC Medical Home Metric 1 [I-19.1]: Use of appropriate medication for specific disease (Heart Failure use of ACEI or ARB) a. Numerator: Number of individuals with heart failure and EF <40% who receive ACEI or ARB b. Denominator: Number of Heart Failure patients appropriate to receive an ACEI or ARB Goal: 95% Data Source: Clinic records

112677302.2.2	***2.2.1***		*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*	
Texas Health Harris Methodist Fort Worth				*112677302*
Related Category 3 Outcome Measure(s):	*112677302.3.6* *112677302.3.7*	*3.IT-3.2* *3.IT-2.1*	*Congestive Heart Failure 30-day readmission rate* *Congestive Heart Failure Admission rate (CHF) - PQI #8*	
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)**
by end of DY 2 Baseline/Goal: 10% of patients enrolled will participate in a group visit by end of DY 2. Data Source: EHR tracking patient interactions Milestone 2 Estimated Incentive Payment *(maximum amount):* $185,585	Payment: $119,790 **Milestone 5** [P-16]: 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. Metric 1 [P-16.1]: semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in 2 meeting annually Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes.		Milestone 7 Estimated Incentive Payment: $126,343 **Milestone 8** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option Metric 1 [I-21.4]: Improved compliance with recommended care regimens (Heart Failure: weight monitoring). a. Numerator: Number of individuals with heart failure that have documentation of weight monitoring b. Denominator: Number of Heart Failure patients seen in clinic. Goal: 60% Data Source: Clinic records Milestone 8 Estimated Incentive Payment: $126,343	Milestone 10 Estimated Incentive Payment: $102,016 **Milestone 11** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option Metric 1 [I-21.4]: Improved compliance with recommended care regimens (Heart Failure: weight monitoring). a. Numerator: Number of individuals with heart failure that have documentation of weight monitoring b. Denominator: Number of Heart Failure patients seen in clinic. Goal: 80% Data Source: Clinic records Milestone 11 Estimated Incentive Payment: $102,016

112677302.2.2	***2.2.1***		*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 3 Outcome Measure(s):	*112677302.3.6* *112677302.3.7*	*3.IT-3.2* *3.IT-2.1*	*Congestive Heart Failure 30-day readmission rate* *Congestive Heart Failure Admission rate (CHF) - PQI #8*

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 5 Estimated Incentive Payment: $119,791		
Year 2 Estimated Milestone Bundle Amount:$371,169	Year 3 Estimated Milestone Bundle Amount: $359,371	Year 4 Estimated Milestone Bundle Amount: $379,029	Year 5 Estimated Milestone Bundle Amount: $306,048
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,415,617			

DSRIP Project Summary: Region 10 Category 2

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)

Unique Project ID: 112677302.2.3
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth (THFW) / 112677302

Provider: THFW is a 726 bed tertiary care medical center serving all of North Central Texas. THFW is the largest hospital and has the busiest ED in North Central Texas. In 2011, THFW treated 26,319 Medicaid patients days (3,976 discharges) and 12,468 Uninsured patients days (2,667 discharges).
Intervention: Goals for the project include improved management of patient health care needs resulting in a reduction of inappropriate ED utilization for non-emergent conditions and increased navigation of patients to appropriate health care resources, including establishing a PCP. This project is a new collaborative initiative.
Need of the project: A regional healthcare group exposed many patients who are exploiting hospital emergency services across the county and beyond. Many patients are getting inappropriate and duplicative care inside the Texas Health Resource system and other hospitals, too.
Target Population: In 2011 THFW served 29,736 uninsured outpatient encounters and 24,496 Medicaid outpatient encounters. The patients with the highest utilization of services are the target population. PD navigators could touch 300 patients per month based on utilization numbers from June 2012 cited below under "Rationale."
Expected patient benefits: Professional nurse navigators will help at risk, disadvantaged community members obtain access to preventive, primary and chronic healthcare services in order to more effectively manage their health. ED CM Navigator will coordinate with chronic disease managers in the Diabetic Management Program and the CHF Management Program. Several other acute hospitals in the RHP (JPS, Baylor All Saints, THHEB, THSW and THAM) will also have ED CM Navigator programs. THFW will collaborate intensely with these facilities to manage this complex population. Based on current collaborative engagement with JPS the program:

1. Enrolls patients into the JPS connection
2. Redirects and make appointments for patients at FQHCs
3. Navigates patients to PCP medical homes
4. Refers patients to MHMR services
5. Enlists patients into charity medication services with the pharmaceutical companies
6. Enrolls patients into community services

Expected project / intervention benefit measurement: Reduce emergency department visits for CHF, Diabetes, ESRD, CV/Hypertension, Behavioral Health/Substance Abuse, COPD and Asthma resulting in reduced claims data and revenue loss.

Category 1 or 2 expected patient benefits: Metric 1[P-2.3]: Frequency of contact with care navigators for high risk patients. The need for contact should increase according to the complexity, compliance and health status of the patient.
Category 3 outcomes: 3.IT-9.2 Right Care, Right Setting: ED appropriate utilization (Stand-alone measure) Reduce Emergency Department visits for target conditions CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma. Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management).

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)

Unique Project ID: 112677302.2.3
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth (THFW) / 112677302
Project Description:
Assign highly skilled nurse case managers to lead a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. The project will implement an ED-based case management program to identify patients who are frequent users of the ED and assist them in more effective and appropriate utilization of health care resources. The ED RN case manager /nurse navigator will work with patients and a multidisciplinary health care team to:

- Navigate patients to obtain necessary community resources to meet identified patient needs.
- Facilitate obtaining a PCP or enroll in nurse practitioner run chronic disease management clinic to more effectively manage their disease on an ongoing basis.
- Intervene as necessary to provide education and monitor identified patients postdischarge to encourage compliance with follow-up plan for receiving ongoing care/support for their health care needs.
- Facilitate arrangements for care, as appropriate, at a lower level, such as an outpatient clinic or skilled facility to avoid hospital admission and reduce risk of ongoing utilization of ED for non-emergent care needs.

Goals and Relationship to Regional Goals:
Project Goals:
Goals for the project include a reduction in inappropriate utilization of ED for non-emergent conditions and increase in the navigation of patients to appropriate health care resources, including establishment with a PCP. It is anticipated that improved management of health needs through navigation of these at-risk patients to appropriate resources and to development of an established relationship with a health care provider who can monitor and manage their health on an ongoing basis would reduce the number of potentially avoidable hospitalizations/ED visits and lower overall health care costs.

This project meets the following Regional goals:
A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to achieving that goal by implementing a RN navigator based in the ED to help at risk, disadvantaged community members obtain access to

preventive, primary and chronic health care services in order to more effectively manage their health.

Challenges:
Eighty-five percent of the U.S. health care dollar is spent on people with chronic conditions. Sixty percent of most costly patients have chronic conditions and functional limitations. Patients with two or more chronic conditions and functional impairments spend three times more than patients with two or more chronic conditions and no functional impairments. Patients with two or more chronic conditions and activity limitations were seven times more likely to be among the top 5% most costly patients. Reduce the amount of these patients who show up in the Emergency Department and find lower cost of care centers for patients.

5-Year Expected outcome for Provider and Patients:
Goal is to reduce inappropriate utilization of the emergency department or hospitalization by 5% over the five-year time period.

Starting Point/Baseline:
We have six-years of data with high utilization patients and attempted interventions. This population has no management and frequently uses multiple providers who are unaware of each other causing duplication of services. These patients have multiple health issues which often include a psychiatric diagnosis also. Utilization of the THFW hospital ED has increased 1.7% in patient volume between 2010 and 2011. Estimates for 2012 (109,000 visits) indicate an additional 12.4% increase in volume will be noted from 2011 to 2012.

Rationale:
An analysis of the 8,934 June 2012 THFW ED patient visits indicated that 45.4 % (4020 patients) of the patients presenting for care in the ED were unfunded or Medicaid. Of this unfunded or Medicaid population, 40% (1608 patients) had diagnoses that did not require emergency care, including conditions such as chronic back pain, prescription refills, follow-up exams or dental disorder. Additional diagnoses, such as limb pain or urinary tract infection might have been managed at a lower level of care making the potential avoidable ED admissions even greater.

Project Components:
All required core project components are included in the project:

- Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
- Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
- Connect patients to primary and preventive care.

- Increase access to care management and/or chronic care management, including education in chronic disease self-management.
- 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.
- CQI component is also included in Milestone 3

Our process milestones and metrics advance development of our project to move patients at risk of receiving fragmented care into a program that provides continuity to more effectively manage their disease or obtain care at the appropriate level. This includes participating with other providers in the RHP to continually evaluate and learn how to improve our effectiveness. Milestones/metrics measure an increasing population receiving assistance through the navigator program and include: (1) hiring and training staff including RN case managers to cover the ED 7 days a week who coordinate a multidisciplinary team including social workers, RNs and physicians/nurse practitioners to more effectively address anticipated needs considering both social and clinical (2) developing policies, procedures and data collection tools to effectively run the program and monitor effectiveness to (3) increase the number of patients served under this model by 20% over the five-year period. These milestones and metrics will measure the volume of at-risk patients navigated to receive care at the appropriate level for ongoing management of their health through an effective, coordinated model (rather than receiving fragmented care).

Unique community need identification numbers the project addresses:

- C CN.10 – Overuse of emergency department (ED) services.
- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/rationale for selecting the outcome measures:

IT-9.2 ED appropriate utilization (Stand-alone measure) Reduce Emergency Department visits for target conditions: CHF, Diabetes, ESRD, CV/Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma

Implementation of this project should assist in getting the patient the care they require in the right setting for that care, avoiding unnecessary emergency department visits. (See data discussed in Section 4.a). Studies have demonstrated the effectiveness of establishment with a

PCP and case management/navigation program to improve management of patient health and reduce risk of avoidable readmissions.[181] RN Navigators assist patients in obtaining resources necessary to more effectively manage their chronic condition or maintain their health. The anticipated outcome is improved health with better quality of life and decreased end organ damage. Patients with effectively managed disease will and a dedicated health care provider will have less need to utilize the ED for emergent conditions or to obtain access to health care providers.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**
  - 112677302.1.1: Wellness for Life – Mobile Health Unit
  - 112677302.2.1: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes
  - 112677302.2.2: Prevention of potentially avoidable heart failure readmissions through improved identification of patients at high risk for readmission, targeted interventions to address specific needs of the individual, and post-acute care monitoring of patient at high risk for readmission.
- **Related Category 4 Population-focused improvements**
  - RD1: Potentially Preventable Admissions 1.Congestive Heart Failure Admission Rate; 2. Diabetes Admission Rate; 3. Behavioral Health and Substance Abuse Admission Rate; 4. Chronic Obstructive Pulmonary Disease Admission Rate; 5. Hypertension Admission Rate
  - RD-5 Emergency Department: 1. Admit decision time to ED departure time for admitted patients (NQF 0497)
  - The ED Case Management program will help navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care. Through the navigation of patients to available resources, patient admissions can be avoided increasing the availability of inpatient beds for those in need of hospitalization. Increased bed availability impacts ED patient throughout and improves time for ED patients to receive their inpatient bed.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

[181] Emergency Department Case Management *The Dyad Team of Nurse Case Manager and Social Worker Improve Discharge Planning and Patient and Staff Satisfaction While Decreasing Inappropriate Admissions and Costs: A Literature Review* **Darlene P. Bristow, MSN, RN, CCRN; Charlotte A. Herrick, PhD, RN** Lippincott's Case Management Vol. 7, No. 3, 121-128
Romania, M. The Benefits of an Emergency Department Case Management Program, *The Pennsylvania Nurse*. September 2006 15,33.
Cannon, J. and Feldman, J. Washington State Hospital Association. *Potentially Avoidable Emergency Room Use*. February 2011.

The program would create unified agreement on goals and measurements across the region. CQI's to be measured would be patient enrollment, utilization of a common tool, and tracking patient compliance.

Project Valuation:

- **Approach/Methodology:** For every ED visit avoided, $507 in cost is saved by the health care system.[182] The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** ED visit outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with greater than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.
- **Community benefits** were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[182] Based on 2011 historical ED visits data for Texas Health Fort Worth

112677302.2.3	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Harris Methodist Fort Worth			112677302
Related Category 3 Outcome Measure(s):	*112677302.3.8*	*3.IT-9.2*	*Right Care, Right Setting: ED appropriate utilization (Stand-alone measure) Reduce Emergency Department visits for target conditions CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*

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)**
Milestone1 [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 (and hire the RN case managers to act as) navigators, develop procedures (including data collection mechanism) and establish continuing navigator education Metric 1[P-2.3]: Frequency of contact with care navigators for high risk patients. Data Source: Patient navigation program materials and database, EHR Baseline/Goal: 200 encounters Milestone 1 Estimated Incentive Payment: $986,152 **Milestone 2** [P-5]: Provide reports on the types of navigation services provided to	**Milestone 3** [P-8]: 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. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Attend 2 programs/year Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes.	**Milestone 5** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: 85% of identified patients Data source: Administrative data on patient encounters and scheduling records from patient navigator program Milestone 5 Estimated Incentive Payment: $1,013,932 **Milestone 6** [I-8]: Reduction in ED use by identified ED frequent users receiving navigation Services Metric 1[I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users (program enrollees).	**Milestone 7** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Data source: Administrative data on patient encounters and scheduling records from patient navigator program Goal: 90% of identified patients Milestone 7 Estimated Incentive Payment: $875,261 **Milestone 8** [I-8]: Reduction in ED use by identified ED frequent users receiving navigation Services Metric 1[I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users (program enrollees).

112677302.2.3	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*	
Texas Health Harris Methodist Fort Worth				112677302
Related Category 3 Outcome Measure(s):	*112677302.3.8*	*3.IT-9.2*	*Right Care, Right Setting: ED appropriate utilization (Stand-alone measure) Reduce Emergency Department visits for target conditions CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*	
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)**
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 represents the liaison between primary, secondary, tertiary and quaternary health care. Metric [P-5.1]: Collect and report on all the types of patient navigator services provided. Baseline/Goal: Data collection completed with at least one report produced	Milestone 3 Estimated Incentive Payment: $954,807 **Milestone 4** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: 80% of identified patients Data source: Administrative data on patient encounters and scheduling records from patient navigator program Milestone 4 Estimated Incentive Payment: $954,807		Goal: 5% reduction Data Source: Claims and EHR/registry Milestone 6 Estimated Incentive Payment: $1,013,931	Goal: 20% reduction Data Source: Claims and EHR/registry Milestone 8 Estimated Incentive Payment: $875,261

112677302.2.3	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*	
Texas Health Harris Methodist Fort Worth				112677302
Related Category 3 Outcome Measure(s):	*112677302.3.8*	*3.IT-9.2*	*Right Care, Right Setting: ED appropriate utilization (Stand-alone measure) Reduce Emergency Department visits for target conditions CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*	
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)**
Data Source: Provider developed database Milestone 2 Estimated Incentive Payment: $986,151				
Year 2 Estimated Milestone Bundle Amount: $1,972,303	Year 3 Estimated Milestone Bundle Amount: $1909,614		Year 4 Estimated Milestone Bundle Amount: $2,027,863	Year 5 Estimated Milestone Bundle Amount: $1,750522
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $7,660,302				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.8.11 – Sepsis: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area.
Unique Project ID: 112677302.2.4
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Provider: THFW is a 726 bed tertiary care medical center serving all of North Central Texas. THFW is the largest hospital and has the busiest ED in North Central Texas. In 2011, THFW had 26,319 Medicaid patient days (3,976 discharges) and 12,468 Uninsured patient days (2,667 discharges)
Intervention: Early intervention and treatment of Sepsis patient entering through the ED. This is a new initiative.
Target population: Sepsis patients in hospital's primary service area. Estimated 3200 (based on the 2011 THFW 816 sepsis patients) patients will be served over course of waiver period.
Expected patient benefits: Mortality and length of stay for Sepsis patients will decrease.
Category 1 or 2 expected patient benefits: Milestone 2 [P-2] Identifies and targets metric to measure impact of Performance Improvement methodology and establish baseline. Identification of metric for measurement will guide the improvement process to decrease the length of stay of sepsis patients and mortality. Milestone 3 [P-3] compares and analyzes clinical/quality data and identify at least one area for improvement and establish baseline. CNS will evaluate the data to find the area being missed in the treatment and approach to care when implementing the bundle.
Category 3 outcomes: Process Milestone 2 [P-2] Establishes baseline rates to determine frequency of bundle usage; affecting mortality, and establish baseline. Identifying rates of bundle usage will allow for improvements to increase the rates resulting in better treatment to decrease the mortality and length of stay of patients.

Project Option 2.8.11 – Sepsis: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area.
Unique Project ID: 112677302.2.4
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Project Description:
Early recognition of severe sepsis and septic shock followed by uniform, consistent early implementation of an evidence-based sepsis resuscitation bundle will decrease mortality. In DY2 this project will target the specific workflow and processes (P-1) in the emergency department (ED) focusing on early diagnosis, initial management and prompt transfer to ICU. Once it is identified that a patient has severe sepsis, we need early implementation of the sepsis resuscitation bundle as defined by Surviving Sepsis Guidelines 2012 (IHI) and Dellinger, Surviving Sepsis Campaign International Guidelines for Management of Severe Sepsis and Septic Shock, Critical Care Medicine 2008. Through a PDSA process in DY2, comparisons and analysis of current process will be completed, allowing for operational procedures needing improvement to be identified and defined in conjunction with other departments (laboratory, pharmacy, clinical nurse specialist) (P-3, P-4). In DY3, target metrics will be identified to measure the impact of the process changes, establishing a baseline (P-2) as well as a dashboard for reviewing trends and improvements (P-10). The implementation of a sepsis clinical nurse specialist (CNS) position in DY3 will permit service line ownership of program implementation (P-6) to monitor and communicate process efficiencies. The CNS will be responsible for the training and education of departments involved in the process change (P-8). The project will also allow leveraging the EMR by embedding a sepsis bundle checklist for clinicians (P-6). Dissemination of information (DY4 and DY5) will occur through, but not limited to communication channels of the Critical Care Committee and ED service line meetings.

Goals and Relationship to Regional Goals:
Project Goals:
THFW has already developed an EMR severe sepsis order set based on the above guidelines and has, over the past three years, sponsored various educational programs. However, we have never measured whether the sepsis bundle is consistently used, whether all components of the bundle are implemented, and whether outcomes improve with its use.

This project meets the following Regional goals:
Implementation of and hardwiring an evidence-based sepsis resuscitation bundle has been proven to decrease mortality and morbidity. As such, this project seeks to promote the triple aim of health care reform, namely, to improve clinical outcomes and the patient experience while lowering per capita costs of care.

Challenges:

Since THFW has already focused on early recognition of sepsis and does have a severe sepsis bundle (although it is not known how frequently it is used), we may find that our mortality rate may not drop precipitously or as much as the 25% quoted in the literature, especially since it is well under the national/state rate at an estimated 17.6%.
Additionally, a challenge for the organization will be education of various staff. The turnover of nursing staff in the emergency department will pose a challenge as well, requiring repeated educational events. As well, education of various physicians in differing specialties will be challenging.

5-Year Expected outcome for Provider and Patients:
Our clinical and medical staff will be better informed of necessity for early diagnosis and treatment of sepsis. Implementation and hardwiring of sepsis resuscitation bundle through the use of a CNS will be accomplished. The Sepsis bundle checklist will be embedded in EMR. Mortality secondary to sepsis will decrease from 17.6% to 15.6%. Additionally the length of stay will decrease from 8.4 days to 6.6 days by DY5.

Starting Point/Baseline:
In 2011 approximately 850 patients were seen for a diagnosis of sepsis. An estimated mortality rate of this population at THFW was 17.6%. However, in DY2 a true baseline for the project will be established.

Rationale:
Implementation of and hardwiring an evidence-based sepsis resuscitation bundle has been proven to decrease mortality and morbidity. The state of Texas has mandated that all hospitals ensure that these evidence-based guidelines are implemented. Mortality rates from severe sepsis are on a similar scale to lung, breast and colon cancer, and are one of the leading causes of death in the ICU. Thirty percent of patients die within the first month of diagnosis. Given our increasing number of elderly and chronically ill patients, the incidence of severe sepsis is expected to increase. Elderly patients are at increased risk of sepsis because they are at higher risk of infections secondary to aging, comorbidities, increased institutionalization and increased use of invasive surgical techniques.

Project Components:
We have selected the early implementation of the entire severe sepsis resuscitation bundle because there is overwhelming evidence in peer-reviewed literature that all of them together are considered a best practice. When the timing and sequence are followed, mortality decreases. The resuscitation bundle combines evidence-based tools/goals that must be completed within the first six hours of identification of severe sepsis. The elements include: measuring a serum, lactate, obtaining blood cultures prior to antibiotic administration, broad-spectrum antibiotic within three hours of ED admission and within one hour of non-ED admission, treat hypotension and/or

elevated lactate with fluids; and in the event of persistent hypotension, despite fluid resuscitation and/or lactate >4mmol/liter, maintain adequate central venous pressure and central venous O2 saturation.

Milestones and metrics chosen predicated on our performance improvement model of PDSA and methodology in tracking compliance. The milestones will determine whether we are decreasing mortality, which is the ultimate goal.

THFW will incorporate CQI by conducting Plan, Do, Study, Act (PDSA) cycles and process improvement evaluations.

Unique community need identification numbers the project addresses:

- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project has been internationally and nationally recommended ever since the 2008 Surviving Sepsis provided overwhelming evidence that by implementing the sepsis resuscitation bundle within 6 hours of identifying a patient with severe sepsis or septic shock, mortality rates drop dramatically.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/rationale for selecting the outcome measures:

IT-4.8 Sepsis Mortality (Stand-alone measure)

- Numerator: Number of patients expiring during current-month hospitalization with sepsis, severe sepsis or septic shock, and/or an infection and organ dysfunction.
- Denominator: Number of patients identified that month with sepsis, severe sepsis or septic shock, and/or an infection and organ dysfunction.
- Data Source: Chart abstraction and EPSI evidence has shown that early identification and implementation of a sepsis resuscitation bundle will decrease mortality dramatically. Given the fact that the elderly are more prone to infections and, therefore, severe sepsis and septic shock, and given the fact that many of our elderly have very low incomes, this project will decrease morbidity/mortality.

Potentially Preventable Complications and Health Care Acquired Conditions – **IT-4.9Average length of stay** (will decrease from 8.4 days to 6.6 days).

Relationship to Other Projects:

- **Related Category 1 and 2 projects**
  - 109574702.2.2: Huguley Memorial Medical Center (HMMC) has proposed a similar project. Our intent is to participate in a learning collaborative with HMMC to share best practices and discuss lessons learned.
- **Related Category 4 Population-focused improvements**
  - RD1: Potentially Preventable Admissions 1.Congestive Heart Failure Admission Rate; 2. Diabetes Admission Rate; 3. Behavioral Health and Substance Abuse Admission Rate; 4. Chronic Obstructive Pulmonary Disease Admission Rate; 5. Hypertension Admission Rate
  - RD-5 Emergency Department: 1. Admit decision time to ED departure time for admitted patients (NQF 0497)
  - The ED Case Management program will help navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care. Through the navigation of patients to available resources, patient admissions can be avoided increasing the availability of inpatient beds for those in need of hospitalization. Increased bed availability impacts ED patient throughout and improves time for ED patients to receive their inpatient bed.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

- **Approach/Methodology**: Decreased mortality rate does not bring any direct health care cost savings. Lives saved are utilized to calculate individual and community costs. The total valuation is calculated by summing individual and community costs.
- **Rationale/Justification:** Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

112677302.2.4	*2.8.11*	*Project Components: N/A*	*Apply Process Improvement Methodology to Improve quality/efficiency implementation of the sepsis resuscitation bundle*
Texas Health Harris Methodist Fort Worth Hospital			*112677302*
Related Category 3 Outcome Measure(s):	*112677302.3.9* *112677302.3.10*	*3.IT-4.8* *3.IT-4.9*	*Decrease Sepsis Mortality* *Average Length of Stay*

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 are as to improve. Metric 1 [P-1.1]: Performing Provider review and prioritization of areas or processes to improve upon Data Source: EPIC, EPSi, chart review Milestone 1 Estimated Incentive Payment: $356,754 **Milestone 2** [P-2] Identify/target metric to measure impact of Performance Improvement methodology and establish baseline Metric [P-2.1]: Define timelines for each part of the resuscitation bundle; define data elements to be collected; determine baseline Data Source: Chart review Milestone 2 Estimated Incentive Payment: $356,754 **Milestone 3** [P-3]: Compare and analyze clinical/quality data and	**Milestone 6** [P-6]: Implement a program to improve efficiencies and/or reduce program variation Metric 1 [P-6.1]: Performance improvement events Goal: Hire CNS to guide sepsis service line Data Source: Human Resources, Internal database populated by chart abstraction Milestone 6 Estimated Incentive Payment: $863,538 **Milestone 7** [P-8]: Train providers/staff in process improvement. Metric 1 [P-8.1]:Number of providers/staff trained Goal: TBD based on educational need assessment Data source: Educational class rosters	**Milestone 8** [I-13]: Progress toward target/goal Metric 1 [I-13.1]: Number or percent of severe sepsis or septic shock having entire sepsis resuscitation bundle implemented within 6 hours Goal: 60% over baseline Data Source: Internal database Milestone 8 Estimated Incentive Payment: $910,774 **Milestone 9** [I-16]: Improve quality and efficiency using innovative project option Metric 1 [I-16.1]: Potential improvement in LOS/cost/case if achieve targets on I-13 Goal: 7.2 days (patients receiving bundle) Data Source: EPSI (cost accounting system)/internal database Milestone 9 Estimated Incentive Payment: $910,774	**Milestone 10** [I-13]: Progress toward target/goal Metric 1 [I-13.1]: Number or percent of severe sepsis or septic shock having entire sepsis resuscitation bundle implemented within 6 hours Goal: 70% over baseline Data Source: Internal database Milestone 10 Estimated Incentive Payment: $735,407 **Milestone 11** [I-16]: Improve quality and efficiency using innovative project option Metric 1 [I-16.1]: Potential improvement in LOS/cost/case if achieve targets on I-13 Goal: 6.6 days (patients receiving bundle) Data Source: EPSI (cost accounting system)/internal database Milestone 11 Estimated Incentive Payment: $735,408

112677302.2.4	*2.8.11*	*Project Components: N/A*	*Apply Process Improvement Methodology to Improve quality/efficiency implementation of the sepsis resuscitation bundle*	
Texas Health Harris Methodist Fort Worth Hospital				*112677302*
Related Category 3 Outcome Measure(s):	*112677302.3.9* *112677302.3.10*	*3.IT-4.8* *3.IT-4.9*	*Decrease Sepsis Mortality* *Average Length of Stay*	
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)**
identify at least one area for improvement Metric 1 [P-3.1]:Analysis and identification of target area Data Source: EPIC, EPSi, chart review Goal: Identify 1 -2 improvements to implement Milestone 3 Estimated Incentive Payment: $356,755 **Milestone 4** [P-4] Define operational procedures needed to improve overall efficiencies in care management. Metric 1 [P-4.1]: Report on at least two new operational procedures needed to improve overall efficiencies in care management Data Source: Internal database populated by chart abstraction Milestone 4 Estimated Incentive Payment: $356,755 **Milestone 5**: [P-10]: Develop a quality dashboard that will quantify and determine the quality of care	Milestone 7 Estimated Incentive Payment: $863,538			

112677302.2.4	*2.8.11*	*Project Components: N/A*	*Apply Process Improvement Methodology to Improve quality/efficiency implementation of the sepsis resuscitation bundle*
Texas Health Harris Methodist Fort Worth Hospital			*112677302*
Related Category 3 Outcome Measure(s):	*112677302.3.9* *112677302.3.10*	*3.IT-4.8* *3.IT-4.9*	*Decrease Sepsis Mortality* *Average Length of Stay*

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)**
provided. Metric [P-10.1]: Submission of quality dashboard development, utilization and results. Goal: [P-10.1] completed Data Source: EPSi, EPIC Milestone 1 Estimated Incentive Payment: $356,755			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $**1,783,773**	Year 3 Estimated Milestone Bundle Amount: $**1,727,076**	Year 4 Estimated Milestone Bundle Amount: $**1,821548**	Year 5 Estimated Milestone Bundle Amount: $**1,470,815***
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $6,803,213			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.7.1: Implement Evidence-based Disease Prevention Programs(Mobile Prevention, Early Detection and Transitions Project for Rural Cancer Screenings)
Unique Project ID: 112677302.2.5
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Fort Worth / 112677302

Provider: THFW is a 726 bed tertiary care medical center serving all of North Central Texas. THFW is the largest hospital and has the busiest ED in North Central Texas. In 2011, THFW had 26,219 Medicaid patient days (3,976 discharges) and 12,468 Uninsured patient days (2,667 discharges).
Intervention: To facilitate access to high quality early cancer detection screening services (breast, colon and cervical cancer) to medically underserved counties (excluding Tarrant County) in Region 10 (RHP 10). The proposal utilizes mobile health services and requires the creation of a robust system for facilitating care transition into specialty care, including genetics counseling and primary care through the use of Registered Nurse Patient Navigators as indicated based on initial patient assessment, prevention and cancer screening activities. The established mobile service travels to rural communities 41 times annually, providing an average of 721 digital screening mammograms. Cervical and colorectal (FOBT) cancer screenings, subsequent referral and follow-up to specialty care and the transitional care component to primary care as indicated will be new initiatives.
Need of the project: RHP 10 Counties (excluding Tarrant) have a need for breast, cervical and colon cancer early detection services. Number of women age 40-69 not having a mammogram in past 24 months is 31,942.Number of women age 21 – 64 not having a Pap test in 3 years is 33,271. Number of adults age 50 -64 not having a blood stool test in 2 years is 113,595.
Target population: The following will be targeted for this project: low income, uninsured, culturally and geographically isolated persons in 8 rural counties (Ellis, Erath, Hood, Johnson, Navarro, Parker, Somerville and Wise) of Region 10. Estimated 14,389 patients will be served over course of waiver period.
Expected patient benefits: This project bridges the gap in prevention, early detection and transitional care to primary and specialty care among low income, uninsured, culturally and geographically isolated communities in the rural counties of Region 10. Mobile health services and the key component of using RN Patient Navigators for facilitating care transition into primary and specialty care will improve patient care, foster a healthier community and reduce costs through high quality and culturally competent prevention and early detection cancer screening activities.
Category 1 or 2 expected patient benefits: Development of a system for facilitating care transitions into specialty care and the ability to overcome geographic barriers to reach patients. A network of primary care and specialty providers will also be developed.
Category 3 outcomes:

a. IT-12.1 Breast Cancer Screening (HEDIS 2012)
b. IT-12.2 Cervical Cancer Screening (HEDIS 2012)
c. IT-12.3 Colorectal Cancer Screening (HEDIS 2012)

Project Option - 2.7.1: Implement Evidence-based Disease Prevention Programs (Mobile Prevention, Early Detection and Transistions Project for Rural Cancer Screenings)
Unique Project ID: 112677302.2.5
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Fort Worth / 112677302

Project Description:
The proposal is to create an expansion of the current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service) - to facilitate access to - high-quality early cancer detection screening services to medically underserved counties (excluding Tarrant County) in Region 10 (RHP 10). The cancer screenings that will be performed are screening mammography, cervical cancer screening and colon cancer screening (fecal occult blood test). The proposal requires the creation of a robust system for facilitating care transition into specialty and primary care through the use of RN patient navigators as indicated based on initial patient assessment, prevention and cancer screening activities. There are only 14 screening mammography facilities, one Texas Breast and Cervical Cancer contractor, and only one Federally Qualified Health Center serving a population of 621,895.[1-3] Families living under the federal poverty level range from 8.7% in Wise County to 14.9% in Navarro County. Families headed by females are particularly vulnerable, with poverty rates ranging between 26.2% in Wise County to 37.8% in Erath County. The Hispanic population is the largest minority group in the Region, and now numbers over 100,000 (18%) and is growing.[4] - A network of primary care and specialty care providers will be engaged as collaborators in the targeted geographic areas of Region 10. Patients identified as in need of primary care will be navigated to primary care by the RN Patient Navigator. Patients in need of specialty care as a result of cancer screening will be navigated to specialty care by the RN patient navigator thereby reducing the time to diagnosis of cancer.We propose to dedicate a mobile health team and mobile coach, equipped with digital screening mammography, comprehensive examination room and satellite communications to travel to distant locations delivering lifesaving services and RN patient navigation facilitated - referrals to those without ready access to primary and specialty care. Screening services provided to patients who are eligible for federal funding will not be charged to this project.

Goals and Relationship to Regional Goals:

Project Goals:
An expansion of the current Wellness for Life Mobile Cancer Screening Service (WFL Mobile Service) is proposed to extend the reach of - early cancer detection screening services to medically underserved counties (excluding Tarrant County) in Region 10 (RHP 10). -.The 5-year goals of this project are: 1) to establish an early cancer detection screenings program in targeted geographic areas of RHP 10 through expansion of mobile health services, including the addition of RN Patient Navigation. -. 2.) Establish a collaborative network of primary care providers and specialty care providers in the targeted geographic areas of RHP 10. 3) Establish a tracking

system for efficient patient navigation and follow-up. The proposed program will lead to a system of better health, better care at reduced costs. -**This project meets the following Regional goals:**

The aims of the Region are: better care for patients, better health of communities and reduced cost per capita. This project bridges the gap in primary care and specialty care services; specifically early cancer detection services within communities, where people live, work and worship in rural settings. It addresses economic and geographic isolation barriers to these services. By taking a systems approach in collaboration with Moncrief Cancer Institute and a network of primary and specialty care providers, comprehensive mammography (screening and diagnostic) specialty care and primary care is accessible to rural communities and allows people to be screened and obtain appropriate follow-up care in their communities. Patients in need of primary care are identified and navigated to primary care. Satellite technology systems allow for transferring mammographic images from distant locations.

Challenges:

The counties in RHP 10 are also located in Texas Health Service 03, which is one of two Regions in the state with the highest age-adjusted rates for female breast cancer.[6] Thirty-eight percent of screening mammography-eligible women did not graduate from high school and 40.8% earn less than $25,000 per year.[7] An estimated 63,000 women ages 40-60 do not have health insurance in Tarrant, Parker, Hood and Johnson counties combined. There is a lack of awareness of the availability of low-cost or free screenings. Transportation, scheduling and availability of screening and care are barriers to screening in rural areas and small towns.[5]

Cervical cancer is considered to be a serious threat to Texas women. The rates of women diagnosed with and dying from cervical cancer in Texas are higher than those of the United States overall.[8] Thirty-nine percent of cervical screening-eligible women did not graduate from high school and 33.9% earn less $25,000 per year.[7]

Colorectal cancer is the third most common cancer diagnosed in men and women and the second leading cause of deaths overall. Blacks have the highest incidence and mortality followed by non-Hispanic whites and Hispanics. There are higher colorectal cancer incidence rates in rural counties.[10] Seventy-nine percent of screening-eligible adults for colorectal cancer graduated from high school and 81.9% earn less than $25,000 per year.[9]

This project was selected because a mobile health program is ideally suited to travel to rural communities where specialty cancer screening services are lacking. The project builds on a two-year record of making comprehensive breast health services accessible in rural areas of North Texas.

In 2010, a joint program between Texas Health Resources and Moncrief Cancer Institute created a systems approach to comprehensive breast health services targeting women in rural medically underserved counties (Montague, Denton, Wise, Hood, Johnson and Parker). This program, Breast Screening and Patient Navigation (BSPAN), provides comprehensive mammography (screening and diagnostic), clinical breast examination and appropriate patient navigation services. The BSPAN program leverages various funding sources for eligible patients including federal, state, and non-profit agencies. Between June 2010 and June 2012, the WFL Mobile mammography team performed 1,224 screening mammograms and detected 14 breast cancers through this program. The positive detection rate of 11.4 breast cancers per 1,000 screened patients exceeds the national rate of by 65%.[10]

5-Year Expected Outcome for Provider and Patients:
The five-year expected outcome of this project is to provide early detection breast, cervical and colorectal cancer screenings to eligible participants in RHP 10 (excluding Tarrant County) with a dedicated mobile cancer screening team. The target number of screenings by the end of the Waiver is: 11,298 screening mammograms, 4,752 cervical cancer screenings, and 563 processed fecal occult blood tests. The number of patients navigated to primary care and specialty care will be tracked and reported.

Starting Point/Baseline:
With its current capacity, the established WFL Mobile service travels to rural communities 41 times annually, providing an average of 721 screening mammograms. Cervical and colorectal cancer screenings will be a new initiative in the rural communities for this project. Each year in Tarrant County, the WFL Mobile service performs 500 cervical cancer screenings and distributes 100 fecal occult blood (FOBT) test kits per mobile health team annually. It utilizes two mobile health/mammography coaches and two mobile health teams. A collaborative network of breast health facilities is in the process of being established by Moncrief Cancer Institute in four RHP 10 counties. A collaborative network of primary care and other specialties does not exist and will need to be created. A tracking system for patient navigation and follow-up is limited and will be enhanced through the use of RN Patient Navigators and a new electronic data system.

The project will require a registered nurse patient navigator, community outreach coordinator, data manager, mobile coach admissions/driver, family nurse practitioner and a mammography technologist. Current staffing is 8.2 FTEs and would increase to - 14.2 FTEs with the addition of a third fully equipped mobile coach and support staff.

DY2: Increase capacity with a third mobile health coach and hire/train a third health team. A specialty care gap assessment based on community need will be performed on each of the eight targeted counties in RHP 10. Administrative run-up will be required to establish a collaborative network of primary and specialty care providers in the target area. A community outreach

coordinator will develop new community relations and identify new locations in rural areas for mobile health visits. Develop new data collection system. Baseline encounters: 738 screening mammograms, 0 cervical cancer screenings, 0 colon cancer screenings.

DY3 – DY5: Increase the number of visits to a rural community in RHP 10 to at least 176 annually. Target number of encounters per year: 3,520 screening mammograms, 1,584 cervical cancer screenings, 188 colorectal cancer screenings (FOBT). The number of patients in need of primary care and referred and followed (phone, electronic media and mail) by the RN Patient Navigator for the purposes of establishing a medical home will be tracked. The number of patients referred and followed (phone, electronic media, and mail contact) by the RN Patient Navigator to specialty care based on screening results will be tracked. Language interpreters will be utilized by phone or in-person as needed to enhance communication with monolingual patients.

Rationale:
The RHP 10 Community Needs Assessment identified a shortage of specialty care. The Region is facing a 22 to 36% growth in provider demand across all specialties. The specialties with the greatest growth in demand are obstetrics/gynecology, vascular health, urology, hematology/oncology, cardiology, and nephrology. Table 1 below illustrates the need for breast, cervical and colorectal cancer screening services within the target population.

Table 1: Screen Eligible Population in RHP -10

County RHP 10	Medically Underserved Population[11]	2010 Estimated Female Population[12]	# of no mammogram in 24 months age 40 -69[13]	# of no Pap test in 3 years age 21 – 64 [14]	2010 Estimated Population age 50 -75[15]	# of no blood stool test in 2 years 50 – 64[16]
Ellis	MUA	28,742	7,616	8,012	36,504	30,955
Erath	MUA	6,053	1,604	2,037	8,740	7,412
Hood	No MUA	11,224	2,974	2,609	18,125	15,370
Johnson	MUA	28,377	7,510	7,961	38,885	32,974
Navarro	MUA	8,938	2,369	2,644	12,850	10,897
Parker	No MUA	23,718	6,285	6,161	32,876	27,879
Somerville	No MUA	1,720	456	471	2,462	2,088
Wise	No MUA	11,805	3,128	3,376	16,411	13,917
Total		120,577	31,942	33,271	166,853	113,595

Project Components:
Expanding the WFL Mobile Cancer Screening Service by adding a third mobile health coach and team will increase - access to early detection of breast, cervical and colorectal cancer in rural counties of RHP 10. Patient navigation, follow-up and tracking will insure timely transition to

specialty care and primary care. The direct cost of these services can be reduced through improved efficiency with satellite communications.

Our milestones measure an increased rural population receiving - early detection cancer screening services and facilitated transition of care to primary and specialty care. (1) we are identifying new medically underserved communities, and (2) expanding - early detection cancer screening capacity by adding one multidisciplinary health team and one fully equipped mobile coach/vehicle, and (3) - facilitate transition of care to primary and specialty services by a RN Patient Navigator and a new collaborative network of primary care and specialty care providers.

Unique community need identification numbers the project addresses:

- CN.3 – Shortage of specialty care
- CN.7 – Need to address geographic barriers that impede access to care
- CN.8 – Lack of access to health care due to financial barriers

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

This project builds on a current initiative to introduce a systems approach to comprehensive breast health services targeting rural communities. The Breast Screening Patient Navigation (BSPAN) is funded by the Cancer Prevention Research Institute of Texas. Cervical and colorectal cancer screening outside of Tarrant County is a new initiative. No federal funding has been received for this project. A system for facilitating care transition into primary and specialty care through the use of mobile health and RN Patient Navigators targeting rural communities significantly enhances the current initiative which is limited to breast cancer screening at this time.

Satellite technology reduces labor costs, and has the potential to reduce the time to diagnostic procedures and diagnosis, improving patient care.

Mobile cancer screening makes facilitated access to primary and specialty care possible in rural medically underserved communities.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

RHP 10 has identified a shortage of specialty care across all disciplines. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. Breast, cervical and colorectal cancer screenings will be performed, targeting low-income and medically underserved populations. The objective is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. The following three outcome measures are selected:

- IT-12.1 Breast Cancer Screening (HEDIS 2012) Non-stand-alone measure. Our goal is to perform 11,298 breast cancer screenings by the end of the Waiver. Breast cancer is a significant health problem in North Texas. Estimates from the 2010 Behavioral Risk Factor Surveillance System indicate that 31,942 screen-eligible women in the target population have not had a mammogram within the past two years (Public Health Administration Region 2/3).
- IT-12.2 Cervical Cancer Screening (HEDIS 2012) Non-stand-alone measure. Our goal is to perform 4,752 cervical cancer screenings among low-income, culturally and geographically isolated populations by the end of the Waiver. Estimates from the 2010 Behavioral Risk Factor Surveillance System indicate that 33,271 screen-eligible women in the target population have not had a Pap test within the past three years (Public Health Administration Region 2/3).
- IT-12.3 Colorectal Cancer Screening (HEDIS 2012) Non-stand-alone measure. Our goal is to distribute 880 colorectal cancer screening (fecal occult blood test) kits and process 563 by the end of the Waiver. Based on current Tarrant County experience, we anticipate a 64% fecal occult blood test return rate compared to the return rate by direct mail (30%).[17]

Relationship to Other Projects:

- **Related Category 1 and 2 projects**: There are no related Category 1 or 2 projects.
- **Related Category 4 population-focused improvements:** TBD

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology**: For every patient affected by early detection of colorectal cancer screening, $24,756 is saved by the health care system. The average length of stay is multiplied by the total affected population to determine the total days saved. Total days saved are used to calculate individual and community costs. The total valuation is calculated by summing health care, individual, and community costs.
- **Rationale/Justification**: Colorectal cancer screening outcome improvement targets are dependent on the target population served, size (e.g., if an MHU is at maximum capacity, rates can only decrease), and current processes in place. Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

-112677302.2.5	*-2.7.1*	*Project Components: N/A*	-.7.1: Implement Evidence-based Disease Prevention Programs (Expand Wellness for Life Mobile Cancer Screening)
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 3 Outcome Measure(s):	*112677302.3.11* *112677302.3.12* *112677302.3.13*	*IT-12.1* *IT-12.2* *IT-12.3*	*Breast Cancer Screening (HEDIS 2012) (Non-stand-alone measure)* *Cervical Cancer Screening (HEDIS 2012) (Non-stand-alone measure)* *Colorectal Cancer Screening (HEDIS 2012) (Non-stand-alone 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. Metric 1 [P-1.1]: Document innovational strategy and plan: Documentation of gap assessment. Develop a network of collaborating primary and specialty care providers. Expand mobile health capacity through the addition of a mobile vehicle and multidisciplinary team. Enhance patient care referral and follow-up. Demonstrate improvement over prior reporting period (baseline for DY2) Baseline/Goal: Develop baseline need in target population. Data Source: Documented plan for expansion to eight counties in RHP 10. Milestone 1 Estimated Incentive Payment *(maximum amount):* $520,503	**Milestone 3** - I-5]: - Identify 738 patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1] -Numerator: Number of individuals of target population reached by the innovative project. Baseline/Goal: - 90% of maximum capacity of the unit (max cap = 5,292). Data Source: EHR Milestone 3 Estimated Incentive Payment: $1,007,919	**Milestone 4** [I- 5.1]: - Identify 5,292 patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [- I-5.1]: Numerator: Number of individuals of target population reached by the innovative project. Goal: - 95% of maximum capacity of the unit (max cap = 5,292).. Data Source: EHR Milestone 4 Estimated Incentive Payment: $1,063,053	**Milestone 5** [I--5.1]: -Identify 5,292 patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [- I-5.1]: -Numerator: Number of individuals of target population reached by the innovative project. -Goal- 100% of maximum capacity of the unit (max cap = 5,292).. Data Source: EHR Milestone 5 Estimated Incentive Payment: $858,365

-112677302.2.5	*-2.7.1*	*Project Components: N/A*	-.7.1: Implement Evidence-based Disease Prevention Programs (Expand Wellness for Life Mobile Cancer Screening)
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 3 Outcome Measure(s):	*112677302.3.11* *112677302.3.12* *112677302.3.13*	*IT-12.1* *IT-12.2* *IT-12.3*	*Breast Cancer Screening (HEDIS 2012) (Non-stand-alone measure)* *Cervical Cancer Screening (HEDIS 2012) (Non-stand-alone measure)* *Colorectal Cancer Screening (HEDIS 2012) (Non-stand-alone 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 2 [P-2]: Implement evidence-based innovational project for targeted population. Metric 2 [P-2]: Document implementation strategy and testing outcomes. -Identify 1 target mobile location in each county (8 counties). New multidisciplinary teams are hired and trained: 1 Mobile Driver 1 Nurse Practitioner 1 Mammography Technologist 1 Community Outreach Coordinator 1 Data Manager 1 RN Patient Navigator Patient Navigation Referral and follow-up tracking system is tested (OncoNav). Acquisition of 1 mobile health vehicle Data Source: Program Records, HR records and Finance Capital Purchase Milestone 2 Estimated Incentive Payment (maximum amount):			

-112677302.2.5	*-2.7.1*	*Project Components: N/A*	-.7.1: Implement Evidence-based Disease Prevention Programs (Expand Wellness for Life Mobile Cancer Screening)
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 3 Outcome Measure(s):	*112677302.3.11* *112677302.3.12* *112677302.3.13*	*IT-12.1* *IT-12.2* *IT-12.3*	*Breast Cancer Screening (HEDIS 2012) (Non-stand-alone measure)* *Cervical Cancer Screening (HEDIS 2012) (Non-stand-alone measure)* *Colorectal Cancer Screening (HEDIS 2012) (Non-stand-alone 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)**
$520,504			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,041,007	Year 3 Estimated Milestone Bundle Amount: $1,007,919	Year 4 Estimated Milestone Bundle Amount: $ 1,063,053	Year 5 Estimated Milestone Bundle Amount: $858,365
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $3,970,344			

Project Option 2.2.1 – Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes
Unique Project ID: 120726804.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Southwest Fort Worth (THSW) / 120726804

Provider: A full-service facility with a steadfast commitment to quality. The hospital has more than 630 physicians on the medical staff, 24-hour emergency services and 222 licensed beds. The hospital offers comprehensive acute-care services, 24-hour emergency services, advanced technology, a progressive rehabilitation program, surgical services and traditional and progressive options in maternity care.
Intervention: This project will increase patient engagement through outpatient education and self-management for the diabetic population therefore increasing the wellness of the diabetic. This is a new project for THSW.
Need of the project: Currently, the uninsured diabetic population is not being served. One in every 12 individuals age 18 or older in Tarrant County has a diagnosis of diabetes. As the age of the community increases, the percentage of diabetes increases. From the community needs assessment data 28% of those individuals who report that they cannot work, have a diagnosis of diabetes. This disease impacts a large percentage of the community and can be a financial burden. Chronic diseases such as diabetes can be managed with education and support.
Target population: The target population includes newly diagnosed diabetic patients and those experiencing frequent Emergency Department visits due to high blood glucose levels. It is estimated that 1,113 patients will be served over the waiver period. This is an increase of approximately 15%. Currently there are no programs in this area for the uninsured to receive management and education on a regular basis.
Category 3 outcomes:

a. Potentially Preventable Re-admissions - 30 Day Readmission Rates (PPRs)- IT.3.3 Diabetes 30-day readmission rate. The proposed program will help low income and uninsured clients with diabetes to better self-manage their disease through disease education and provide them with appropriate access to chronic care management support resources.

b. Primary Care and Chronic Disease Management: Diabetes care: HbA1c poor control (>9.0%)

c. Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g. if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g. keeping lower acuity patients under observation instead of admitting them).

Project Option 2.2.1 – Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes
Unique Project ID: 120726804.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Southwest Fort Worth (THSW) / 120726804

Project Description:
This project will increase patient engagement through outpatient education and self-management. Diabetes patients will be identified through the ED, inpatient stays, or community outreach partnerships we will provide them with information about our diabetes management program and help them find a medical home and provide innovative services to manage and monitor patient progress. We will identify lessons learned and key challenges to the implementation of the program to improve processes going forward.

Goals and Relationship to Regional Goals:
Project Goals:
The goal of this program is to establish an outpatient diabetes education and management program to assist all clients identified with diabetes to be empowered to make informed decisions and develop self-management skills. Relying on an empirically validated, evidence-based self-management educational and clinical support approach, our goal is to improve the health outcomes and self-management competency of the THSW community. The proposed program will help low income and uninsured clients with diabetes to better self-manage their disease through disease education and provide them with appropriate access to chronic care management support resources.

- Partner with hospitalists to utilize protocols: A1C>8, history of DKA, > one admission in the last 12 months as criteria for referrals to outpatient diabetes education.
- Create the role of an inpatient diabetes educator to identify patients with the same criteria as above, and/or who do not currently have a medical home, and/or have not received diabetes education within the last five years, and any others appropriate for education.
- Develop a comprehensive care management program.

Challenges:
Historically underserved patients have not been effectively educated on how to manage their diabetes. Moreover, they have not been followed to measure their outcomes and long term goals. This program will link diabetes patients who present to THSW and the diabetes management resources that will provide seamless care for the Medicaid, managed Medicaid, and uninsured patient population.

5-Year Expected Outcome for Provider and Patients:
The five-year expected outcome is to reduce readmissions of chronic diabetes patients and reduce ED visits as outlined below.

- Increase usage of the aforementioned criteria by primary care clinicians, case managers, and diabetes educators.
- Patients referred to the program will self-select goals that will be monitored routinely throughout the program with a 50% compliance rate at program completion.
- Enrollment growth rate of 55% over baseline of Medicaid, Medicare, and uninsured patients with a diabetes diagnosis in the self-management program by the end of the Waiver period.

Starting Point/Baseline:
Currently THSW refers patients to an outpatient diabetes education program provided by Texas Health Harris Methodist Hospital Fort Worth. A diabetes educator and a nutritionist met with approximately 195 clients in 2011. The clients seen are rarely under age 18, with 10-29% ages 19-40, 39-51% 41-64, and 28-45% over 65. These are insured clients who are referred by their primary care physician.

Rationale:
- One in every 12 individuals age 18 or older in Tarrant County has a diabetes diagnosis. As the age of community increases the percentage of diabetes increases. From the Community Needs Assessment data 28% of those individuals who report that they cannot work have a diagnosis of diabetes; therefore this disease impacts a large percentage of the community and can be a financial burden. The number of patients in our EDs and hospitals with a primary diagnosis of diabetes is a small percentage of our outpatient diabetes management programs. Therefore there needs to be a link from ED and inpatient to outpatient resources and education.
- The Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute, has helped hundreds of providers improve care for people with chronic conditions. Fifteen randomized trials of system change interventions include Diabetes Cochrane Collaborative Review and JAMA Re-review, which looked at about 40 studies, mostly randomized trials, with interventions classified as decision support, delivery system design, information systems, or self-management support; 19 of 20 studies included a self-management component that improved care, and all five studies with interventions in all four domains had positive impacts on patients.[xxv]

Project Components:
The care team will be designed and implemented based on the needs of the diabetic patient. An advanced practice nurse or care coordinator will work with the ED nurse navigator and inpatient health care providers to identify patients and guide the patient journey. The team will be available to the client by email. Through diabetes education, the client will increase engagement and self-management skills. The clients will be provided with the tools and resources to make

appropriate choices regarding their chronic disease. The team will identify lessons learned and barriers or challenges associated with the expansion of the program.

The milestones were identified to measure our development and implementation of the program. The advancement of the program is reliant on the appropriate development and implementation

Unique community need identification numbers the project addresses:
Diabetes is one of the top 10 causes of morbidity and mortality in Tarrant County. Currently, the Diabetes Outpatient program for THSW is conducted by Texas Health Ft. Worth and reaches 200 insured patients annually. Approximately 56% of the inpatient population and 55% of the outpatient population at THSW is covered by Medicare/Medicaid or is uninsured, indicating a need for innovation and creativity to reach this population. Since a large percentage of THSW patients have limited access to insurance and other resources, it is paramount that we intervene by educating the people in the community we serve.

There is a necessity for patient education programs. (CN13) Many community residents lack basic health literacy and healthy lifestyle knowledge. Lack of adequate health education impacts a person's ability to understand the medical information and recognize early symptoms of disease. Factors of low health literacy include education level and socio-economic status. Region 10 has a smaller percentage of the population that did not receive a high school diploma (16.9% versus 14.4% of the population, respectively). Region 10 also has a smaller percentage the population living at or below the 100% federal poverty level (12.9% versus 13.8%, respectively), yet the rate is nearly 20% of the population in two counties in Region 10. There is a need for more care coordination (CN11). All counties identified it as a system gap and need. Barriers include complexity of coordination, lack of staff, lack of financial integration, fragmented system service, and practicing in silos. Providers did not feel there was strong care coordination between primary care providers, hospitals, and specialists. There is a lack of access to health care due to financial barriers (i.e. lack of affordable care). (CN8) Providers overwhelmingly list lack of coverage/financial hardship as a major barrier for low-income patients.

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

THSW does not currently and will not receive any funding for this project or any other project.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/rationale for selecting the outcome measures:

IT-1.10 Diabetes care: HbA1c poor control (>9.0%) (stand-alone)
By the end of the Waiver, our goal is to have ≤15% of patients 18-75 years old with diabetes (type 1 or type 2) out of glycemic control (HbA1c >9.0%). Baseline was established from an

intervention population of 167 and will be readjusted based on changes if any in DY3 (See attached narrative)

IT-3.3 Diabetes 30-day readmission rate (stand-alone)
By the end of the Waiver, our goal is to decrease readmission rate of patients 18-75 years old with diabetes (type 1 or type 2) out of glycemic control (HbA1c >9.0%) by 15%.
Baseline for intervention population is 471 and will be adjusted in DY3 if needed (See attached narrative)

Relationship to Other Projects:

- **Related Category 1 and 2 projects:** Patient-centered health care (emergency department): ED patient navigator will coordinate patient journey from admission to discharge and through outpatient diabetes education.

- **Related Category 4 population-focused improvements** Potentially Preventable Admissions (Diabetes Admission Rates and CHF). Our project focuses on providing diabetes education to empower the patient to self-manage their disease thus avoiding hospitalization for diabetes or other complications that could occur.
    i. 15-Day Readmission (Diabetes: 15-day readmission): Our project focuses on self-management of diabetes thus reducing the likelihood of readmission.
    ii. Potentially Preventable Complications (diabetes specific): Knowledge gained through diabetes education provided by a diabetes care team will properly equip the patient to avoid complications.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology:** For every inpatient admission avoided, $9,640 in cost is saved by the health care system.[183] Health care costs are calculated by multiplying $9,640 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current

[183] Based on 2011 historical inpatient diabetes admissions data for Texas Health Southwest

processes in place that already prevent avoidable inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).

- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

120726804.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes*	
Texas Health Harris Methodist Hospital Southwest Ft. Worth				*120726804*
Related Category 3 Outcome Measure(s):	*120726804.3.1* *120726804.3.2*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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 a comprehensive care management program Metric 1 [P-3.1]: Documentation of care management program using the Wagner Chronic Care Model Goal: Complete implementation of outpatient clinic for heart failure patients to receive ongoing care. Includes procurement of equipment and supplies to run clinic, Data Source: Program description Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,079 **Process Milestone 2** [P-2]**:** Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care)Numerator: Number of care navigation encounters Metric 1 [P-2.1]: Increase percent of staff trained a) Numerator: number of relevant staff trained in the Chronic Care	**Milestone 3** [P-4]Formalize multidisciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric 1[P-4].1: Increase the number of multidisciplinary teams (e.g.,, teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams Data source: Team Rosters Baseline/Goal: develop 1 multidisciplinary team Milestone 3 Estimated Incentive Payment: $13,631 **Milestone 4** [P-9**]**: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventive tests, or other clinical services Numerator: number of patients		**Milestone 5** [I-17]: Apply the Care Model to targeted chronic disease, which are prevalent locally Metric 1 [I-17.1]: 5% additional patients receive care under the Care Model for diabetes. Chronic disease diabetes Data source: registry Goal: 5% increase over baseline Milestone 5 Estimated Incentive Payment: $14,377 **Milestone 6** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patient with self-management goals Numerator: the number of patients with diabetes X goal to reduce HbA1c below 9.0% Denominator: Total number of patients with type 1 or 2 diabetes Data source: registry Goal: 80% Data Source: registry Milestone 6 Estimated Incentive	**Milestone 7** [I-17]: Apply the Care Model to targeted chronic disease, which are prevalent locally Metric 1 [I-17.1]: 5% additional patients receive care under the Care Model for diabetes. Chronic disease diabetes Data source: registry Goal: 5% increase over DY4 Milestone 5 Estimated Incentive Payment: $11,609 **Milestone 8** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patient with self-management goals Numerator: the number of patients with diabetes X goal to reduce HbA1c below 9.0% Denominator: Total number of patients with type 1 or 2 diabetes Data source: registry Goal: 90% Data Source: registry Milestone 6 Estimated Incentive

120726804.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes*	
Texas Health Harris Methodist Hospital Southwest Ft. Worth				*120726804*
Related Category 3 Outcome Measure(s):	*120726804.3.1* *120726804.3.2*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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)**
Model b) Denominator: Total Number of relevant staff Baseline/Goal: 90% of involved staff complete training Data Source: Training records Milestone 2 Estimated Incentive Payment *(maximum amount):* 14,079	identified as needing screening test, preventive tests, or other clinical services Data source: Clinic registry Baseline/Goal: Increase # of patients identified by 5% over baseline Milestone 4 Estimated Incentive Payment: $13,631		Payment: $14,377	Payment: $11,609
Year 2 Estimated Milestone Bundle Amount: $28,158	Year 3 Estimated Milestone Bundle Amount: $27,262		Year 4 Estimated Milestone Bundle Amount: $28,754	Year 5 Estimated Milestone Bundle Amount: $23,218
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ 107,392				

Project Option 2.8.11 – Sepsis: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area.

Unique Project ID: 120726804.2.2
Performing Provider Name/TPI: Texas Health Harris Methodist Southwest (THSW) / 120726804

Provider: A full-service facility with a steadfast commitment to quality. The hospital has more than 630 physicians on the medical staff, 24-hour emergency services and 222 licensed beds. The hospital offers comprehensive acute-care services, 24-hour emergency services, advanced technology, surgical services and traditional and progressive options in maternity care.
Intervention: Early intervention and treatment of Sepsis patient entering through the ED. This is a new project for THSW.
Need for the project: Mortality rates from severe sepsis are on a similar scale to lung, breast and colon cancer, and are one of the leading causes of death in the ICU. Thirty percent of patients die within the first month of diagnosis. Given our increasing number of elderly and chronically ill patients, the incidence of severe sepsis is expected to increase in this region.
Target population: Patients with a primary diagnosis of sepsis

a. Estimated number of patients to be served over course of waiver period: Approx 1000. Currently there are no programs in this area for the uninsured to receive management and education on a regular basis. 23% of the local area adult residents have no health insurance. Of those, approx 18% did not seek the care of a physician due to cost. This program creates processes which decrease mortality and ultimately leads to more efficient and cost effective care or CMS patients by reducing length of stay. Currently, THSW's ED visit volume reflects a 31% Medicaid/unfunded rate. It is anticipated the sepsis rate would correspond to the overall ED rate.

Category 1 and 2 expected patient benefit: Milestone 2 [P-2] Identifies target metrics to measure impact of Performance Improvement methodology and establish baseline. Identification of metric for measurement will guide the improvement process to decrease the length of stay of sepsis patients and mortality. Milestone 3 [P-3] compares and analyzes clinical/quality data and will identify at least one area for improvement and establish baseline. CNS will evaluate the data to find the area being missed in the treatment and approach to care when implementing the bundle. In DY 4, it is anticipated 118 patients will benefit from the bundle implementation increasing to 150 in DY 5.

Category 3 outcomes: Process Milestone 2 [P-2] establishes baseline rates to determine frequency of bundle usage; affecting mortality, and establishing baseline. Identifying rates of bundle usage will allow for improvements to increase the rates resulting in better treatment to decrease the mortality and length of stay of patients.

Project Option 2.8.11 – Sepsis: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area.

Unique Project ID: 120726804.2.2
Performing Provider Name/TPI: Texas Health Harris Methodist Southwest (THSW) / 120726804
Project Description:
Early recognition of severe sepsis and septic shock followed by uniform, consistent early implementation of an evidence-based sepsis resuscitation bundle will decrease mortality. In the ED we will focus on early diagnosis, initial management and prompt transfer to ICU, utilizing enhanced lab biomarker technology and embed a 24/7 ED-based pharmacists in order to expedite early administration of antibiotics. THSW will also leverage EMR to embed a sepsis bundle checklist for clinicians. We have also identified an opportunity for earlier recognition of severe sepsis on our inpatient medical-surgical units. Part of this project will be to enhance education of all clinicians in early recognition of sepsis. Once it is identified that a patient has severe sepsis we need early implementation of the sepsis resuscitation bundle as defined by Surviving Sepsis Guidelines 2012 (IHI) and Dellinger, RP et Surviving Sepsis Campaign International Guidelines for Management of Severe Sepsis and Septic Shock, Critical Care Medicine 2008.

The other part of the project is to develop a system for continuous data collection analysis and disseminate of performance along with PDSA Performance Improvement model.

Goals and Relationship to Regional Goals:
Project Goals:
THSW has begun the data collection phase and preliminary implementation of a sepsis protocol based on the above guidelines and has, over the past year, sponsored various educational programs for ED nursing staff and physician partners. Our primary focus moving forward will be to implement the protocol in the EHR, measure whether or not the sepsis protocol is consistently used, whether or not all components of the protocol are implemented, and whether or not outcomes improve with its use. In 2011 we had 169 patients with a primary diagnosis of sepsis (this includes patients who had sepsis along with severe sepsis or septic shock) with an overall mortality rate of 13.6%. The goal is to prospectively identify severe sepsis and septic shock early, determine our baseline rate of sepsis protocol implementation, educate in use of the protocol, increase compliance rate and thereby decrease mortality.

This project meets the following Regional goals:
Implementation of and hardwiring an evidence-based sepsis resuscitation protocol has been proven to decrease mortality and morbidity. The state of Texas has mandated that all hospitals ensure that these evidence-based guidelines are implemented. Mortality rates from severe sepsis

are on a similar scale to lung, breast and colon cancer, and are one of the leading causes of death in the ICU. Thirty percent of patients die within the first month of diagnosis. Given our increasing number of elderly and chronically ill patients, the incidence of severe sepsis is expected to increase. Older people are at increased risk of sepsis because they are at higher risk of infections secondary to aging, comorbidities, increased institutionalization and increased use of invasive surgical techniques.

Challenges:
Although still a challenge, THSW has focused on early recognition of sepsis and has a severe sepsis protocol (bundle). Early recognition in the triage phase is a challenge faced as well as rapidly progressing through the treatment process and initial implementation of the sepsis bundle. Physician willingness to diagnose based on the 4-tier sepsis model (SIRS, Sepsis, Severe Sepsis and Septic Shock) acts as a barrier to accurately reflecting the total population of sepsis patients and patients presenting to the ED late in the course of illness results in higher acuity levels and mortality.

5-Year Expected Outcome for Provider and Patients:
Our clinical and medical staff will be better informed of necessity for early diagnosis and treatment of sepsis. Implementation and hardwiring of sepsis resuscitation protocol will be accomplished. Sepsis protocol/order sets will be embedded in EMR. Mortality secondary to sepsis will decrease.

Starting Point/Baseline:
In 2011, 169 patients had a primary diagnosis of sepsis coded. Mortality rate was 13.6%

Rationale:
Implementation of and hardwiring an evidence-based sepsis resuscitation protocol has been proven to decrease mortality and morbidity. The state of Texas has mandated that all hospitals ensure that these evidence-based guidelines are implemented. Mortality rates from severe sepsis are on a similar scale to lung, breast and colon cancer, and are one of the leading causes of death in the ICU. Thirty percent of patients die within the first month of diagnosis. Given our increasing number of elderly and chronically ill patients, the incidence of severe sepsis is expected to increase. Older people are at increased risk of sepsis because they are at higher risk of infections secondary to aging, comorbidities, increased institutionalization and increased use of invasive surgical techniques.

Project Components:
We have selected the early implementation of the entire Severe Sepsis Resuscitation Protocol because there is overwhelming evidence in peer reviewed literature that all of them together are considered a best practice. That when the timing and sequence are followed, mortality

decreases. The resuscitation bundle is combined evidence-based tools/goals that must be completed within the first 6 hours of identification of severe sepsis. The elements include: measuring a serum, lactate, obtaining blood cultures prior to antibiotic administration, broad spectrum antibiotic within 3 hours of ED admission and within 1 hour of non-ED admission, treat hypotension and/or elevated lactate with fluids; and in the event of persistent hypotension, despite fluid resuscitation and/or lactate >4mmol/Liter, maintain adequate central venous pressure and central venous O2 saturation.

Milestones and metrics chosen predicated on our Performance Improvement model of PDSA and methodology in tracking compliance. The milestones will determine whether we are decreasing mortality, which is the ultimate goal.

Continuous quality improvement will be conducted using the Plan, Do, Study, Act (PDSA) model. ED sepsis data is collected daily and reported for analysis on a monthly basis to the ED physicians and staff. Based on findings, opportunities for improvement are identified and plans are enacted to insure compliance with the bundle.

Unique community need identification numbers the project addresses:

- CN 11 – Need for more care coordination

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

This project has been internationally and nationally recommended ever since the 2008 Surviving Sepsis provided overwhelming evidence that by implementing the sepsis resuscitation bundle within 6 hours of identifying a patient with severe sepsis or septic shock, mortality rates drop dramatically.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

Potentially Preventable Complications and Health Care Acquired Conditions – IT-4.8 Sepsis Mortality (Stand-alone measure)

- Numerator: Number of patients expiring during current-month hospitalization with sepsis, severe sepsis or septic shock, and/or an infection and organ dysfunction.
- Denominator: Number of patients identified that month with sepsis, severe sepsis or septic shock, and/or an infection and organ dysfunction.
- Data Source: Chart abstraction and EPSI evidence has shown that early identification and implementation of a sepsis resuscitation bundle will decrease mortality dramatically. Given the fact that the elderly are more prone to infections and, therefore, severe sepsis and septic shock, and given the fact that many of our elderly have very low incomes, this project will decrease morbidity/mortality.

Potentially Preventable Complications and Health Care Acquired Conditions – IT-4.9 Average length of stay (Non stand-alone measure)

Relationship to Other Projects:

- **Related Category 1 and 2 projects**
  - 109574702.2.2: Huguley Memorial Medical Center (HMMC) has proposed a similar project. Our intent is to participate in a learning collaborative with HMMC to share best practices and discuss lessons learned.

- **Related Category 4 Population-focused improvements**:
  - RD1: Potentially Preventable Admissions 1.Congestive Heart Failure Admission Rate; 2. Diabetes Admission Rate; 3. Behavioral Health and Substance Abuse Admission Rate; 4. Chronic Obstructive Pulmonary Disease Admission Rate; 5. Hypertension Admission Rate
  - RD-5 Emergency Department: 1. Admit decision time to ED departure time for admitted patients (NQF 0497)
  - The ED Case Management program will help navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care. Through the navigation of patients to available resources, patient admissions can be avoided increasing the availability of inpatient beds for those in need of hospitalization. Increased bed availability impacts ED patient throughout and improves time for ED patients to receive their inpatient bed.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

- **Approach/Methodology:** Decreased mortality rate does not bring any direct health care cost savings. Lives saved are utilized to calculate individual and community costs. The total valuation is calculated by summing up individual and community costs.
- **Rationale/Justification:** Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

120726804.2.2	*2.8.11*	*Project Components: N/A*	*Apply Process Improvement Methodology to Improve quality/efficiency implementation of the sepsis resuscitation bundle*	
Texas Health Harris Methodist Hospital Southwest				*1363269-08*
Related Category 3 Outcome Measure(s):	*120726804.3.3* *120726804.3.4*	*3.IT-4.8* *3.IT-4.9*	*Decrease Sepsis Mortality* *Average Length of Stay*	
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 Performance Improvement methodology and establish baseline Metric 1 [P-2.1]: Define timelines for each part of the resuscitation bundle; define data elements to be collected; determine baseline Baseline/Goal: Review 50 severe sepsis charts from year 1 to determine baseline Data Source: Chart review Milestone 1 Estimated Incentive Payment: $**77,968** **Milestone 2** [P-3]: Compare and analyze clinical/quality data and identify at least one area for improvement Metric 1 [P-3.1]: Analyze data collected in P-2 and correlate with mortality rate, ALOS, cost/patient from year 1; target opportunities for improvement Baseline: **TBD** Goal: Identify and target	**Milestone 5** [P-3]: Compare and analyze clinical/quality data and identify at least one area for improvement Metric 1 [P-3.1]: Analyze data collected in P-2 and correlate with mortality rate, ALOS, cost/patient from year 1; target opportunities for improvement Baseline/Goal: TBD based on Year 2 Data Source: Internal database populated by chart abstraction Milestone 5 Estimated Incentive Payment: $**100,654** **Milestone 6** [P-12]: Report findings and learning Metric 1 [P-12.1]: Final report/report summary Baseline/Goal: Monthly reports Data Source: Internal database populated by results of chart abstraction Milestone 6 Estimated Incentive Payment: $**100,654**		**Milestone 8** [I-13]: Progress toward target/goal Metric 1 [I-13.1]: Number or percent of severe sepsis or septic shock having entire sepsis resuscitation bundle implemented within 6 hours Goal: 70% over baseline (approximately 118 patients) Data Source: Internal database Milestone 8 Estimated Incentive Payment: $**159,239** **Milestone 9** [I-16]: Improve quality and efficiency using innovative project option Metric 1 [I-16.1]: Potential improvement in LOS/cost/case if achieve targets on I-13 Goal: Reduce ED LOS by 10% (approximately 15 minutes) Data Source: EPSI (cost accounting system)/internal database Milestone 9 Estimated Incentive Payment: $**159,240**	**Milestone 10** [I-16]: Improve quality and efficiency using innovative project option Metric 1 [I-16.1]: Potential improvement in LOS/cost/case if achieve targets on I-13 Goal: Reduce ED LOS by 10% (approximately 30 minutes) Data Source: EPSI (cost accounting system)/internal database Milestone 11 Estimated Incentive Payment: $**128,578** **Milestone 11** [I-13]: Progress toward target/goal Metric 1 [I-13.1]: Number or percent of severe sepsis or septic shock having entire sepsis resuscitation bundle implemented within 6 hours Goal: 90% over baseline (approximately 150 patients) Data Source: Internal database Milestone 12 Estimated Incentive Payment: $**128,579**

120726804.2.2	*2.8.11*	*Project Components: N/A*	*Apply Process Improvement Methodology to Improve quality/efficiency implementation of the sepsis resuscitation bundle*	
Texas Health Harris Methodist Hospital Southwest				*1363269-08*
Related Category 3 Outcome Measure(s):	*120726804.3.3* *120726804.3.4*	*3.IT-4.8* *3.IT-4.9*	*Decrease Sepsis Mortality* *Average Length of Stay*	
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)**
opportunities for improvement Data Source: Internal database populated by chart abstraction Milestone 2 Estimated Incentive Payment: $**77,969** **Milestone 3** [P-10]: Develop a quality dashboard that will quantify and determine quality of care provided for CQI process Metric 1 [P-10.1]: Submission of a quality dashboard, development and utilized Goal: P-10.1 completed Data Source: Internally developed database Milestone 3 Estimated Incentive Payment: $**77,969** **Milestone 4** [P-12]: Report findings and learning Metric 1 [P-12.1]: Final report/report summary Goal: Monthly reports Data Source: Internal database populated by results of chart abstraction	**Milestone 7** [P-15]: Participate in face-to-face learning, ID and agree upon several improvements and commit to implementing improvements Metric 1 [P-15.1]: Participate in semi-annual face-to-face meetings or seminars organized by RHP Baseline/Goal: Participate in 2 meetings per year Data Source: Milestone 7 Estimated Incentive Payment: $**100,654**			

120726804.2.2	*2.8.11*	*Project Components: N/A*	*Apply Process Improvement Methodology to Improve quality/efficiency implementation of the sepsis resuscitation bundle*	
Texas Health Harris Methodist Hospital Southwest				*1363269-08*
Related Category 3 Outcome Measure(s):	*120726804.3.3* *120726804.3.4*	*3.IT-4.8* *3.IT-4.9*	*Decrease Sepsis Mortality* *Average Length of Stay*	
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 4 Estimated Incentive Payment: $**77,969**				
Year 2 Estimated Milestone Bundle Amount: $311,875	Year 3 Estimated Milestone Bundle Amount: $301,962		Year 4 Estimated Milestone Bundle Amount: 318,479	Year 5 Estimated Milestone Bundle Amount: $257,157
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,189,472				

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)

Unique Project ID: 120726804.2.3
Performing Provider Name/TPI: Texas Health Harris Methodist Southwest Hospital / 120726804

Provider: A full-service facility with a steadfast commitment to quality. The hospital has more than 630 physicians on the medical staff, 24-hour emergency services and 222 licensed beds. The hospital offers comprehensive acute-care services, 24-hour emergency services, advanced technology, a progressive rehabilitation program, surgical services and traditional and progressive options in maternity care.
Intervention: This project proposes to implement an Emergency Department Case Management Program (EDCM) using skilled case managers (Navigators) to identify high risk population patients (those who are unfunded, underfunded, or have Medicaid) requiring intervention and guidance in the use of care settings in primary care, non-emergent clinics, and community-based resources.
Need for the project: In Region 10, there is a need for more care coordination to reduce the need for emergency services.
Target population: At this time the EDCM does not exist at THSW. For 2012, it is estimated 61,991 THSW ED visits will occur. Of this total, 20% of the ED admissions meet the identified population criteria (Unfunded/Medicaid) yielding an estimated total of 12,386 potential EDCM clients for 2012. Of the potential 12,386 Unfunded/Medicaid clients; 10.5% (n=1301) required services that would have been prevented with the use of an ED Navigator to provide for:

- Enrollment with a PCP for initial care of medical condition and ongoing follow up.
- Referral to specialized medical clinics such as the JPS Sickle Cell Clinic, THFW Wound Care clinic, and Healing Wings clinic for AIDS patients.
- Referral to urgent care centers for non-emergent conditions.
- Referral to social agencies such as the Catholic Charities, Lutheran Social Services, Cabellero Cathleen, and The Girls Service League.
- Referral to disease specific teaching and assistance agencies such as the Diabetes Club, Breast and Cervial Cancer Control Program, Preventative Medicine Clinic, or the Cancer Care Services Center.
- Follow up (by the ED Navigator) with individual patients/families to ensure ongoing compliance with treatment plan and efficacy of referral activities.

Category 1 or 2 expected patient benefits: Patients will benefit from Naviations services by showing increase in referrals to a primary care provider and also experience a reduction in ED use as a result. Anticipated number of patients enrolled in Navigator services will increase in:

- DY 2 - 1301
- DY 3 - 1366
- DY 4 - 1405
- DY 5 - 1457

Category 3 outcomes: The outcome for this project is tracking ED-appropriate utilization in these target conditions: CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, and Asthma.

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)

Unique Project ID: 120726804.2.3
Performing Provider Name/TPI: Texas Health Harris Methodist Southwest Hospital / 120726804

Project Description:
This project proposes to implement an Emergency Department Case Management Program (EDCM) using skilled case managers (Navigators) to identify high risk population patients (those who are unfunded, underfunded, or have Medicaid) requiring intervention and guidance in the use of care settings in primary care, non-emergent clinics, and community-based resources. The Emergency Department (ED) Navigator will use the collaborative processes of assessment, planning, facilitation, advocacy and patient follow up to meet the identified population's health needs via communication and education to:

- Obtain the necessary community resources to meet identified patient needs.
- Facilitate finding and obtaining a primary care provider (PCP).
- Enroll in chronic disease management clinics/support groups.
- Provide education and monitoring of identified patients postdischarge.
- Encourage compliance with ongoing care/support for their health care needs.
- Facilitate arrangements for care at a less resource intensive level.
- Reduce the risk of ongoing utilization of ED for non-emergent care needs.

Of the potential 12,386 Unfunded/Medicaid clients; 10.5% (n=1301) required services that would have been prevented with the use of an ED Navigator to provide for:

- Enrollment with a PCP for initial care of medical condition and ongoing follow up.
- Referral to specialized medical clinics such as the JPS Sickle Cell Clinic, THFW Wound Care clinic, and Healing Wings clinic for AIDS patients.
- Referral to urgent care centers for non-emergent conditions.
- Referral to social agencies such as the Catholic Charities, Lutheran Social Services, Cabellero Cathleen, and The Girls Service League.
- Referral to disease specific teaching and assistance agencies such as the Diabetes Club, Breast and Cervial Cancer Control Program, Preventative Medicine Clinic, or the Cancer Care Services Center.
- Follow up (by the ED Navigator) with individual patients/families to ensure ongoing compliance with treatment plan and efficacy of referral activities.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of the project is to reduce the number of non-emergent ED visits and the number of potential hospitalizations for the identified population. This is made problematic as the growing demand for ED services are expected to account to an additional 68 million visits per year (Holtz-Eakin & Ramlet, 2010). In light of these findings, the focus for the EDCM should be:

- A reduction in non-emergent ED utilization.
- Assistance in establishing a medical home.
- Ensuring the use of appropriate health care resources.
- A reduction in the number of hospitalizations.

This project meets the following Regional goals:

The EDCM will be designed to align with the goals of the DSRIP Waiver and CMS triple aims by improving the health of individual, improving the health of the identified population and the increasing quality of care while reducing the costs associated with these improvements.

Challenges:

While ED costs are expected to outpace reimbursement by $6.8 billion by 2019 (Bamezai, Melnick, Nawathe, 2005) the heaviest financial burden will be those with chronic conditions that account for an estimated $0.85 of every dollar spent on health care. Additionally, data from National Adult Literacy Survey (NALS) finds that 16.9% of the population in Region 10 did not receive their high school diploma and 12.9% live at or below the 100% federal poverty level; thus the EDCM must also address the issues of lack of education, chronic disease and poor primary care access for low-income and uninsured residents in Region 10.

Additonal challenges will result from a limited number of physicians willing to accept the identified population (Unfunded/Medicaid). In addition to geographicial disadvanteges as many resources are at least 10 miles distant whivh already aggrevates the transportation issues found within this population.

5-Year Expected Outcome for Provider and Patients:

- Complete project planning including identification and hiring of staff, and development of policies/procedures and processes.
- Develop and test reporting and monitoring process to evaluate EDCM efficacy and establish the baseline.
- In DY3, our goal is to reduce the number of avoidable inpatient admissions by 5%, by conducting PDSA performance improvement projects to work toward further reductions in non-emergent ED admissisons while disseminating information to key stakeholders regarding our progress.

- In DY4, our goal is to reduce the number of avoidable patient admissions by 8% from baseline
- In DY5, our goal is to reduce number of avoidable patient admissions by 12% from baseline.

Starting Point/Baseline:
At this time the EDCM does not exist at THSW. For 2012, it is estimated 61,991 THSW ED visits will occur. Of this total, 20% of the ED admissions meet the identified population criteria (unfunded/Medicaid) yielding an estimated total of 12,386 potential EDCM clients for 2012.

Rationale:
An analysis of ED utilization at THSW shows that a majority of the patients presenting for care in the ED were unfunded or Medicaid. Of this disadvantaged low income target population, over half had diagnoses that did not require emergency care, including conditions such as chronic back pain, prescription refills, follow-up exams or dental disorder. Additional diagnoses, such as limb pain or urinary tract infection might have been managed at a lower level of care or prevented with appropriate primary care. This program will guide the disenfranchised medically complex patient more appropriately through and across our system, from provider to provider, ensuring they can get to and make multiple appointments, get prescriptions filled, access community services for people with special needs (such as getting cancer patients access to support groups), etc. The patient navigator represents the liaison between primary, secondary, tertiary and quaternary health care

Project Components:
All required core project components, which are listed below, are included in the project:

i. Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
ii. Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
iii. Connect patients to primary and preventive care.
iv. Increase access to care management and/or chronic care management, including education in chronic disease self-management.
v. 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.

The EDCM milestones and metrics will engage the identified population to provide education on how to manage their chronic disease(s), obtain timely follow up and receive appropriate levels of care. To ensure the effectiveness of the EDCM, THSW will actively participate with other RHP providers to evaluate and improve the program's efficacy. Milestones and metrics will measure

Navigators' assistance provided via the EDCM to the identified high-need population and will include:

i. Hiring and training navigators to cover the ED 7 days a week during peak ED admission hours to coordinate the EDCM.
ii. Developing policies, procedures and data collection tools to effectively administer and monitor the effectiveness of the EDCM.
iii. Increasing the identified population served per year (DY3 through DY5).
iv. Measuring the total at-risk clients receiving navigation services to ensure the identified population's access to appropriate levels of care for ongoing management of their health care needs.

Unique community need identification numbers the project addresses:

- CN.10 – Overuse of emergency department (ED) services.
- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/rationale for selecting the outcome measures:
IT-9.2 Right Care, Right Setting – ED appropriate utilization (Stand-alone measure)
This project will reduce inappropriate ED visits for the following target conditions:
CHF, diabetes, ESRD, CV/hypertension, behavioral health/substance abuse, COPD, asthma

This project provides navigation services so the patient gets the right care, in the right setting and in a timely fashion, avoiding unnecessary ED visits and avoidable hospital admissions. (See data discussed in the rational section). Many studies have demonstrated the effectiveness of case management/navigation program to improve management of patient health, reduce risk of avoidable readmissions and provide better primary care access.[184] RN Navigators will assist patients in obtaining resources necessary to more effectively manage their chronic condition or maintain their health. Patients with effectively managed disease and access to a dedicated health care provider will be less likely to utilize the ED for non-emergent conditions and will manage their health through primary and non-emergency health care providers. The program also assists

[184] Emergency Department Case Management *The Dyad Team of Nurse Case Manager and Social Worker Improve Discharge Planning and Patient and Staff Satisfaction While Decreasing Inappropriate Admissions and Costs:A Literature Review*
Darlene P. Bristow, MSN, RN, CCRN; Charlotte A. Herrick, PhD, RN Lippincott's Case Management Vol. 7, No. 3, 121-128
Romania, M. The Benefits of an Emergency Department Case Management Program, *The Pennsylvania Nurse*. September 2006 15,33.
Cannon, J. and Feldman, J. Washington State Hospital Association. *Potentially Avoidable Emergency Room Use*. February 2011.

in avoiding inpatient hospitalizations by providing patients with more appropriate alternatives to receive care and coordinating the necessary services from the ED.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**:
  - This project is related to project 2.2 Expand Chronic Care Management Models. The ED case manager will utilize the chronic care clinics as a resource to refer patients needing assistance with management of their chronic condition.

- **Related Category 4 population-focused improvements**
  - RD1: Potentially Preventable Admissions 1.Congestive Heart Failure Admission Rate; 2. Diabetes Admission Rate; 3. Behavioral Health and Substance Abuse Admission Rate; 4. Chronic Obstructive Pulmonary Disease Admission Rate; 5. Hypertension Admission Rate
  - RD-5 Emergency Department: 1. Admit decision time to ED departure time for admitted patients (NQF 0497)
  - The ED Case Management program will help navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care. Through the navigation of patients to available resources, patient admissions can be avoided increasing the availability of inpatient beds for those in need of hospitalization. Increased bed availability impacts ED patient throughout and improves time for ED patients to receive their inpatient bed.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology:** For every inappropriate inpatient admission avoided, $9,302 in cost is saved by the health care system.[185] The average length of stay per inpatient admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inappropriate inpatient admissions outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with greater than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent inappropriate inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).

[185] Based on 2011 historical ED visits data for Texas Health Arlington Memorial

- **Community benefits** were calculated using lost productivity (net of lost wages), lost in payroll taxes, and lost sales tax. Individual benefits were calculated using: lost wages, caretaker expense and extension of life (if applicable).

120726804.2.3	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Harris Methodist Southwest Fort Worth			*120726804.2.3*
Related Category 3 Outcome Measure(s):	*120726804.3.5*	*3.IT-9.2*	*IT- 9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department visits for target conditions* *CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*

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]: 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 (and hire the RN case managers to act as) navigators, develop procedures (including data collection mechanism) and establish continuing navigator education Metric 1 [P-2.3]: Frequency of contact with care navigators for high risk patients. Baseline/Goal: *120* encounters Data Source: Patient navigation program materials and database, EHR Milestone 1 Estimated Incentive Payment: $128,305 **Milestone 2** [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The	**Milestone 4**[P-8]: 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. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Attend 2 programs/year Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes.	**Milestone 6** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: 35% of identified patients Data source: Administrative data on patient encounters and scheduling records from patient navigator program Milestone 6 Estimated Incentive Payment: $196,533 **Milestone 7** [I-8]: Reduction in ED use by identified ED frequent users receiving navigation services Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent	**Milestone 8** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1[I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: 50% of identified patients Data source: Administrative data on patient encounters and scheduling records from patient navigator program Milestone 8 Estimated Incentive Payment: $158,692 **Milestone 9** [I-8]: Reduction in ED use by identified ED frequent users receiving navigation Services Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users.

120726804.2.3	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*	
Texas Health Harris Methodist Southwest Fort Worth				*120726804.2.3*
Related Category 3 Outcome Measure(s):	*120726804.3.5*	*3.IT-9.2*	*IT- 9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department visits for target conditions* *CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*	
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)**
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 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: Data collection completed with at least one report produced Data Source: Provider developed database	Milestone 4 Estimated Incentive Payment *(maximum amount):* $186,340 **Milestone 5** [P-3]: Provide care management/navigation services to targeted patients. Metric [P-3.1] Increase percent of targeted patients enrolled in the program Goal: 5% improvement (n=1366) over baseline Data Source: Claims and EHR/registry Milestone 5 Estimated Incentive Payment: $186,341		users. Goal: 8% improvement)n=1405) over baseline Data Source: Claims and EHR/registry Milestone 7 Estimated Incentive Payment: $196,534	Goal: 12% improvemen (n=1457) over baseline Data Source: Claims and EHR/registry Milestone 9 Estimated Incentive Payment: $158,692

120726804.2.3	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Harris Methodist Southwest Fort Worth			*120726804.2.3*
Related Category 3 Outcome Measure(s):	*120726804.3.5*	*3.IT-9.2*	*IT- 9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department visits for target conditions* *CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*

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 2 Estimated Incentive Payment: $128,305 **Milestone 3** [P-8]: 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. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Attend 2 programs/year Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting			

120726804.2.3	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Harris Methodist Southwest Fort Worth			*120726804.2.3*
Related Category 3 Outcome Measure(s):	*120726804.3.5*	*3.IT-9.2*	*IT- 9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department visits for target conditions* *CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*

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)**
notes. Milestone 3 Estimated Incentive Payment *(maximum amount):* $128,306			
Year 2 Estimated Milestone Bundle Amount: $384,916	Year 3 Estimated Milestone Bundle Amount: $372,681	Year 4 Estimated Milestone Bundle Amount: $393,067	Year 5 Estimated Milestone Bundle Amount: $317,384
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,468,048			

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.2.1 – Health e Care NTSP & THPG Extensivist Clinics
Unique Project ID: 120726804.2.4
Performing Provider Name/TPI: Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician Group/ 120726804

Provider: A full-service facility with a steadfast commitment to quality. The hospital has more than 630 physicians on the medical staff, 24-hour emergency services and 222 licensed beds. The hospital offers comprehensive acute-care services, 24-hour emergency services, advanced technology, a progressive rehabilitation program, surgical services and traditional and progressive options in maternity care.
Intervention: The Extensivist Clinic is an outpatient primary care clinic in the Project Area designed to deliver an innovative coordinated care approach to at-risk populations with chronic conditions. This is a new Initiative
Need of the project: Tarrant County Public Health Department Behavioral Risk Factor Surveillance System 2009/2010 notes that among Tarrant County adults in 2007, heart disease ranked as the leading cause of death for both men and women. Also, during the years 2000 to 2005, Tarrant County residents spent about $500 million on preventable hospitalizations due to angina, CHF, and high blood pressure.
Target population: The target population for this project is Medicare and Medicaid beneficiaries with Chronic Conditions. Estimated 5000 patients will be served over course of waiver period.
Expected patient benefits: This project provides an innovative approach to chronic care management in the region which includes improved access and coordinated care approach of at-risk target population that is patient-centered, culturally competent and disease-focused. Improvement in % of Medicare, Medicaid patients with chronic conditions accessing care at Extensivist clinic and subsequent improvement in admission, readmissions rates for target population with diagnosis heart failure and acute myocardial infarction.
Category 1 or 2 expected patient benefits: Clinic development and implementation milestones tie to project goal for expanding chronic care access in Region.
Category 3 outcomes: Category 3 metrics align to improvements in target population outcomes specifically admission and readmission rates for patients with chronic conditions heart failure and acute myocardial infarction.

Project Option 2.2.1 – Health e Care NTSP & THPG Extensivist Clinics
Unique Project ID: 120726804.2.4
Performing Provider Name/TPI: Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group / 120726804

Project Description:
The Extensivist Clinic is an outpatient primary care clinic under development in the Project Area designed to deliver an innovative coordinated care approach to at-risk populations with chronic conditions. These populations include those who are currently underserved, underinsured and/or insured in governmental programs. This clinic model will embrace a patient-centered coordinated care approach with a goal to achieve better care overall. Key components of the care model include dedicated primary care teams, multidisciplinary care management support, collaboration with community providers, specialists and other partners in care to ensure patient-centered care, treatment and services for optimal health outcomes.

Goals and Relationship to Regional Goals:
Project Goals:
The Extensivist model is designed to address primary, secondary and tertiary prevention strategies with an overreaching goal to reduce the burden of disease and gaps in care for patients with chronic conditions. Goals include ensuring access to care and better coordinated care through an evidence-based, patient-centered approach for improved health outcomes.

This project meets the following Regional goals:
The Regional Goals include Expanding Chronic Care Management Models to support high-quality clinical and disease focused care for improved outcomes and reduced cost of care. This project provides an innovative model for chronic care management in the Region.

Challenges:
The Extensivist model proposes to improve care through an expanded Chronic Care model that includes better communication and coordination of care use of innovative technology for timely communication and clinical information exchange. Key issues to address include early identification and evidence-based interventions to those at highest risk for chronic disease. The Extensivist model will ensure intensive day- to day management of patients through all levels of service and places of care. The clinical team will include board certified primary care physicians, advanced practice nursing professionals, physician assistants, care managers, social workers, care logistic managers and other allied health care providers to ensure a multidisciplinary approach to care that is patient-centered and outcomes oriented. Pharmacists will support medication management and reconciliation across-systems of care, social workers will address socio-economic needs, advance care planning needs and provide interventions and assistance

with community support services as identified. Advance practice nurses will integrate health promotion and disease prevention interventions and ensure patient education and support for better patient self-management of chronic conditions. Embedded care logistic managers will assist with key aspects of care management to ensure timely and coordinated preventive care. The Sandlot HIE will support fully integrated electronic clinical information exchange. The Extensivist model is comprehensive and consistent with goals of the national IHI Triple Aim to improve the experience of care, improve the health of populations and reduce per capita cost of care.

5-Year Expected Outcome for Provider and Patients:
The expected outcomes of this project are:

- Apply the Extensivist Chronic Care model to targeted patients with chronic conditions including CHF, MI.
- Improve access to chronic care by 10% from baseline for patients with MCCs/chronic conditions in project area.
- Improve the outcomes as demonstrated by HEDIS measures and potentially preventable admission rate reduction for heart failure patients by 15%, readmissions rates that are reduced for CHF and AMI by 20% from baseline.

Starting Point/Baseline:

- The targeted population is Medicare and Medicaid with Chronic Conditions at an estimated number of 50,000.
- The number of dual eligible clients currently identified with diagnosis heart failure and acute myocardial infarction is 2600.
- Percent of providers trained in this project is 0% for DY1.
- Time period of baseline is 10/01/2012 through 09/30/2013.

This is a new initiative with implementation set for DY2.

Rationale:
Tarrant County Public Health Department Behavioral Risk Factor Surveillance System 2009/2010 notes that among Tarrant County adults in 2007, heart disease ranked as the leading cause of death for both men and women. Also, during the years 2000 to 2005, Tarrant County residents spent about $500 million on preventable hospitalizations due to angina, CHF, and high blood pressure.

The Extensivist clinic model supports an evidence-based approach to care for clinical and quality improvements in at-risk populations with chronic conditions. This model enhances continuity of care and provides a multifaceted approach to care that is patient-centered and outcomes oriented.

Project Components:
Project Option 2.2.1 is redesign the outpatient delivery system to coordinate care for patients with chronic diseases.
The reasons for selecting the core components for this project are as follows:

- Extensivist model that employs board-certified primary care physician, physician assistants, advance practice nurses, pharmacists, care managers, social workers, and care logistic managers will ensure comprehensive approach to care management of target population that is patient-centered, culturally competent and disease focused.
- The comprehensive approach of the Extensivist staffing model will increase patient access through in-person, telephonic and electronic outreach, home visits and communication interventions.
- Developing and deploying two chronic care programs in the Extensivist model will promote an expanded approach to interventions and patient engagement for improved self-management of chronic condition.
- Utilizing evidence-based interventions beyond the one-to one office visits will increase patient interactions and promote motivation for lifestyle change and improved self-management.
- Applying the Chronic care model to targeted diseases of CHF and AMI will impact the high prevalence in Region.

In DY2 we will develop two Chronic Care Extensivist Clinics and hire/train multidisciplinary providers including 2 primary care physician board- certified in internal medicine.

- Process Metric 1: - (P-1) (P-4) Two clinics opened. Multidisciplinary team hired to support model.
- Rationale: Introducing two multidisciplinary Chronic Care Extensivist clinics in the Region is expected to increase access for patients with chronic conditions.

In DY2 we will develop a program to identify and manage chronic care patients needing further clinical interventions.

- Process Metric 3: Two chronic care programs developed to identify and manage chronic care patients.
- Rationale: Early identification and management of chronic conditions will ensure the implementation of prevention strategies for improved outcomes.

In DY2 we will establish baseline measures: patients eligible for program including those with MCCs CHF and AMI. Baseline measures will include HEDIS, PAA, and PPR for CHF and AMI..

- Process Metric 4: Establish baseline metrics of patients with chronic conditions related to HEDIS, PAA, and PAR for CHF and AMI.

In DY3, we will expand and document interventions types beyond the traditional one-to one in office visits for identified chronic care patients.

- Process Metric 5: Number of intervention types developed beyond the traditional one-to-one office visits for chronic care patients.
- Rationale: Care management that includes individualized interventions has demonstrated positive health outcomes in both quality of care and associated costs.

In DY4 we will apply this model to targeted patients with MCCs including CHF, AMI and increase the access as noted by 5% additional patients in target group.

- Metric 6 [I-17.1]: 5% additional patients in target group with CHF, AMI and other MCCs receive care in the Extensivist Clinic model.

In DY5 we will improve access to care for patients with chronic conditions/MCC through the Extensivist Clinic model.

- Metric 7 [I-21.1]: 10% increase in number of patient served in Extensivist Clinics with MCC, CHF, and AMI.
- Rationale: Research supports the expected outcomes of innovative models like the Extensivist clinic model for chronic conditions.

Unique community need identification numbers the project addresses:

- CN.11 – Need for more care coordination

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

This project enhances access and contributes to the Region identified need for expansion of chronic care models and improved care coordination. This model utilizes state of the art information systems for timely capture and communication of key clinical information. The Sandlot HIE will contribute to better coordination of care and communication among caregivers. The Sandlot portal for electronic exchange of key clinical information aligns with national goals for patient safety around communication among caregivers.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-3.5 Acute Myocardial Infarction (AMI) 30-day readmission rate

By the end of the Waiver, our goal is to decrease 30-day (all-cause) readmission for acute myocardial infarction (AMI) by 20% from baseline.

- Initial data pull from CMS claims indicates that the baseline rate for readmission due to AMI may be as high as 24.5% in target population.
- Rationale: This outcome measure is aligned with TMF Health Quality Institute Partnership for Patients in Texas to focus on avoidable readmissions. Recent research indicates 17.6% of beneficiaries are rehospitalized within 30 days of a hospital discharge and nearly 76% of those readmissions may be preventable. Better coordinated care and timely follow-up have been demonstrated to improve transitions of care and reduce 30-day readmissions for patients with chronic conditions.

Potentially Preventable Complications – Congestive Heart Failure IT-3.2 (CHF) 30-day readmission rate

By the end of the Waiver, our goal is to decrease 30-day (all-cause) readmission for congestive heart failure by 20% from baseline.

- Initial data pull from CMS claims indicates that the baseline rate for readmission due to AMI may be as high as 20% in target population.
- Rationale: This outcome measure is aligned with TMF Health Quality Institute Partnership for Patients in Texas to focus on avoidable readmissions. Recent research indicates 17.6% of beneficiaries are rehospitalized within 30 days of a hospital discharge and nearly 76% of those readmissions may be preventable. Better coordinated care and timely follow-up have been demonstrated to improve transitions of care and reduce 30-day readmissions for patients with chronic conditions.

Potentially Preventable Admissions – IT-2.1 Congestive Heart Failure Admission rate (CHF)

By the end of the Waiver, our goal is to decrease 30-day admission (all-cause) for heart failure patients by 15% from baseline.

- An initial data pull from our database shows that the baseline rate may be as high as 20%.
- Rationale: Tarrant County Public Health Department Behavioral Risk Factor Surveillance System 2009/2010 notes that among Tarrant County adults in 2007, heart disease ranked as the leading cause of death for both men and women. Also, during the years 2000 to 2005, Tarrant County residents spent about $500 million on preventable hospitalizations due to angina, CHF, and high blood pressure.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $9,203 in cost is saved by the health care system.[186] The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.
- **Individual benefits** were calculated using lost wages, caretaker expense and extension of life (if applicable).
    - The number of patients with Medicare and/or Medicaid and chronic conditions is estimated to be 50,000.
    - Based on claims data from 2011, the total number of dual eligible beneficiary with CHF and AMI diagnosis is estimated to be 2,672.
    - The project scope addresses chronic care management of at risk beneficiaries in Region including moderate to high-risk patients with diagnosis of heart failure and acute myocardial infarction.
    - The estimated baseline readmission rate for CHF is currently at 20%.
    - The estimated baseline readmission rates for AMI is 24.5 %
    - Tarrant County spends about $500 million on preventable hospitalizations.
    - A coordinated approach to improving care transitions and chronic care management is a priority for reduction of medical costs in at risk patients.

[186] Texas Department of State Health Services with a 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

120726804.2.4	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Health E Care NTSP & THPG Extensivist Clinics: Expand Chronic Care Management Model. Redesign the outpatient delivery system to coordinate care for patients with chronic diseases through an Extensivist Clinic Model*
Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group			*120726804*
Related Category 3 Outcome Measure(s):	*120726804.3.6* *120726804.3.7* *120726804.3.8*	*2 IT-2.1* *3 IT-3.2* *3 IT-3.5*	*Congestive Heart Failure Admission Rate* *Congestive Heart Failure 30-Day Readmission Rate* *Acute Myocardial Infarction 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-1]**:** Expand the Chronic Care Model by opening two Extensivist Clinics Metric 1 [P-1.1] Baseline/Goal: (2) Extensivist Clinics Open Data Source: Documentation of clinics operational in DY2. Milestone 1 Estimated Incentive Payment: $185,702 **Milestone 2** [P-3]: Develop two programs to identify and manage chronic care patients needing further clinical interventions. Metric 2 [P-3.1]: Two chronic care programs developed to identify and manage chronic care patients. Data Source: Documentation of Chronic Care programs developed. Milestone 2 Estimated Incentive Payment: $185,704	**Milestone 5** [P-10]: Expand and document interaction types between patient and health care team beyond one-to one office visits to include group visits, telephone visits, and other interaction types. Metric 5 [P-10.1]: Numerator: Number of group visits/telephonic or telehealth visits, home visits beyond office one-to-one visits. Data Source: Documentation from EM & claims. Milestone 5:Estimated Incentive Payment: $719,204	**Milestone 6** [I-17]: Apply the Chronic Care Model to targeted chronic diseases CHF & AMI Metric 6 [1-17.1]: 5% additional patients in target group with CHF, AMI receive care in the Extensivist Clinic Model. Data Source: Baseline data, Patient Registry, & Claims information from CMS and Sandlot HIE. Milestone 6: Estimated Incentive Payment: $758,545	**Milestone 7:** [I-21] (10%) Improvement in access to care of patients with MCC/ chronic condition Metric 7 [I-21.1]: Increase of 10% from baseline in number of patients served in clinic with MCC. Numerator: Number of unique patients with an MCC in target population receiving care in Extensivist clinic. Denominator: Number of individuals in the target population.. Data Source: Baseline data, Patient Registry, & Claims information from CMS and Sandlot HIE. Milestone 7: Estimated Incentive Payment: $612,490

120726804.2.4	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Health E Care NTSP & THPG Extensivist Clinics: Expand Chronic Care Management Model. Redesign the outpatient delivery system to coordinate care for patients with chronic diseases through an Extensivist Clinic Model*
Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group			*120726804*
Related Category 3 Outcome Measure(s):	*120726804.3.6* *120726804.3.7* *120726804.3.8*	*2 IT-2.1* *3 IT-3.2* *3 IT-3.5*	*Congestive Heart Failure Admission Rate* *Congestive Heart Failure 30-Day Readmission Rate* *Acute Myocardial Infarction 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 3 [P-3.2]: Increase the number of patients enrolled in the chronic care programs including target conditions CHF and AMI over baseline. (initial starting point 0 patients) Metric 3 [P-3.2] Baseline/Goal: Increase to an enrollment of approximately 2,600 patient in DY 2 Data source: Program enrollment records. Milestone 3 Estimated Incentive Payment: $185,704 **Milestone 4** [P-4]: Formalize a multidisciplinary team to support the chronic care model: 2 board certified primary care physicians and 6 primary care providers] Metric 1 [P-4.1] Total number hired: 2 board certified primary care physicians and 6 primary care providers to support chronic care			

120726804.2.4	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Health E Care NTSP & THPG Extensivist Clinics: Expand Chronic Care Management Model. Redesign the outpatient delivery system to coordinate care for patients with chronic diseases through an Extensivist Clinic Model*
Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group			*120726804*
Related Category 3 Outcome Measure(s):	*120726804.3.6* *120726804.3.7* *120726804.3.8*	*2 IT-2.1* *3 IT-3.2* *3 IT-3.5*	*Congestive Heart Failure Admission Rate* *Congestive Heart Failure 30-Day Readmission Rate* *Acute Myocardial Infarction 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)**
model. Data source: HR Records Milestone 4 Estimated Incentive Payment: $185,704			
Year 2 Estimated Milestone Bundle Amount: $742,814	Year 3 Estimated Milestone Bundle Amount: $719,204	Year 4 Estimated Milestone Bundle Amount: $758,545	Year 5 Estimated Milestone Bundle Amount: $612,490
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,833,053			

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 2.2.1 – Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes
Unique Project ID: 121794503.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Stephenville / 121794503
Provider: Texas Health Harris Methodist Hospital Stephenville (THS) is a 98 bed hospital in Stephenville, Texas serving a 1,870square mile area and a population of 51,677. Texas Health Harris Methodist Hospital Stephenville (THS) is the only hospital in Erath County, and provides community services, including inpatient and outpatient surgery, women's services, diagnostic imaging, inpatient physical therapy, and outpatient wound care.
Intervention: This project will identify patients who do not have a medical home and others appropriate for diabetes education, but who lack funds to pay for outpatient diabetes education classes. These patients will be referred to comprehensive outpatient diabetes education classes offered by Texas Health Stephenville free of charge. This project is a new initiative. We have not received any funds from the USDHHS.
Need of the project: There are no other outpatient diabetes education programs available to Medicaid and unfunded/indigent individuals in our area. This program will help improve access to care to promote participants' self-management of their diabetes. By funding program, CMS will lower the cost burden that keeps these patients from receiving this type of care and education
Target population: Patients with type 1 or type 2 diabetes, pre-diabetes, or gestational diabetes are the targeted population. The project seeks to provide diabetes education to 75-100 participants in DY 2 and increase the number of participants in DY 3, DY4 and DY5 by an additional 5% per year.
Category 1 or 2 expected patient benefits: A comprehensive care management program will be developed to capture strategies for reaching the Medicaid and Uninsured population and embrace up-to-date best practices to optimize effectiveness of program. Staffs will be trained on how to properly deliver the developed program to develop the foundation for growing a good reputation for the program in the community that will, in turn, eventually help promote awareness of program's availability and value. Program to assist patients to better self-manage their diabetes will be implemented to reduce the number of complications these patients have to, in turn, reduce the related financial drain to the health care system as a whole. By expanding and documenting interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types, program effectiveness will increase by increasing the various mechanisms of available message delivery to patients. Applying the Care Model to the locally prevalent targeted diabetes population and improving the percentage of patients with self-management goals will increase the number of lives in the community that the program positively impacts.
Category 3 outcomes: 1.10 Diabetes care: HbA1c poor control (> 9.0%) –This translates into a lower likelihood of having diabetes-related complications, such as a hospital admission. **IT-3.3 Diabetes 30-day readmission rate** - reducing the number of readmissions mitigates financial drain for the patient as well as the health care system.

Project Option 2.2.1 – Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes

Unique Project ID: 121794503.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Stephenville / 121794503
Project Description:
Physicians refer to the THS Outpatient Diabetes Education Program contingent on a diagnosis of diabetes type 1 or 2, pre-diabetes, or gestational diabetes. The program lasts for 3 months during which a series of educational classes are provided, both group and individual, with assessment at the end of the third month to measure effectiveness/success.
Second, inpatient clinical education efforts will be made to:

- Identify patients with the same criteria as above to facilitate a physician referral to the THS Outpatient Diabetes Education Program upon discharge.
- Identify patients who do not currently have a medical home and others appropriate for diabetes education, but who lack funds to pay for the above mentioned multisession classes. These patients will be referred to the free diabetes classes offered by the THS Outpatient Diabetes Education Program.

There are no other diabetes programs available in our area. This program will help improve access to care to promote participants' self-management of their diabetes.

Goals and Relationship to Regional Goals:
Project Goals:
There are no other diabetes programs available in our area. This program will help improve access to care to promote self-management of their chronic disease.

In the community, we anticipate an increased number of referrals from the identified patient population, a decrease in ED usage and a decrease in admissions/ readmissions for diabetes related diagnoses.

Goals include an enrollment growth rate of 5% over baseline (established in DY2) of Medicaid, Managed Medicaid, and uninsured patients with a diabetes diagnosis in the self-management program by the end of the Waiver period.

Individually, patients will self-manage their diabetes with the skills obtained through diabetes education. Patients will verbalize understanding of diabetes disease process, nutrition, medications, monitoring, goal setting and problem solving, psychosocial adjustment, physical activity, acute and chronic complications and preconception and pregnancy care, if applicable. Patients referred to the free program will self-select goals that will be monitored routinely

throughout the program with an expected 80% success rate at completion of the program, i.e., the participants will meet their self-selected goals 80% of the time or more.

This project meets the following Regional goals:
A goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. We aim to improve access to care, promote improved quality of care, and improve health outcomes. This project relates to this goal because it will provide our community with a disease management program to help people with diabetes, regardless of their income.

Challenges:
Historically, underserved patients have not been effectively educated on how to manage their diabetes. Some challenges this population encounters to receive proper education to manage their disease include the inability to pay, transportation limitations, Medicaid does not cover the service in a hospital and there are no other programs in the area. Moreover, they have not been tracked to measure their outcomes and long term goals. This program will link diabetes patients who present to the ED or are admitted to a primary care physician and diabetes management resources to provide seamless care for the Medicaid, managed Medicaid, and uninsured patient population.

5-Year Expected Outcome for Provider and Patients:

- Patients referred to the program will self-select goals that will be monitored routinely throughout the program with an 80% success rate at completion of the program.
- Enrollment growth rate of 5% over baseline (established in DY2) of Medicaid, Managed Medicaid, and uninsured patients with a diabetes diagnosis in the self-management program by the end of the Waiver period.

Starting Point/Baseline:
Texas Health Hospital Stephenville is the project's primary provider. The project will begin with establishing baseline data in DY2 (January 2013 through September 2012, with extrapolation for the full 12 months). Current enrollment in our diabetes classes is approximately 75-100 people per year, and we expect an increase in enrollment. Erath County is the geographic area we are trying to reach. Our target population is adults with diabetes, pre-diabetes, and gestational diabetes.

Rationale:
One in every nine individuals age 18 or older in Erath County has a diabetes diagnosis. As the age of community increases, the percentage of diabetes increases. The number of patients in our EDs and hospitals with a primary diagnosis of diabetes is a small percentage of our outpatient diabetes management programs. Therefore, there needs to be a link from ED and inpatient to outpatient resources and education.

The Chronic Care Model, developed by Ed Wagner and colleagues at the MacColl Institute[187], has helped hundreds of providers improve care for people with chronic conditions. Fifteen randomized trials of system change interventions include Diabetes Cochrane Collaborative Review and JAMA Re-review, which looked at about 40 studies, mostly randomized trials, with interventions classified as decision support, delivery system design, information systems, or self-management support; 19 of 20 studies included a self-management component that improved care, and all five studies with interventions in all four domains had positive impacts on patients.

Project Components:
Our project includes all of the components listed in the project option 2.2.1. We have a multidisciplinary care team which includes dietitians, nurses, physicians, and potentially other disciplines such as pharmacy and physical therapy. The participants have access to the care team through a variety of methods including email, phone, and in person. The participants will receive instruction from staff in a series of free weekly classes which include, among other topics, diabetes survival skills, meal planning, complications, pathophysiology, goal setting,, medications, monitoring, coping skills, pregnancy care and exercise. Participants may enroll in the classes at any week as they do not have to be taken in a specific order. Patients are empowered to develop diabetes self-management skills to help manage their disease through goal setting and classroom instruction. Quality improvement projects are ongoing.

In our service area the Hispanic community makes up approximately 20 % of the population and is the fastest growing ethnicity in Erath County where Stephenville is located. Hispanic people are about 1.5 times more likely to develop diabetes than non-Hispanic white people. In the current Texas Health Harris Methodist Stephenville Hospital Outpatient Diabetes Education Program, approximately 80-85% of those served are Caucasian, thus indicating a need for innovation and creativity to reach the Hispanic population.

Another area of opportunity is cost of managing diabetes. Since a large percentage of THR patients have limited access to insurance and other resources, it is paramount that we intervene by educating the people in the community we serve.

Unique community need identification numbers the project addresses:

- CN.10 – Overuse of emergency department services
- CN.12 – Need for more culturally competent care to address unmet needs
- CN.13 – Necessity of patient education programs

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

[187] Source: The Chronic Care Model website. Please see http://www.improvingchroniccare.org for more information.

This project is a new initiative. We have not received any funds from the USDHHS.

Related Category 3 Outcome Measures:

Outcome Measures:

1.10 Diabetes care: HbA1c poor control (>9.0%)

a) Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or 2) who had hemoglobin A1C (HbA1c) control> 9.0%

b) Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and 2)

3.3 Diabetes 30-day readmission rate

a) Numerator: number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index diabetes admission. If an index admission has more than one readmission, only the first is counted as a readmission.

b) Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Reasons/Rationale for Selecting the Outcome Measures:

The chronic care model has six elements for effective care for chronic disease and our program includes elements of this model. Programs that incorporate at least one element of the model have a beneficial effect on outcome measures. In their meta-analysis, diabetes interventions led to a reduction in A1C in patients with diabetes.[188] In the Diabetes Prevention Program study, lifestyle interventions reduced the incidence of diabetes by about 58% over three years in people with pre-diabetes.[189] Diabetes management with an A1C goal of < 7% has protective effects on patients with type 1 diabetes and promotes micro and macrovascular complication prevention.[190] There is also a correlation between glycemic control and the cost of medical care with increase in medical charges for every 1% increase in A1C above 7%.[191]

Relationship to Other Projects:

- **Related Category 1 and 2 projects:** There are no other diabetes programs available in our area. This program will help improve access to care to promote self-management of a participant's chronic disease. We are located in a remote part of Region 10 and there is no identified overlap between our entity's project and other projects in Region 10.

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[188] Tsai AC, Morton SC, Mangione CM, et al.: A meta-analysis of interventions to improve care for chronic illnesses. *Am J Manag Care* 2005; 11(8); 478-88.

[189] Knowler WC, Barrett-connor E, Fowler SE, et al.: Reducation in the incidence of type 2 diabetes with lifestyle intervention or metformin. *N Engl J Med* 2002; 346 (6): 393-403.

[190] Holman RR, Paul SK, Bethel MA, et al.: 10-year follow-up of intensive glucose control in type 2 diabetes. *N Engl J Med* 2008; 359 (15): 1577-89.

[191] Tsai AC, Morton SC, Mangione CM, et al.: A meta-analysis of interventions to improve care for chronic illnesses. *Am J Manag Care* 2005; 11(8); 478-88.

- **Related Category 4 population-focused improvements** RD.1: Potentially Preventable Admissions RD.1.2: Diabetes Admission Rate should improve for at-risk patients who would not otherwise be able to access care to manage their diabetes. Diabetics whose disease is managed will decrease their risk of developing complications from their disease that would result in hospital admissions. RD 2: 30 Readmission Rate – RD 2.2 Diabetes 30-day Readmissions are Category 3 Outcome Measures selected as an anticipated outcomes to measure the effectiveness of this project. By providing access to care and assistance in self-management of their disease, risk of admission and readmission are reduced.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

- **Approach:** For every inpatient admission avoided, $8,297[192] in cost is saved by the health care system. Health care costs are calculated by multiplying $8,297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale:** Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).

[192] Assumes a cost-to-revenue of 30%. Texas Department of State Health Services. http://www.dshs.state.tx.us/ph/county.shtm.

121794503.2.1	***2.2.1***	***2.2.1 A, 2.2.1.B, 2.2.1.C, 2.2.1.D, 2.2.1.E***	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*
Texas Health Harris Methodists Hospital Stephenville			*121794503*
Related Category 3 Outcome Measure(s):	*121794503.3.1* *1217945033.2*	*3.IT-1.10* *3.IT-3.3*	*1.10 Diabetes care: HbA1c poor control (>9.0%)* *3.3 Diabetes 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 a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Goal: Implement the diabetes education program at our facility. Data Source: Program records. Metric 2 [P-3.2]: Increase the number of patients enrolled in a care management program over baseline Baseline: 75-100 participants per year Data source: program records Milestone 1 Estimated Incentive Payment: $10,931	**Milestone 3** [P-11]: Develop and implement program to assist patient to better self-manage their chronic conditions. Metric 1 [P-11.1]: Increase the number of patients enrolled in a self-management program. Goal: 5 % additional patients over baseline Data Source: Program records Milestone 3 Estimated Incentive Payment: $10,583 **Milestone 4** [P-10]: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types. Metric 1 [P-10.1]: Increase the number of group visits and/or telephone visits and/or other interaction types. Baseline: One group visit per week. Data Source: Program records	**Milestone 5** [I-17]: Apply the Care Model to targeted chronic disease, which are prevalent locally Metric 1 [I-17.1]: X additional patients receive care under the Care Model for diabetes. Goal: 5% additional patients over DY 3 Data Source: Program records Milestone 5 Estimated Incentive Payment: $11,162 **Milestone 6** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I.18.1]: Patient with self-management goals Numerator: The number of patients with diabetes self-management goal. Denominator: Total number of patients with diabetes enrolled in program. Goal: 85% of patients to set self-management goals. Data Source: Program records	**Milestone 7** [I-17]: Apply the Care Model to targeted chronic disease, which are prevalent locally Metric 1 [I-17.1]: X additional patients receive care under the Care Model for diabetes. Goal: 5% additional patients over DY 4 Data Source: Program records Milestone 7 Estimated Incentive Payment: $9,013 **Milestone 8** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patient with self-management goals Numerator: The number of patients with diabetes self-management goal. Denominator: Total number of patients with diabetes enrolled in program. Goal: 95% of patients to set self-management goals. Data source: Program records

121794503.2.1	***2.2.1***	***2.2.1 A, 2.2.1.B, 2.2.1.C, 2.2.1.D, 2.2.1.E***	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*
Texas Health Harris Methodists Hospital Stephenville			*121794503*
Related Category 3 Outcome Measure(s):	*121794503.3.1* *1217945033.2*	*3.IT-1.10* *3.IT-3.3*	*1.10 Diabetes care: HbA1c poor control (>9.0%)* *3.3 Diabetes 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 2 [P-2]**:** Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1] Increase percent of staff trained Numerator: number of relevant staff trained in the Chronic Care Model Denominator: Total Number of relevant staff Goal: 100% of staff trained Datasource: Staff records Milestone 2 Estimated Incentive Payment: $10,931	Milestone 4 Estimated Incentive Payment: $10,584	Milestone 6 Estimated Incentive Payment: $11,163	Milestone 8 Estimated Incentive Payment: $9,013
Year 2 Estimated Milestone Bundle Amount: $ 21,862	Year 3 Estimated Milestone Bundle Amount: $ 21,167	Year 4 Estimated Milestone Bundle Amount: $22,325	Year 5 Estimated Milestone Bundle Amount: $18,026
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ 83,381			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.2.2 – JPS Diabetes Chronic Care Management

Unique Project ID: 126675104.2.1
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS is also Fort Worth's only acute psychiatric care facility.
Intervention: The project will improve diabetes clinical outcomes and self-management skills in a patient-centered medical home. This is a new intervention based on Wagner's chronic care model interwoven into a new medical home setting.
Need for the project: The region has noted a lack of care coordination. With a diabetes prevalence rate of 9.7 % in Texas and 8.3% in Tarrant County, this is a disease that should be addressed.
Target population: There are about 17,000 diabetic patients in our current primary care setting. We estimate that we will positively impact about 50% of the target population.
Both Medicaid and county-sponsored uninsured patients are in our ambulatory clinics. We will focus on those patients with diabetes who will receive education and focused clinical interventions to improve clinical outcomes.
Category 1 or 2 expected patient benefit: Milestones include developing a comprehensive program using multi-disciplinary teams implemented at first in one clinic. We will spread the program to 3 additional clinics with defined training. Increasing number of patients will treated in this model and with a focus on creating self-management goals. All of these milestones will create capacity for bringing patients into a diabetes chronic disease model to improve self-management skills and clinical outcomes.
Category 3 outcomes: Clinical outcomes have been chosen to decrease diabetic complications and include improving hemoglobin A1C control, Blood pressure control, and completing foot examinations.

Project Option 2.2.2 – JPS Diabetes Chronic Care Management

Unique Project ID: 126675104.2.1
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
JPS Health Network will improve diabetes management for our medical home patients by implementing Wagner's chronic care model.[193] This comprehensive disease management program to be rolled out in each of our primary care clinics will include evidence-based protocols and team-based, coordinated care delivered in a patient-centered medical home that will enable patients to access their care teams in person, phone or email. We will use registry implementation, focused prevention services, and self-management education to enhance patients' medical home access. We will engage patients in peer to peer education, psychosocial support groups and motivating classes. We will improve physician/patient communication and goal-setting through strategic visits and active multidisciplinary planning and execution. The Plan-Do-Study-Act (PDSA) method will be used to roll out our care model; measurement and feedback will be used to improve program quality. We expect to use our experience in developing and implementing this program to address other chronic diseases.

Goals and Relationship to Regional Goals:
Chronic disease management will enable us to meet our five-year goals of improving quality outcomes for our diabetic medical home patients while reducing health care costs.

Project Goals:

- Empower our patients to take an active part in their own care;
- Decrease complications and improve quality of life through evidence-based interventions and age-appropriate prevention; and
- Improve care coordination through planning, coaching and navigation with the medical home team.

This project meets the following Regional goals: This project addresses specific specialty and primary care access and chronic care management issues for a vulnerable patient population: low-income individuals with diabetes.

193 Improving Chronic Illness Care created the Chronic Care Model, the well-documented and tested leading model for treating chronic diseases, which summarizes the basic elements for improving care in health systems. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. By using evidence-based change concepts within each element in combination with one another, patients are better-informed and then take an active part in their care, while patient care teams have the resources and expertise they need to better manage the chronic illnesses of their patients. The results are more productive interactions between patients and their care teams, and better clinical outcomes for patients with chronic diseases. See http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2 for detailed information about the Care Model.

Challenges:
About 17,000 JPS Health Network medical home patients and 12% of our frequent ED/hospital users are diabetic. Many of these patients are seen sporadically within our network, receiving care that varies and may not meet evidence-based guidelines. Only a small percentage sees a primary care doctor regularly. Developing an improved chronic care management approach will improve their continuity of care and lead to improvement in diabetes indicators. For example, 19% of diabetic patients have a hemoglobin A1c (HbA1c)> 9 (indicator of blood sugar levels out of control or poor glycemic control). Similarly, only 35% of those patients had eye exams that year. Developing a program of standardized care and improved patient engagement will improve patient's glycemic control levels and reduce their ED visits, inpatient admissions, disability and premature death. Similarly, encouraging regular eye exams will benefit this population.

5-Year Expected Outcome for Provider and Patients:
JPS Health Network will implement an evidence-based chronic care model for the approximately 17,000 patients with diabetes seen annually in our clinics. By the end of the Waiver period, 40% of those patients will have received care under the care model and 30% will have self-management goals. We will be able to improve clinical outcomes for diabetes patients, including specific metrics such as Hemoglobin A1c (HbA1c), BP control, interval eye and foot exams, and renal function monitoring to mitigate or prevent complications.

Starting Point/Baseline:
In fiscal year 2011, we served 17,041 diabetic patients who used JPS Health Network clinics for primary care. Our current diabetes case management program relies primarily on individual diabetes case managers located in primary clinics. We case managed 2038 diabetic patients in 2011. At this time most of our case management consists of one-on-one education and with inconsistent results. Group visits have been sustained in a few clinics but are not universally appreciated. On average we were able to decrease HbA1cof the case managed patients by 0.5% after six months of case management in 2011. Fifty-one percent of the time this diabetic population had eye exams and 66% of the time had foot exams. BP values have not been documented electronically until this year. The average HbA1c for these individuals under our present approach is 9.2.

Rationale:
Diabetes is one of 10 major causes of morbidity in our Region.[194] Diabetes prevalence in Tarrant County is at 8.3%, according to the latest Behavioral Risk Factor Surveillance System (BRFSS) report in 2007,[195] a 2% increase from the same survey in 2006. The 2010 statewide BRFSS result

194Texas DSHS (http://www.cancer-rates.info/tx/index.php, http://www.dshs.state.tx.us/chs/info/info_disease.shtm)

195 Texas Behavioral Risk Factor Surveillance System, 2007. Center for Health Statistics, Texas Department of State Health Services

for Texas was 9.7% in 2010.[196] This project makes sense for our community because we will better manage individuals with diabetes and offer improved appropriate treatment in the medical home.

Project Components:
We have incorporated all core components in this outpatient delivery system redesign to coordinate care for patients with chronic diseases. This comprehensive disease management program will include team-based care in a patient-centered medical home. Our team will include a clinical pharmacist, a nurse coach, a population care manager with the patient's personal practitioner (C2Milestone 2,P-4). The program will be rolled out first in one clinic (C2Milestone 4,P-1) and then spread to three more clinics after evaluating and improving the model. The medical home team will provide access to patients in person, phone or through our electronic medical record portal. We will use registry implementation, focused prevention services, and self-management education to enhance the health of our patients. We will engage patients in peer to peer education including through group visits, psychosocial support groups and motivating classes. We will improve physician/patient communication and self-management goal-setting (C2Milestone 8, I-18) through strategic visits and active multidisciplinary planning and execution. Metrics and milestones designated for the diabetes chronic disease management program will be used. Initially, we will create a stakeholder group to review the current state and determine a timeline for the project and its implementation. (C3, Milestone 1, P-1) We will validate our baseline for each measure. (C3, Milestone 2, P-2) The data system will be tested for accuracy. (C3, Milestone 3, P-3)We will pilot the program in one clinic with data collected pre- and post-patient interventions before rolling it out to additional clinics. The Plan-Do-Study-Act (PDSA) method will be used to evaluate and adjust our care model; measurement and feedback will be used to improve program quality.(C3 Milestone 4,P-5) Clinical results, registry use, and barriers will be identified and learning with best practices will be embedded in the program. Stakeholders will be kept informed. (C3 Milestone 5, P-5)The process will be expanded to every medical home and will become a framework for focus on other chronic diseases. According to the Region 10 needs assessment survey**,** all counties in the Region identified lack of coordination as a major area for system improvement. Barriers identified included complexity of coordination, lack of staff, and lack of financial integration, fragmented system service, and "practicing in silos". Providers did not feel that there was strong care coordination between primary care providers, hospitals, and specialists. Other health behaviors contributing to diabetes prevalence and management in Region 10 are adult obesity (30%) and lack of physical activity (28%). Region 10 had a lower rate of health screening than the nation and the state as a whole.

Unique community need identification numbers the project addresses:

196 Texas Behavioral Risk Factor Surveillance System, 2010. Center for Health Statistics, Texas Department of State Health Services

- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
We will create a medical home in 15 clinics and roll out chronic disease management in each clinic to provide patient with improved access to behavioral and medical services in an ambulatory setting. We will re-position some staff to focus on network transitions, and use the registry to manage patients at the right intensity. With tools such as EPIC and Crimson Population risk management and with a team-based approach, we will optimize care and open up access for diabetic patients in our clinics. Physicians will have the support needed to offer evidence-based care, assistance with following through on individualized care plans, and high-quality education. Physicians in the inpatient and ED/urgent care setting and patients themselves will feel the impact and will appreciate being quickly navigated to the appropriate level of care. The new diabetes management program will track diabetes patients through a registry to ensure appropriate service delivery and risk stratification for intensity. Improved transitions from the inpatient setting will help prevent readmissions and transitions from the outpatient setting will inform the inpatient team of particular patient needs. Diabetes patients will be linked with appropriate education and medication management with a clinical pharmacist. In the new medical homes, clinical teams will develop a plan for each patient's care, driven by an RN coach and led by a physician. Medical home service delivery will include 24-hour access to clinical decision making as well as delivery of acute, chronic, and preventive care.

No federal funds have been received or are associated with this program.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

- IT-1.10 Diabetes Care: HbA1c poor control (>9.0%) Stand-alone measure

Diabetic patients must maintain glucose control because it impacts many physiologic systems. Proven methods to impact control include self-management skills and pharmaceutical treatment. In the hospital's fiscal year 2011, 8% of JPS medical home patients with diabetes and low income had anHbA1c> 9. When the same population was evaluated recently, 25% of the patients had anHbA1c> 9. We think this worsening control is multi-factorial, but our current clinical system did not help our patients maintain their control of the glucose levels. The chronic care model (CCM) has been shown to improve the Diabetes Knowledge Test and the Diabetes Empowerment Score as documented in a randomized control trial in an underserved urban community. Self-monitoring of glucoses and A1C were also improved in this population.[197] Similar intermediate outcome goals including improved hemoglobin HbA1c were also confirmed

197 Platt G, Orchard T, Emerson S, et al. Translating the Chronic Care Model Into the Community. Diabetes Care, 2006:29(4), 811-817.

in a two-year CCM study according to Chin et al through the Health Disparities Collaborative.[198] The development of a strong chronic disease management program with registry capabilities can impact the patient's glucose control through education, case finding through analysis of our diabetic population, and targeted interventions. Wagner, in his paper on the IHI breakthrough series collaborative for Chronic Illness Care noted improvement of HbA1cby about 20% over a 13-month period.[199] We will also decrease the patients with HbA1c> 9 by 20% in our diabetic population after implementing a diabetes chronic care program.

- IT-1.11 BP control (Diabetes Care: BP control 140/80) Stand alone
- Control of blood pressure (BP) in the diabetic patient has been determined to be the most important factor to target to avoid coronary artery disease, chronic kidney disease, and retinal disease. Aggressive management will be needed in many patients to bring their BP down to this goal. We had not collected BP data on our patients in our paper charts. We will need to collect and validate data to document our baseline. The Study of Cardiovascular Risk Intervention by Pharmacists-Hypertension (SCRIP-HTN) study using a team approach with a pharmacist and nurse care manager brought the BP down 14% with a six-month intervention.[200] By the end of our five-year project, we will decrease the number of our patients with BP >140/80 by 30% from the baseline determined in our baseline using a similar team-based approach.
- IT-1.13 Diabetes Care: Foot Exam Non-stand-alone

The economic cost of a diabetic foot ulcer is estimated at $7,000 to $10,000; the per person cost of amputation is estimated at $65,000. However, a yearly foot exam looking for vascular, neurologic and foot abnormalities can prevent a foot ulcer. The IHI collaborative project described by Dr. Wagner in the Journal of Quality Improvement, noted a 50% increase in the number of foot exams done in the 13 month collaborative.[7] By the end of the five-year project, we will increase the number of diabetic patients receiving a yearly foot exam to 50% more from baseline.

Relationship to Other Projects:

In four hospitals throughout Tarrant County, and in Erath County, patients will receive coordinated diabetic outpatient care. These efforts will reinforce each other and encourage community resource development. A Tarrant county program to reduce smoking in diabetic patients will be an additional community resource for our diabetic patients.

198 Chin MH, Drum ML, Guillen M, et al. Improving and sustaining diabetes care in community health centers with the Health Disparities Collaborates. *Med Care* 2007; 35(12):1123-5.

199 Wagner EH, Glasgow RE, Davis C, et al. Quality Improvement in "Chronic Illness Care: A Collaborative Approach. Journal of Quality Improvement 2001:27 (2), 63-80.

200 McLean DL, McAlister F, Johnson,J et al. A randomized trial of the effect of community pharmacist and nurse care on improving blood pressure management in patients with diabetes mellitus. *Arch Intern Med*.2008;168(21):2355-2361.

Across the JPS Health Network system, patient-centered medical home transformation will provide critical support to the diabetic chronic disease program with delivery of acute, chronic and preventive services including mammogram, Pap smears, and pneumonia vaccinations. (IT 3.12.1, 12.2, 12.4).The diabetes chronic care management project will be reinforced with the expansion of specialty eye care (1.9.2) and yearly eye exams. The call center project will expand access and enhance medical advice (IT.1.6) will assist our diabetic patients to receive clinical decision support 24 hours per day and may help the diabetic patient (often with comorbidities) avoid an ED visit or an admission for an ambulatory sensitive condition. (IT2.12) The patient experience improvement program will address the needs of the diabetic patient who may have anxiety or otherwise need encouragement to complete self-management goals. (IT-6.1) Diabetics may suffer from depression, and our chronic management program will include screening to identify depression. Patients exhibiting criteria for depression will be provided virtual psychiatric and clinical services. (IT-2.16) Several behavioral health and primary care collaborative projects will assist our chronic disease management patient through integration of primary care and behavioral health care in medical home locations (2.15.1). Also, as the diabetes chronic care program will facilitate care management for improved outcomes and support, we will now add an additional care management resource that will integrate primary and behavioral health needs with a focus on the whole person. (2.19.1)

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as 17,000 JPS Medical Home patients with diabetes. The percentage of the population expected to be positively impacted by the project is 50%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or her ability to control diabetes is significantly improved.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, - the community has a whole is not significantly impacted.

126675104.2.1	*2.2.2*	*2.2.2*	Apply evidence-based care management model to patients identified as having high-risk health care needs
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.10 126675104.3.11 126675104.3.12	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)Diabetes
		IT-1.11	Diabetes care: BP control (<140/80mm HgDiabetes
		IT-1.13	Diabetes care: foot exam

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 a comprehensive care management program Metric 1 [P-3.1]**:** Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute Illness Care's Assessment Model may be utilized in program development. Baseline/Goal: Develop a program based on Wagner's Chronic Care model Data Source: Program Materials Milestone 1 Estimated Incentive Payment: $1,770,823 **Milestone 2** [P-4]: Formalize multidisciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar. Metric 1 [P-4.1]: Increase the number of multidisciplinary teams (e.g.,, teams may include physicians, mid-level practitioners, dieticians, licensed	**Milestone 5** [P-1]:Expand the Care Model to primary care clinics Metric 1 [P-1.1]:Increase number of primary care clinics using Chronic Care Model Baseline/Goal: 3 additional clinics4 total clinics) Data Source: Training documentation of practice management: registry usage, and education class rosters and pre and post diabetic indicator results. Milestone 5 Estimated Incentive Payment: $3,622,261 **Milestones 6** [P-2]:Train Staff in the Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1[P-2.1]: Increase percent of staff trained Numerator: Number of relevant staff trained in the Chronic Care Model Denominator: Total number of	**Milestone 7** [I-17]:Apply the Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]: Additional patients receive care under the Care Model for a chronic disease or for MMC Numerator: Number of diabetics in the medical home receiving care under a chronic care model Denominator: number of patients with type 1 or type 2 diabetes in the medical home Goal:30% of type 1 and type 2 JPS Medical Home Diabetics under chronic care model(Approximately 5112 patients) Data Source: Diabetes Registry, EMR Milestone 7 Estimated Incentive Payment: $3,874,977 **Milestone 8** [I-18]: Improve percentage of patients with self-management Goals.	**Milestone 9** [I-17]:Apply the Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]: Additional patients receive care under the Care Model for a chronic disease or for MMC Numerator: Number of diabetics, type 1 and type2 in the medical home receiving care under a chronic care model Denominator: number of patients with type 1 or type 2 diabetes in the medical home Goal: Goal 40% of type 1 and type 2 Diabetes in the medical home:6816 patients) Data Source: Diabetes registry, EMR Milestone 9 Estimated Incentive Payment: $3,201,068 **Milestone 10** [I-18]:Improve percentage of patients with self-management goals Metric 1 [I-18.1]: Patient with self-

126675104.2.1	*2.2.2*	*2.2.2*	Apply evidence-based care management model to patients identified as having high-risk health care needs
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.10 126675104.3.11 126675104.3.12	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)Diabetes
		IT-1.11	Diabetes care: BP control (<140/80mm HgDiabetes
		IT-1.13	Diabetes care: foot exam

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)**
clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams Baseline/Goal: Increase number of clinic sites to 1 clinic Data Source: Education roster for Team list, Registry, Program calendar Milestone 2 Estimated Incentive Payment: $1,770,823 **Milestone 3** [P-2]: Train Staff in the Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1]: Increase percent of staff trained Numerator: Number of relevant staff trained in the Chronic Care Model Denominator: Total number of relevant staff Baseline/Goal: 100% of all medical home staff at one clinic	relevant staff Baseline/Goal: 100% at three clinics (4 clinics total) Data Source: Sign-in Sheets for training Milestone 6 Estimated Incentive Payment: $$3,622,261	Metric 1 [I-18.1]: 5112Patient with self-management goals Numerator: The number of patients with the specified chronic condition/MCC in the registry with at least one recorded self-management goal Denominator: Total number of patients with the specified chronic condition/MCC in the registry Baseline/Goal: 20% of patients with type 1 or type 2 Diabetes with self-management goals :3408 patients Data Source: Diabetes Registry, EMR Milestone 8 Estimated Incentive Payment: $3,874,977	management goals Numerator: The number of patients with the specified chronic condition/MCC in the registry with at least one recorded self-management goal Denominator: Total number of patients with the specified chronic condition/MCC in the registry Goal: Goal 30% of type 1 or type 2 Diabetics in the medical home will have self-management goals (approximately 5112 patients) Data Source: diabetes registry and EMR Milestone 10 Estimated Incentive Payment: $3,201,068

126675104.2.1	*2.2.2*	*2.2.2*	Apply evidence-based care management model to patients identified as having high-risk health care needs
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.10 126675104.3.11 126675104.3.12	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)Diabetes
		IT-1.11	Diabetes care: BP control (<140/80mm HgDiabetes
		IT-1.13	Diabetes care: foot exam

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)**
Data Source: Sign-in Sheets for training Milestone 3 Estimated Incentive Payment: $1,770,823 **Milestone 4** [P-1]:Expand the Care Model to primary care clinics Metric 1 [P-1.1]: Increase number of primary care clinics using Care Model. Baseline/Goal: Baseline-0. Implement the Care Model in 1 clinic. Data Source: Training documentation, registry usage, education class rosters, pre- and post-indicator results Milestone 4 Estimated Incentive Payment: $1,770,823			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):*	Year 3 Estimated Milestone Bundle Amount: $7,244,522	Year 4 Estimated Milestone Bundle Amount: $7,749,954	Year 5 Estimated Milestone Bundle Amount: $6,402,136

126675104.2.1	*2.2.2*	*2.2.2*	Apply evidence-based care management model to patients identified as having high-risk health care needs
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.10 126675104.3.11 126675104.3.12	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)Diabetes
		IT-1.11	Diabetes care: BP control (<140/80mm HgDiabetes
		IT-1.13	Diabetes care: foot exam

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)**
$7,083,292			

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$28,479,904

Project Option 2.1.1 – Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.

Unique Project ID: 126675104.2.2
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: The project is designed to implement the patient-centered medical home model in the primary care clinics at JPS Health Network. This project represents a new initiative.
Need for the project: The implementation of Patient-centered medical homes has been shown to improve health outcomes and reduce unnecessary costs of care such as potentially avoidable ED visits.
Target population: Current and future enrolled JPS Connection patients under 75 years of age. Our current medical home population is estimated at 68,000. Implementation of the PCMH is targeted to reach all the current and prospective future medical home patients. Not all of our Connection patients currently seek service in the medical home. About 25-50 new patients are enrolled each week. Two of the Category 3 outcomes for this project are targeted at females enrolled in the medical home within certain age groups. For those projects, the categories have some overlapping patients but the targeted interventions are different (pap smears and mammograms). Currently the estimated female population between ages 21 and 69 years.
Expected patient benefits: The project is designed to improve health outcomes and enhance access to care in the primary care clinics.
Category 1 or 2 expected patient benefits: -The project milestones include all of the following required core components:

1. Utilizing a gap analysis to assess and/or measure readiness for NCQA PCMH readiness
2. Conduct feasibility studies to determine necessary steps to achieve PCMH status.
3. Conducting educational sessions for primary care physician offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision.
4. Conducting quality improvement for the project using rapid cycle, lessons learned, etc.

Patients will benefit from a coordinated care delivery system with the patient centered medical home as the center of that system. A patient-centered focus on wellness with 24/7 access to care teams and other resources will build a healthier community.

Category 3 outcomes: Category 3 outcomes include improving compliance with preventive screening tests including pap smears and mammograms and reducing avoidable admissions. Using the current baseline data, JPS will work to reduce PQI Ambulatory Care Sensitive Conditions (IT 2.12) from 1104 to less than 875 potentially preventable admissions. Using

referral tracking systems and improved emphasis on wellness, the medical home team will work to increase compliance with preventive screening for eligible females in the medical homes. For females eligible for mammograms, the project will increase compliance to 50% of our 22,600 plus eligible females. The project will increase compliance to 40% for our 15,600 females that are eligible in this age group.

Project Option 2.1.1 – Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.

Unique Project ID: 126675104.2.2
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
JPS Health Network will implement a Patient-Centered Medical Home (PCMH) model in all 14 of its community-based primary care sites over the next five years.[201] In doing so, JPS Health Network will move from a provider-based care system to a team-based care system. We will assess gaps in policy and practice as compared with the NCQA hospital-affiliated Medical Home Certification Program. Staff, providers and patients will be trained in PCMH principles and JPS culture will be adapted throughout to ensure staff commitment at all levels. Each medical home will include a learning center where patients and other community members can learn about healthy lifestyle options and ways that they can improve their health. JPS Health Network roles and job descriptions will be modified to support team-based care. These community-based care teams will consist of providers, navigators, health coaches, clinical pharmacists, population health managers, behavioral health specialists, and others to be determined based upon patient care needs. The teams will provide ongoing preventive, chronic and acute care at the medical home site delivered in person, by telephone and by home visits when necessary. We will partner with community agencies that conduct home visits. (See project 126675104 2.12)

Medical homes will provide comprehensive and timely primary care services and coordinate patients' other health care needs. Provider teams will focus care on wellness and preventive health care by developing care plans that include a strong emphasis on self-management of chronic conditions. Same day access for acute care visits will be a key component of creating timely access for patients receiving care in the medical home. A welcome clinic for patients newly enrolled in the JPS Connections program will be implemented to assist patients in assignment to a medical home and first visit within 60 days. The Connections program is designed for the working poor of Tarrant County – working-age low-income adults that do not qualify for Medicaid, Medicare or Chip benefits. Currently, this group of patients represents more than half of our medical home population. We will work closely to develop and right-size PCMH team members to support medical home infrastructure once patient panels are determined. This PCMH program is a first critical step in a broad 10-year commitment by JPS to consolidate its existing 14 primary care sites into four large ambulatory care centers strategically located around Tarrant County to serve as the base of its patient medical homes. The transformation of the medical home in our safety net system will improve health quality and reduce health care costs for the county and RHP 10.

Goals and Relationship to Regional Goals:
Project Goals:

201 1https://www.pcpcc.net

The five year goals of this project include the following key components: Improving the timely assignment of patients to medical home teams, ensuring that patients receive care from their assigned medical home team, and improving the number of medical home patients receiving preventive services as clinically indicated. The medical home model will be implemented at all 14 sites with a goal to achieve PCMH certification at 7 of 14 sites by a nationally recognized agency such as the Joint Commission or NCQA.[202,203] JPS will use the Safety Net Medical Home Initiative Implementation Guide published by the Commonwealth Fund to transform our care delivery model.[204] JPS expects to reduce potentially preventable admissions to our ED and inpatient service. With a focus on preventive care and tracking of preventive care compliance, JPS will expect an increase in the number of patients receiving timely preventive services.[205]
This project meets the following Regional goals: A major Regional goal is to improve access to timely care at the right place and reduce the cost of care. When a patient cannot get timely access to medical care, they seek care outside their medical home. Some of our patients are seeking urgent or emergent care in other hospital systems.

Challenges:
JPS Health Network has 14 medical home sites delivering primary care services spread across Tarrant County. There are inconsistencies across the sites in terms of phone answering, message delivery and response timeliness and processes, based on patient satisfaction survey results and complaints received by our Office of Patient and Family Experience. Further, even though same day walk-in slots are available at all clinics, staff are not offering them to patients consistently. This lack of timely access to medical advice or care is a major reason our patients seek care in the ED or Urgent Care. Another problem to be resolved by the PCMH project and other JPS patient-centered initiatives will be reducing wait times to first appointment in their medical home. At this time, wait times are variable and can be as lengthy as 130 days at certain sites; and patients are told to seek care in the urgent care center while waiting for a first visit in the medical home. Additionally, JPS has implemented an evening nurse triage line for our medical home patients. Of 450 phone calls averaged each month, 10% of those patients are sent to the ED after speaking to the nurse. The other callers report that they would have sought care in the ED or urgent care center for even prescription refills if the nurse call line had not been available. Implementation of a Patient-Centered Medical Home (PCMH) across our clinical sites will increase our competence in delivering coordinated care across our system and managing a complex population of patients with a high incidence of chronic disease and psychosocial issues that impact patients' ability to manage their chronic disease outside the physician's office on their own. A system of well-coordinated resources such as health coaches, social workers,

202 https://www.jointcomission.org
203 https://www.ncqa.org
204 https://www.commonwealth.org
205 Nielsen M, Langner B, Zema C, Hacker T, Grundy, P. Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, 2012.

navigators, behavioral health teams, dietitians and clinical pharmacists linked to community resources will have a greater impact on wellness for this unique population.

5-Year Expected outcome for Provider and Patients:
The project's five year expected outcomes are to decrease inpatient admissions by 20% based on PQI admissions data. For this intervention, the JPS Connection enrolled patients will be targeted. We also expect increased compliance with preventive breast and cervical cancer screening treatment protocols by 30% over baseline for the defined population.

Starting Point/Baseline:
More than 120,000 patients received care in one of our primary care clinics in FY2011. This project will serve both current and prospective patients seeking care in any of our Medical Home sites. About half of all Medical Home patients in JPS 2011 are working poor Tarrant County citizens enrolled in our Connections program. A total of 121,000 Connections patients received care in our outpatient clinics during FY2011. In a review of the records of a sample of about 500 Connections patients (excluding the homeless and those with a primary diagnosis of mental illness), we determined that they have on average visited our ED/inpatient more than four times this year. About 10% of this sample has at least two chronic conditions: diabetes and hypertension. The sample accounted for more than 2,200 visits of which 43% could be considered potentially avoidable based on the New York University Avoidable Algorithm.[206] In looking at a broader sample of hospital admissions that had potentially preventable admissions for FY2011, we had 2,291 PPAs based on prevention quality indicators (PQI).[207] This indicator set is related to the quality of community-based health care systems.

There are 100 primary care providers currently providing care at 14 primary care clinic sites. We anticipate hiring at least 4.0 FTE physician providers, 4.0 mid-levels, 6.0 clinical pharmacists, 7.0 social workers, 2.0 registered dietitians, and additional LVNs, navigators and RN coaches to support team-based staffing models. The final number of team members will depend on the number of providers and panel size and panel accuity. A project to determine panel size is currently in progress. Team members will be trained in team-based care and the medical home model. Managers, directors and providers will be trained in LEAN methods of reducing waste. All team members will be trained in health literacy and communication skills to embrace the patient as a shared partner in health outcomes.

Rationale:
We have selected this project because primary care expansion and capacity have been shown to link directly with the health of a community. The lack of access to quality primary care services

[206] Potentially avoidable ED encounters were identified using the New York University (NYU) Avoidable ED Algorithm
[207] Prevention Quality Indicators. www.qualityindicators.ahrq.gov

has been directly linked to increases in potentially preventable admissions. The PCMH model has been shown by other organizations to allow for better management of both acute and chronic conditions, thus reducing costs.[2] Additionally, Patient-Centered Medical Homes have been shown to reduce overall costs in total health care expenditures for patients enrolled in the PCMH.[208] Implementing the PCMH model will directly impact the health of our patients, improve patient satisfaction and reduce costs. Right care will be provided at the right time in the right place.

Project Components:
All required core components are included in this project. In order to increase timely access to primary preventive care, the PCMH model of care will be implemented in our community-based primary care clinics. This project will improve coordination of care across our system and community. Our milestones measure our implementation of the components of the PCMH, making sure that the patients are directed to medical homes for their first appointment in a timely manner and ensuring that compliance with preventive medical care is tracked and encouraged across the system. As a result of these improvement milestones we expect to increase capacity of the community-based primary care system in RHP 10. The milestones chosen ensure that we reach our five year target to reduce potentially preventable PQI hospitalizations for ambulatory care sensitive conditions. In an initial data pull from our EMR, members of our Medical Home population had 1,104 PQI admissions in hospital fiscal year 2011.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.2 – Shortage of primary care services
- CN.4 – Lack of access to mental health services
- CN.10 – Overuse of ED services
- CN.11 – Need for more care coordination
- CN.15 – Need for more education, resources and promotion of healthy lifestyles

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This is a new project and we have received not received any other federal funding for this project.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/rationale for selecting the outcome measures:
IT-2.12 PQI Composite Measures for potentially preventable hospital admissions for Ambulatory Care Sensitive Conditions

208 Grumbach, MD, K, Grundy MD Paul. Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States. November 2010.

Overuse of the ED has been identified as a key priority in the Region 10 community health needs assessment. A 2012 publication from the Patient-Centered Primary Care Collaborative (PCPCC) details the early cost and quality results of 34 PCMH initiatives across the United States.[2] Almost all participants have shown a reduction in admissions and most have shown a reduction in cost per member. Additional evidence of improved health outcomes is outlined in a report by Grumbach and Grundy. [8] Both publications have compiled the results of many medical home initiatives over a period of several years. As these reviews are both updated, the authors are finding consistency in their findings. Medical home interventions are noted to improve quality of care and patient experience as well as reduce admissions.

IT-12.1 Breast Cancer Screening

We have selected this outcome measure because of the greater compliance with preventive screening due to enrollment in a medical home delivery model.

IT-12.2 Cervical Cancer Screening

In a report by the Commonwealth Fund, patients with a medical home reported greater compliance with routine preventive screenings largely due to the system of reminders and care coordination that is essential to the medical home delivery model. [209]Both breast cancer screening and cervical cancer screening have been shown to limit disease severity thereby improving outcomes for women.

Relationship to Other Projects:

Related Category 1 and 2 projects:

The following projects and interventions support the PCMH in the network:

Project 126675104.1.2 is a 24/7 call center with nurse advice available to direct patients to the right place for care.

Project 126675104.2.5 will enhance care coordination for better transitions from the hospital and ED to the medical home.

Project 126675104.2.11 relates to improving the patient experience in the community health clinics.

The following projects will have a subset of shared reporting outcomes:

Project 126675104.2.-8 will assist with managing a targeted group of patients who have had four or more ED/inpatient admissions. The Category 3 outcomes related to ED utilization will be reported in that project.

Project 126675104.2.12 will provide maternal medical homes.

Project 126675104.2.4 will provide care transitions for patients with CHF. The subset of medical home patients who are represented in this project will have Category 3 outcomes reported in that project.

Related Category 4 population-focused improvements

209 Beal A, Doty M, Hernandez S, Shea K, Davis K. Closing the Divide: How Medical Homes Promote Equity in Health Care- Results from the Commonwealth Fund 2006 Health Care Quality Survey. The Commonwealth Fund, June 2007.

RD 1.3 – This project will measure compliance with pneumonia vaccination for those patients empaneled in the PCMH.
RD2.7 – Patients getting care in a patient-centered medical home are less likely to seek care in the Emergency Department.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as Tarrant County patients seeking primary care. The percentage of the population expected to be positively impacted by the project is 15%, an estimate which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4**.** We believe this to be the correct number because when a person is positively impacted, - their access primary care will be increased as well as improved clinical outcomes associated with early detection of high risk cancers.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or her cost to and dependence on the community - should be diminished and increase access to inpatient beds will be available if less hospitalizations occur as a result of ambulatory care sensitive conditions.

126675104.2.2	2.1.1	2.1.1(A-D)	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards. Core components to include: utilize gap analysis to assess NCQA readiness, conduct feasibility studies to determine necessary steps to achieve NCQA certification, conduct educational sessions for physicians, staff, board members and senior leadership on core elements and CQI.
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	*126675104.3.13* *126675104.3.14* *126675104.3.15*	IT-2.12 IT-12.1 IT-12.2.	PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions Breast Cancer Screening Cervical 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-1]: Implement the medical home model in primary care clinics Metric 1 [P-1.1]: Increase number of primary care clinics using medical home model Baseline/Goal: 12 or 85% of primary care clinics implement the medical home model Data Source: Documentation of education/training and implementation of selected core components with assessment of implementation Milestone 1 Estimated Incentive Payment: $1,590,489 **Milestone 2** [P-X]: Utilize a gap analysis	**Milestone 6** [P-5]: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Empanelment should be based on the following principles: Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis; Assess practice supply and demand, and balance patient load accordingly; Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need. Metric 1 [P-5.1]: Determine Panel size	**Milestone 11** [I-12.]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric1 [I-12.1]: Number or percent of eligible patients assigned to medical homes where "eligible" is defined by the Performing Provider. Determine patient assignment, Identify gaps and develop processes using rapid cycle improvement to increase percent assigned to medical homes. "Eligible" is defined as patients eligible for the Connection program Baseline/Goal: Baseline is 65%. Improve by 25%. Data Source: EMR data DY2 and	**Milestone -15** [I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 [I-12.1]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the Performing Provider Determine patient assignment to medical home, identify gaps and develop processes using rapid cycle improvement to increase percent assigned to medical homes Baseline/Goal: Baseline is 65%. Improve by 30%. Data Source: EMR and other practice management software

126675104.2.2	2.1.1	2.1.1(A-D)	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards. Core components to include: utilize gap analysis to assess NCQA readiness, conduct feasibility studies to determine necessary steps to achieve NCQA certification, conduct educational sessions for physicians, staff, board members and senior leadership on core elements and CQI.

JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	*126675104.3.13* *126675104.3.14* *126675104.3.15*	IT-2.12 IT-12.1 IT-12.2.	PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions Breast Cancer Screening Cervical 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)**
to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness. Comparative gap analysis for NCQA certification Metric 1 [P-X.1]: Baseline/Goal: Complete gap analysis for two regions (Arlington and Northeast) Data Source: Documentation of gap analysis and action planning compared to requirements for NCQA certification Milestone 2 Estimated Incentive Payment*:* $1,590,489 **Milestone 3** [P-2]: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling	Baseline/Goal: Determine panel size for all primary care providers and disseminate to individual providers Data Source: EMR, HRA and Registry stratification Milestone 6 Estimated Incentive Payment: $1,626,692 **Milestone 7** [P-7]: Track the assignment of patients to the designated care team Metric 1 [P-7.1]: Tracking medical home patients Baseline/Goal: 65% of medical home patients are assigned to primary care physicians Data Source: EMR and claims data Milestone 7 Estimated Incentive Payment *(maximum amount):* $1,626,692	other practice management software Milestone 11 Estimated Incentive Payment*):* -$2,197,775 **Milestone 12** [I-16]: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home Metric 1 [I-16.1]: Percent of primary care visits at medical home Determine patient visit trends using EMR in DY2, develop processes using rapid cycle improvement to improve patients receiving their visits in their medical home Baseline/Goal: Increase by 15%. Data Source: EMR and other practice management software	Milestone -15 Estimated Incentive Payment: $2,395,903 **Milestone - 16** [I-16]: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home Metric1 [I-16.1]: Percent of primary care visits at medical home Determine patient visit trends using EMR in DY2, develop processes using rapid cycle improvement to improve percent of patients receiving care in their medical home. Baseline/Goal: Increase by 25% Data Source: EMR and other practice management software Milestone -16 Estimated Incentive

126675104.2.2	2.1.1	2.1.1(A-D)	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards. Core components to include: utilize gap analysis to assess NCQA readiness, conduct feasibility studies to determine necessary steps to achieve NCQA certification, conduct educational sessions for physicians, staff, board members and senior leadership on core elements and CQI.
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	*126675104.3.13* *126675104.3.14* *126675104.3.15*	IT-2.12 IT-12.1 IT-12.2.	PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions Breast Cancer Screening Cervical 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)**
Metric 1 [P-2.1]: Performing Provider policies on medical home Baseline/Goal: Develop policies/ guidelines and measurement tools for increasing access Data Source: Documentation of medical home policies Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,590,489 **Milestone 4** [P-3]: Reorganize staff into primary care teams responsible for the coordination of patient care. Teams can be designed in a variety of ways depending on the size and needs of the patient population and the resources of the practice. Ideally, primary care practices should be structured to respond to all common problems for which their patients seek care. Most successful practices are organized around	**Milestone 8** [P-9]: Train medical home personnel on PCMH change concepts. Metric 1 [P-9.1]: Number of medical home personnel trained. Baseline/Goal: Develop training modules for medical home concepts and ensure that 100% of staff and providers receive training Data Source: Training records and HR documents Milestone 8 Estimated Incentive Payment *(maximum amount):* $1,626,692 **Milestone 9** [P-11]: Identify current utilization rates of preventive services and implement a system to improve rates among targeted population Metric 1 [P-11.1]: Implement a patient registry that captures preventive services utilization.	Milestone 12 Estimated Incentive Payment: -$2,197,775 **Milestone 13** [P-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care Metric 1 [P-17.1] Reminders for patient services Baseline/Goal: 80% of patients needing a preventive service will receive a reminder Data Source: EMR Milestone 13 Estimated Incentive Payment *(maximum amount):* $2,197.775	Payment: $2,395,903 **Milestone -17** [I-18]: Obtain medical home recognition by a nationally recognized agency. Metric 1 [I-18.1]: Medical home recognition/accreditation Baseline/Goal: Obtain recognition for 7 of 14 designated sites Data Source: Documentation of recognition/accreditation for each clinic site Milestone -17 Estimated Incentive Payment: $2,395,903

126675104.2.2	2.1.1	2.1.1(A-D)	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards. Core components to include: utilize gap analysis to assess NCQA readiness, conduct feasibility studies to determine necessary steps to achieve NCQA certification, conduct educational sessions for physicians, staff, board members and senior leadership on core elements and CQI.
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	*126675104.3.13* *126675104.3.14* *126675104.3.15*	IT-2.12 IT-12.1 IT-12.2.	PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions Breast Cancer Screening Cervical 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)**
an accountable clinician (usually a physician or advanced registered nurse practitioner or physician assistant) and a medical assistant dyad that interact continuously throughout the day. Other team members are usually responsible for providing self-management support (e.g.,, nurse or clinical pharmacist, or health educator) or arranging other resources (e.g.,, social worker). Regardless of team composition, care must be taken to keep the team size relatively small (fewer than five to seven members) because team functioning breaks down as teams grow. Other clinic staff members, including billing staff, receptionists, computer technicians, and laboratory personnel, complement the primary care teams. Each of these staff members can play important roles in engendering strong trusting relationships between patients and their	Baseline/goal: Implement registry in EMR for 2 chronic conditions and track patients overdue for preventive services. Data source: EMR registry <u>Metric 2</u> [P-11.2]: Implement a recall system that allows staff to report which patients are overdue for which preventive services and track when and how patients were notified on their needed service Baseline/goal: Develop robust tracking and notification system using EMR and registries and health maintenance alerts Data Source: Documentation of recall report Milestone 9 Estimated Incentive Payment: $1,626,692 **Milestone 10** [P-X]: Engage both internal	**Milestone 14** [I-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care <u>Metric 1</u>[P-17.1] Reminders for patient preventive service Baseline/Goal: Implement reminders for breast and cervical cancer preventive screening at 12 of 14 sites Documentation: EMR and registry data Milestone 14 Estimated Incentive Payment: $2,197,775	

126675104.2.2	2.1.1	2.1.1(A-D)	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards. Core components to include: utilize gap analysis to assess NCQA readiness, conduct feasibility studies to determine necessary steps to achieve NCQA certification, conduct educational sessions for physicians, staff, board members and senior leadership on core elements and CQI.

JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	*126675104.3.13* *126675104.3.14* *126675104.3.15*	IT-2.12 IT-12.1 IT-12.2.	PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions Breast Cancer Screening Cervical 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)**
care team. Metric 1 [P-3.1]: Determine primary care team Baseline/Goal: Determine primary care team members and staffing needs for Arlington and Northeast and implement Data Source: Documented designation of primary care teams and verification of staffing matrix and implementation at designated sites Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,590,489 **Milestone 5** [P-4]: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members. Metric 1 [P-4.1]: Expanded primary care team member roles	and external resources to conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status Metric 1 [P-X.1] Completed study and identification of focus areas for intervention Baseline/Goal: -Complete assessment for two regions Data Source: Documented plan Milestone 10 Estimated Incentive Payment $: 1,626,692		

126675104.2.2	2.1.1	2.1.1(A-D)	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards. Core components to include: utilize gap analysis to assess NCQA readiness, conduct feasibility studies to determine necessary steps to achieve NCQA certification, conduct educational sessions for physicians, staff, board members and senior leadership on core elements and CQI.

JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	*126675104.3.13* *126675104.3.14* *126675104.3.15*	IT-2.12 IT-12.1 IT-12.2.	PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions Breast Cancer Screening Cervical 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)**
Baseline/Goal: Staffing plan developed, job descriptions completed and education modules created Data Source: Documented staffing plan, updated job descriptions, documentation of training for staff and providers <u>Metric 2</u> [P-4.2]: Schedule of training Baseline/Goal: 75% of employees/providers/Board of managers/senior leaders will be trained on the medical home Data Source: Documentation of training schedules, sign in sheets Milestone 5 Estimated Incentive Payment *(maximum amount):* $1,590,489			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $7,952,445	Year 3 Estimated Milestone Bundle Amount: $8,133,460	Year 4 Estimated Milestone Bundle Amount: $8,700,911	Year 5 Estimated Milestone Bundle Amount: $7,187,709

126675104.2.2	2.1.1	2.1.1(A-D)	Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards. Core components to include: utilize gap analysis to assess NCQA readiness, conduct feasibility studies to determine necessary steps to achieve NCQA certification, conduct educational sessions for physicians, staff, board members and senior leadership on core elements and CQI.
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	*126675104.3.13* *126675104.3.14* *126675104.3.15*	IT-2.12 IT-12.1 IT-12.2.	PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions Breast Cancer Screening Cervical 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)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$31,974,525			

Project Option 2.12.2 – Implement/Expand Care Transitions Programs- Care Connections for the Homeless
Unique Project ID: 126675104.2.3
Performing Provider Name/TPI: JPS Health Network / 126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: This project will improve care transition and health outcomes for the Tarrant County population designated as Homeless. Multi-disciplinary teams of medical, behavioral health, advanced practices, paramedics, and care transition support staff will be deployed to provide services to individuals living on the streets, shelters, or in supportive housing. This project is a new initiative and has no other federal funding. This program will coordinate/supplement other federally-funded program (i.e. rental assistance from HUD or Supplemental Supportive Services for Veterans' Families from the VA) but will not supplant existing dollars.
Need for the project: The 2011 point in time count of the Homeless was 2,169 and the "annualized" HUD estimate of people experiencing Homelessness was 4,847. Receiving integrated health and support services tailored to the needs of the Homeless population is vital for improved health outcomes in this vulnerable population.
Target population: The target Homeless population for this project includes persons in Tarrant County living unsheltered including in cars, abandoned buildings, under bridges, etc., in emergency shelters and tenants in supporting housing. This project is estimated to serve 2,100 unduplicated patients in the Homeless population in the reporting period.
Expected patient benefit: Care Connections for the Homeless will improve access to care and improve overall health status of Tarrant County's Medicaid, self-pay, and uninsured Homeless individuals.. A seamless network of care will improve ED appropriate utilization, improve health outcomes and reduce financial costs through reduced ED visits and hospital admissions.
Category 1 or 2 expected patient benefits: 2,100 unduplicated Homeless patients will be served with the goal of (I-11) – improving the number of Homeless patients receiving standardized care according to the approved clinical protocol and care transition policies, and (I-10) identifying the top chronic conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions.
Category 3 outcomes:

- IT 1.10 Our goal is to reduce Homeless individuals identified as diabetic that have HbA1c poor control (>9.0%) by 10% in DY4 and 15% in DY5.
- IT 1.18 Our goal is to increase access to follow-up after hospitalization for mental illness by 15% in DY4 and 20% in DY5.
- IT 9.2 Our goal is to reduce ED visits for target conditions by 10% in DY4 and 15% in DY5.

Project Option 2.12.2 – Implement/Expand Care Transitions Programs- Care Connections for the Homeless

Unique Project ID: 126675104.2.3
Performing Provider Name/TPI: JPS Health Network / 126675104

Project Description:
Care Connections for the Homeless will improve care transitions and health outcomes for Tarrant County patients who are homeless[210] and ensure they receive integrated health and human services tailored to their life circumstances to both improve their health and quality of life, and prevent hospital readmissions. People who are homeless constitute a significant number of inappropriate, potentially preventable, cyclical and expensive ambulance transports and admissions to emergency services (medical and psychiatric) and inpatient care.[211] By improving access to better coordinated and holistic care, the Care Connections for the Homeless program will achieve the triple aim of providing better care, improving health, and reducing costs.

Multidisciplinary teams of medical, behavioral health, advance practice paramedics, and social services professionals will be deployed along with peer specialists to provide services to individuals living on the street, in shelters, or in supportive housing. The teams will coordinate and provide care transitions and follow-up care after hospital admissions and ED visits 24 hours per day, seven days per week in the location that best meets the needs of the individual, i.e., in a shelter, hotel, supportive housing program, community clinic, or on the streets. Robust social services will be concurrently delivered. This project also will develop an innovative solution for the supervised administration of medicines in emergency shelters to improve treatment compliance and medication adherence. Care team delivery protocols will be based on evidence and best practices cited by the Substance Abuse and Mental Health Services Administration (SAMHSA),[212] the U.S. Department of Health and Human Services,[213] the U.S. Department of Housing and Urban Development,[214] and the academic literature.[215] Ongoing and transitional care (especially postdischarge) will include outreach and engagement, screenings and assessments,

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[210] The target "homeless" population for this project includes persons in Tarrant County living unsheltered (including in cars, abandoned buildings, under bridges, etc.), in emergency shelters and tenants in supportive housing.
[211] Add citation from JPS population data pulled by Evan.
[212] SAMHSA's Permanent Supportive Housing Evidenced-based Toolkit: http://homelessness.samhsa.gov/Channel/Permanent-Supportive-Housing-KIT-557.aspx; and, Olivet J, Bassuk E, Elstad E, Kenney R & Jassil L. *Outreach and engagement in homeless services: a review of the literature*, *The Open Health Services and Policy Journal*, 2010, 3, 53-70 (Guest edited by the SAMHSA's Homeless Resource Exchange).
[213] Burt MR, Wilkins C, & Mauch D. *Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Literature Synthesis and Environmental Scan*; January 6, 2011; U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy; *Medicaid Financing For Services In Supportive Housing For Chronically Homeless People: Current Practices And Opportunities*; February 2012.
[214] http://www.huduser.org/portal/bestpractices/study_08072012_1.html
[215] http://www.urban.org/housing/homeless.cfm

primary care (including acute and chronic conditions), behavioral health care, crisis intervention and care coordination, as well as resources for medication adherence, translation, transportation, motel respite, and specialty care services. Supportive services for the formerly homeless in supportive housing have significantly reduced service utilization and other costs at JPS Health Network.[216] Thus, a key project component is concurrent and coordinated delivery of allied social services tailored to those who are homeless. This project includes our collaborative partners: JPS Health Network, homeless clinics, MedStar ambulance services, the City of Fort Worth, supportive housing (rental assistance) programs, Mental Health Mental Retardation of Tarrant County, and Tarrant County Medical Society's Project Access.[217]

Goals and Relationship to Regional Goals:

Project Goals:

The overall goal of Care Connections for the Homeless is to transform the fragmented and under resourced health care system for homeless individuals by creating a coordinated, right-sized network of health care and allied human services delivered in convenient locations. Our purpose is to better serve individuals living on the street, in emergency shelters or in supportive housing and to achieve measurable improvements for people who are homeless.

This project meets the following Regional goals:

This project meets a number of Regional goals aligned with the goals of the Waiver and CMS' triple aim. Specifically, by serving the most vulnerable persons at their most vulnerable time, this project will reduce morbidity and mortality as well as financial and human costs, including a reduction in ED visits and subsequent hospitalizations.

Challenges:

JPS Health Network and its partner agencies provide an array of hospital services and primary care, behavioral health care, crisis intervention, and social services for homeless people. However, transitions between types and systems of care pose significant challenges for homeless individuals. They present with limited personal resources, decreased medical and social supports, as well as numerous circumstantial barriers to treatment compliance, medication adherence and access to willing specialty providers.

5-Year Expected Outcome for Provider and Patients:

Care Connections will develop a seamless, integrated network of care enabling homeless patients to access and transition between appropriate levels of care. This project addresses fragmented,

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[216] In a cohort of supportive housing tenants, post-housing service reductions "were largest for urgent care (64%), psychiatric ER (50%), and medical ER (45%)." Petrovich, J. and Spence-Almaguer, E., *Evaluation of Directions Home Supportive Housing and the Use of Critical Service Systems: Preliminary Results;* August 10, 2010; http://www.DirectionsHome.org

[217] The Tarrant County Homeless Coalition, the United Way of Tarrant County and the City of Fort Worth work together to encourage and facilitate collaboration among more than 90 agencies who deliver a wide range of housing, social services, employment, and emergency shelter.

incomplete and uncoordinated systems faced by patients and will provide better-quality and better-coordinated care for homeless patients, resulting in improved individual and community health as well as lowered cost. During the Waiver period Care Connections will serve a target, point-in-time population of 2,100.[218] Clinical objectives include: reduced Emergency Department visits for target conditions from baseline by 15%; increased access to follow up after hospitalization for mental illness by 20% from established baseline; and, reduced baseline number of homeless individuals identified as diabetic with HbA1c poor control (>9.0%) by 15%.

Starting Point/Baseline:

Those who are homeless have numerous health problems and complex, frequently acute, chronic and/ or communicable disease.[219] In Tarrant County, medical care for the homeless is delivered through hospitals, EDs, hospital-affiliated primary care clinics, charity clinics, advanced practice paramedics, and clinics conducted by students and faculty of an academic medical center. Behavioral health care is principally delivered through the JPS Health Network Hospital, Mental Health Authority, Recovery Resource Council, NGO-based counselors, Recovery Support Networks, and faith congregations. The 2011 point-in-time count of the homeless was 2,169 and the "annualized" HUD estimate of people experiencing homelessness was 4,847.[220] In FY 2011, JPS Health Network identified 233 homeless frequent hospital utilizers (four or more encounters per year in the emergency department and/or as inpatient admissions). Incurred charges in 2011 for these homeless individuals was $10,174.589.

Rationale:

The evidenced-based, multidisciplinary, and timely interventions at the heart of the Care Connections will improve the health of a vulnerable and high acuity population, enable the provision of better patient-centered care and prevent increased health care costs and preventable hospital readmissions. Transitions between care present optimal opportunities for the strategic and integrated delivery of health care, behavioral health care and allied social services with this highly mobile, underserved population. Consistent with national statistics, the medical needs of the homeless in Tarrant County are numerous and complex, frequently acute, chronic and/ or communicable while services are in short supply, poorly coordinated and insufficiently integrated.[221] For example, one study reported that the delivery of services to people living in supportive housing reduced their JPS Health Network services utilization by substantial amounts

[218] Using a HUD-proscribed algorithm with point-in-time count data, the Tarrant County Homeless Coalition estimates that 4,847people experienced homelessness in Tarrant County over the course of calendar year 2011: http://ahomewithhope.org/homeless-facts/homeless-statistics.aspx.

[219] Cardarelli, K; Carlson, E; Jackson, R; Ward, K; *A Plan for the Delivery of Health Care to the Homeless: A report prepared for Tarrant County Commissioner Roy Brooks by The Blue Ribbon Task Force on Health Care for the Homeless*; Center for Community Health University of North Texas Health Science Center, 2008.

[220] Tarrant County Homeless Coalition, 2011; Annualized estimates are derived by the application of a HUD-proscribed algorithm to point-in-time count data: http://ahomewithhope.org/homeless-facts/homeless-statistics.aspx

in numerous categories, including, urgent care, 64%, psychiatric ED, 50%; and medical ED, 45%. [222]

Project Components:

The JPS Health Network and Region 10 implement and continuously improve pilot interventions in care transitions for the homeless (2.12.2) to address known challenges facing these vulnerable patients, such as medication storage and adherence. By investing strategically in partnerships, this initiative leverages and better coordinates existing community resources. The interventions at the heart of this program will be piloted to identify which work best for people who are homeless. Project milestones and metrics address this population's high burden of disease and include: (1) Establishing a care transitions program specific to the homeless; (2) increasing the percentage of the homeless population receiving standardized care; and (3) identifying and reporting on the top chronic conditions prevalent among program participants. In total these milestones ensure clear linkages among providers and support personnel to improve care transitions, increase the quality and availability of care, positively impact health outcomes and prevent avoidable readmissions and inappropriate ED utilization.

The project will include a focus on continuous quality improvement by:

- Completing rapid cycle improvement initiatives that will focus on identifying the medical needs of the Tarrant County homeless community and removing barriers to maintaining health and providing health care services to the homeless.
- Identifying project impacts through the measurement of homeless patients seen for potentially preventable admissions to the emergency department
- "Lessons learned" will be utilized to identify barriers to care with special considerations for safety-net populations
- Identifying key challenges and process opportunities associated with expansion of access points that provide care to the homeless community.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.4 – Lack of access to mental health services
- CN.5 – Insufficient integration of mental health care in the primary care medical care system
- CN.10 – Overuse of ED services
- CN.11 – Need for more care coordination

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

This project is a new initiative and has no other federal funding from the U.S. Department of Health and Human Services. The program will coordinate with and supplement other federally-

funded programs (such as rental assistance from HUD or Supplemental Supportive Services for Veterans Families from the VA) but will not supplant existing dollars.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

Outcome Measure 1: IT-9.2 ED appropriate utilization.

Rationale: This project will reduce avoidable ED visits by those who are homeless. In FY2011, 232 homeless patients had 4 or more ED visits and/or inpatient admissions at the JPS Health Network totaling 1,967 visits and $10,174,589.81 in charges. Homeless adults visit EDs nearly four times more than the general population and are among the highest repeat visitors.[223] Our aim in creating a team that: (1) networks with discharge planners, social services, primary care, behavioral health care, crisis intervention and supportive services, (2) coordinates discharges from the hospital – both ED and inpatient, (3) identifies the homeless persons immediately, (4) makes contact, (5) assesses social and medical needs, (6) provides critical medication support , (7) provides and coordinates timely care is improved access and transitions along with better health and reduced inappropriate ED utilization.

Outcome Measure 2: IT-1.18 Follow-Up After Hospitalization for Mental Illness.

Rationale: The identified population cannot adequately access primary or secondary mental health services, comply with medication schedules, or consistently obtain prescribed medications. Mental health disorders increase the risks of and the tendency toward homelessness. An opportunity exists to identify this subpopulation of homeless and provide coordinated, collaborative posthospital care. JPS Health Network, in FY 2011, identified 937 homeless patients with mental illness who had at least one ED or inpatient visit that year. JPS Health Network also identified 233 homeless persons who were frequent hospital utilizers (>4 visits/year), and of this group, those with mental health diagnoses (including substance abuse) numbered 214, and incurred charges of $9,583,258. By coordinating with all partnering mental health agencies serving the homeless, the city emergency medical services, and the discharge planners at JPS Health Network, the Care Teams will identify and reach out to the homeless population upon discharge from JPS inpatient and ED. Medications and other psychosocial and medical needs will be addressed upon discharge, with intermediate follow up and referrals scheduled and supported.

Outcome Measure 3: IT-1.10 Diabetes care: HbA1c-poor control.

Rationale: Diabetes – a common chronic disease – in combination with homelessness, magnifies the documented poor health and welfare of the individuals affected, and increases social service demands, medical costs, and disability. The Tarrant County homeless population includes a disproportionate number of patients with diabetes due to higher numbers of subpopulations with higher prevalence of diabetes: Hispanic, African-Americans, and American Indians. The homeless are lacking medical and social services to manage diabetes and its complications. In FY 2011, JPS Health Network identified 35 homeless persons diagnosed with

[223] McMurray-Avila, M. (2001). *Organizing health services for homeless people: A practical guide.* Nashville, TN: National Health Care for the Homeless, Inc.

diabetes who had >4 visits/year, incurring charges of $2,311,858 for the year. Intervening with this population by addressing both medical and social needs, providing for medications and testing, enhancing dietary support, addressing comorbid medical issues, referring to appropriate secondary care, are all expected to improve blood sugar control and improve health. Medical literature has long established that better control reduces the morbidity, complications, costs and mortality from diabetes.

Relationship to Other Projects:
This project works in tandem with other important JPS Health Network initiatives: Expand Behavioral Health Care Capacity (126675104.1.1), which ensures followup after hospitalization for mental illness; (2) JPS Health Network Family-Centered Medical Home (126675104.2.2), which focuses on improving quality outcomes for the diabetic population; (3) JPS Health Network -MedStar Patient Navigation Program (126675104.2.-8), which will reduce all ED visits and reduce ED visits for target conditions; and Community Connect (126675104.2.1), which improves diabetic care by reducing HbA1c poor control and by improving the vaccination status for older adults. This project also addresses RD-1, Potentially Preventable Admissions; RD-2.3, Behavioral Health and Substance Abuse 30-day readmission; and, RD-2.7, All-cause Admission.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
The Care Connections for the Homeless project will be closely coordinated with the University of North Texas Health Science Center's (UNTHSC) "Health Navigation and Incentives for Dual Diagnosis Patients." The UNTHSC project will address a different set of outcomes for a subset of the Care Connections for the Homeless project: supportive housing tenants who have co-occurring mental health and substance abuse problems. Because of their complexity, this group has special needs that may benefit from the more intensive UNTHSC project, which specifically targets those with substance abuse and mental health problems, and measures outcomes related to both aspects. Staff of the UNTHSC project will regularly meet with and actively cross-refer patients for the unique services delivered by the Care Connections for the Homeless and vice versa.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as homeless patients in Tarrant County. The percentage of the population expected to be positively impacted by the project is 15%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when people are positively impacted, their ability sustain themselves is not significantly improved.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or her dependence on the community for health care needs is significantly reduced.

126675104.2.3	*2.12.2*	*2.12.2*	*Care Connections for the Homeless*	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.16* *126675104.3.17* *126675104.3.18*	*IT 1.10* *IT 1.18* *IT 9.2*	*Diabetic care:HbA1c poor control* *Follow-Up Hospitalization for Mental Illness* *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-4]**:** Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients postdischarge. Metric 1 [P-4.1]: Care transitions assessment Baseline/Goal: Conduct a care transitions assessment for the Homeless population Data Source: Milestone 1 Estimated Incentive Payment: $295,256 **Milestone 2** [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program Metric 1 [P-7.1]**:** Document the staffing plan. Baseline/Goal: Data Source: Milestone 2 Estimated Incentive Payment: $295,257	**Milestone 3** [P-2]**:** Implement standardized care transition processes Metric 1 [P-2.1]**:** Care transition policies and procedures Baseline/Goal: Submission of protocols and establishment of baseline data on number in population receiving standardized care according to approved clinical protocols and care transition policies. Data Source: EPIC, EMR, HIE, spreadsheets, policies and procedures Milestone 3 Estimated Incentive Payment: $603,954		**Milestone 4** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transition policies. Metric 1 [I-11.1]:Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: 1,500 unduplicated patients in the Homeless population will be served through this program that receive standardized care according to the approved clinical protocols and care transition policies from established baseline. Data Source: Milestone 4 Estimated Incentive Payment: $323,045 **Milestone 5** [I-10]: Identify the top chronic conditions and other patient	**Milestone 6** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transition policies. Metric 1 [I-11.1]:Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: 2,100 unduplicated patients in the Homeless population served through this program that receive standardized care according to the approved clinical protocols and care transition policies from established baseline. Data Source: Milestone 6 Estimated Incentive Payment: $266,863 **Milestone 7** [I-10]: Identify the top chronic conditions and other patient

126675104.2.3	*2.12.2*	*2.12.2*	*Care Connections for the Homeless*	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.16* *126675104.3.17* *126675104.3.18*	*IT 1.10* *IT 1.18* *IT 9.2*	*Diabetic care:HbA1c poor control* *Follow-Up Hospitalization for Mental Illness* *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)**
			characteristics or socioeconomic factors that are common causes of avoidable readmissions. Metric 1 [I-10.1]: Identification and report of those conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmission Goal: Submission of frequency report of most prevalent chronic conditions, patient factor or other socioeconomic factors in the patient panel resulting in the highest admission rates. Data Source: EPIC, Registry, HIE Milestone 5 Estimated Incentive Payment: $323,045	characteristics or socioeconomic factors that are common causes of avoidable readmissions. Metric 1 [I-10.1]: Identification and report of those conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions Goal: Submission of frequency report of most prevalent chronic conditions, patient factor or other socioeconomic factors in the patient panel resulting in the highest admission rates. Data Source: EPIC, Registry, HIE Milestone 7 Estimated Incentive Payment: $266,864
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $590,513	Year 3 Estimated Milestone Bundle Amount: $603,954		Year 4 Estimated Milestone Bundle Amount: $646,090	Year 5 Estimated Milestone Bundle Amount: $533,727
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,374,283				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.12.1 – Coordinated CHF Program

Unique Project ID: 126675104.2.4
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: The purpose is to reduce readmissions; reduce length of stay and to improve quality outcomes for the congestive heart failure population. The project intervention is a new initiative.
Need for the project: JPS Health Network is addressing the region needs of a growing chronic care population through increased access and more appropriate utilization of clinical resources. .JPS has identified a population of patients that utilizes the emergency department for exasperation of CHF symptoms causing an increase in ED utilization and an increase in inpatient admissions including 30-day readmissions. We anticipate that this program will have significant positive impact on this population as the program is designed to be coordinated with the JPS multi-disciplinary team Patient Centered Medical Home.
Target population: The target population is approximately 4,000 patients that annually visit the ED with a primary or secondary diagnosis of congestive heart failure. The benefit for the uninsured and Medicaid population of our service area is to offer alternative resources outside of the ED and to have those resources available before the patient's condition is critical enough to require an admission or ED visit and to integrate them into a primary care model for long-term benefits. Our target volume of 250 patients in DY3, 400 patients in DY4 and 400 patients in DY5 will be receiving care as evidenced by best practices. Our systems will be integrated to assure early identification of this at risk population and to assure long term continuity of care. Our process will be to link patients at discharge to our CHF Clinic as part of our discharge planning. This will be a key component of our program. Processes of the program also include analyzing readmission rates with our multidisciplinary cross continuum of care team along with a review of metrics and the implementation of PDCA initiatives.
Category 1 and 2 expected patient benefits: Milestones P-1.1, P-5.1, P-7.1, P-2.1, P-12.1, I-10.1, I-11.1, I-12.1 were selected. Each milestone selected was due to their natural progression to project implementation or a natural result of implementing integrated care components.
Category 3 outcomes. Outcomes I-10.1, I-11.1 and I-12.1 were selected. There is an evidence base to suggest that integrated care will have positive impact on each of those outcome areas.

Project Option 2.12.1 – Coordinated CHF Program

Unique Project ID: 126675104.2.4
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
We are implementing an outpatient congestive heart failure (CHF) clinic program. Inpatients with CHF who are at high risk of readmission for CHF will be enrolled in the program, which we have named Care Transitions. While the patient is in the hospital, the program will focus on readiness for discharge and inpatient counseling with a CHF physician specialist in order to prepare the patient to successfully manage their condition out of the hospital. Upon discharge, the program will connect patients with ongoing outpatient care that includes continuous CHF management at the dedicated CHF clinic, including monthly outpatient visits with medication management and lab work, and routine quarterly/annual visits for patients with implanted devices. The project also provides ongoing, regular outpatient monitoring, including remote telephone monitoring, for enhanced identification of patient symptoms. CHF program participants will also receive general posthospitalization follow up and nutrition education and services. Patients will have access to a clinical pharmacist who will regularly review the patient's medication program so that patients can stay healthy and out of the hospital. The end result will be a reduced rate of unnecessary readmissions and improved quality of life for CHF patients.

Our dedicated CHF clinic will increase access to a cardiology specialist and specially trained support staff including a specialist in remote monitoring after discharge for those of the targeted CHF patients who receive device implants. After this program is implemented, CHF patients who, in the absence of this program readmit to the hospital due to lack of understanding of their disease and no community-based resources, will have the clinical and support resources to keep them healthy and in the community. The program's readmission avoidance/frequent user component includes a detailed specific patient education effort about medication and dietary management of their disease. A physician assistant will support and provide day to day oversight of this aspect of the program. The physician assistant will also identify all inpatients admitted to JPS Health Network with a diagnosis of CHF to ensure each patient has clinic appointments scheduled for post hospital follow up and receives patient education prior to discharge. We anticipate that this CHF program will have a significant positive impact on individuals with congestive heart failure. This program will work in tandem with JPS Health Network's coordinated multidisciplinary team Patient-Centered Medical Home project.

Goals and Relationship to Regional Goals:
Project Goals:

A dedicated CHF clinic with remote monitoring capability will focus on reducing the incidence of unnecessary ED visits and inpatient admissions of identified CHF patients through disease-specific counseling that includes medication management and dietary management as well as ongoing telephonic counseling and appointment scheduling assistance.

This project meets the following Regional goals:
The project relates to Regional goals by addressing the needs of a growing chronic care patient population through increased access to care and more appropriate utilization of clinical resources with an emphasis on patient self-management and outpatient chronic disease management. This project is an aspect of JPS Health Network's Patient-Centered Medical Home initiative – ensuring that this chronic need population is brought into a patient-centered approach that focuses on appropriate chronic disease management and support.

Challenges:
JPS Health Network has an identified CHF patient population that relies unnecessarily on the emergency department for management of their CHF symptoms. The challenge for this project will be to retrain both our clinical teams and our CHF patient population to alter this care-seeking behavior to ensure more appropriate ongoing management of CHF patients.

5-Year Expected Outcome for Provider and Patients:
Our five year outcome is to improve JPS Health Network CHF clinical capacity and improve the clinical experience and treatment received by CHF patients. We expect a 25% volume increase in outpatient encounters compared to baseline. We also expect increased remote monitoring capacity (an estimated 3600 annual remote monitoring encounters); a 50% reduction in ED utilization from our baseline of 263 annual visits; and a reduced inpatient LOS for patients with primary diagnosis of CHF from baseline of 7.1 to 5.5. The end result will be a reduction in unnecessary ED utilization and a reduction in inpatient admissions including 30-day readmissions.

Starting Point/Baseline:
Patients with a primary or secondary diagnosis of CHF account for approximately 4,000 annual emergency department visits at JPS Health Network. In addition, JPS Health Network has over 2,200 annual inpatient admissions for CHF as the primary diagnosis. In 2010 Tarrant County had 3,271 avoidable admissions with a diagnosis of congestive heart failure. The incidence of CHF related illnesses continues to be a major cost driver for our health care system (19% of CHF patients account for 46% of the visits).

Rationale:
With high emergency department utilization patterns for patients with congestive heart disease we have selected this project as an opportunity to improve the health status of these patients with

early intervention. This program will allow patients to have access to an outpatient congestive heart failure clinic and to be monitored remotely allowing the physician to identify early clinical changes for the patient and reducing the need for an emergency department visit.

Project Components:
This project contains all of the core components including disease-specific education and self-management support. A clinically led and mission-driven coordinated multidisciplinary team of pharmacists, cardiologists, technicians and primary care physicians that work together to improve communication and seamless care of this specific patient population. The project would utilize technology with remote monitoring of this high risk population and provide routine quarterly/annual visits for patients with implanted devices and monthly visits for patients with medications with lab work provided. It will also offer disease-specific education for patients and families to better understand the disease and the management of the disease. As part of our implementation of the CFH clinic, we will be (a) reviewing best practices in cardiology, IHI and the Institute of Medicine. Our process will include (e) bridging discharge planning by our dedicated physician assistant to our outpatient program. We will be (c)(d) establishing an integrated IT system with our Emergency Room and inpatient services to assure we identify at risk patients and to assure continuity of care of this population as part of our learning collaborative. Our (f) multi-disciplinary cross-continuum team will be (b) analyzing our readmissions utilizing the STAAR tool and focused interventions with our patients. This team will also review performance metrics and develop PDCA performance improvement projects as needed. The milestones we have selected include the hiring of staff for a congestive heart failure clinic, including a residency trained pharmacist in medication management; a device specialist with experience in remote monitoring of patients with implantable devices with congestive heart failure chips allowing early identification of physical changes; a mid-level provider to work with the physician in the inpatient setting to begin the education process and referral to the outpatient clinic; an additional nurse and medical assistant to augment the congestive heart failure physician; and a case manager to work in conjunction with the inpatient physicians to set up a case management structure for tracking and monitoring this population. In addition, the milestones include the implementation of a remote device monitoring system; setting up a dedicated congestive heart failure clinic in current clinical space; developing an education program for patients with congestive heart failure including patient families; developing an education program for primary care physicians and emergency physicians regarding the service that includes identification of congestive heart failure patients who utilize the emergency department so that that patient population can be readily targeted in the first phase of the program and brought into chronic disease management for their CHF disease.

Unique community need identification numbers the project addresses:

- CN. 11 – Inefficient care coordination
- CN. 3 – Shortage of specialty care services

- CN. 1 – Lack of provider capacity
- CN.10 – Overuse of emergency services
- CN.13 – Necessity of patient education programs

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This is a new initiative and is not receiving any other federal funding.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

IT-3.2 Congestive Heart Failure 30-day readmission rate (stand-alone measure)

By the end of the Waiver, our goal is reduce readmission rates for the CHF population by 5% for all patients admitted with a primary diagnosis of CHF. CHF readmission rate for our facility is 18% and a dedicated focus on this population will improve the overall health of the community especially low-income patients without access to this specialized care.

IT-6.1 Percent improvement over baseline of patient satisfaction scores

By the end of the Waiver, our goal is to determine baseline patient satisfaction score and reach a 10% improvement overall. Patients who are satisfied with their care are more likely to participate in the overall plan of care and follow the direction of the physician especially regarding medication management and dietary restrictions both categories that are critical in the management of the congestive heart failure patient.

Relationship to Other Projects:

Our integrated approach to CHF management continues with the relationship to the community MedStar program (- 126675104.2.8), which is an alternate disposition program that will also positively impact the CHF population. Our community EMS provider is developing a program that will send a clinical provider to specific patients who contact the EMS provider, such as patients with CHF symptoms, and who need a resource for clinical care. This provider will have direct access to schedule patients directly into the CHF clinic as appropriate. In addition, they will have access to the providers for consultation to determine the best course of action for any specific patient. This method of care transitions will decrease the utilization of the emergency department by giving direct access to outpatient appointments. The integrated Patient-Centered Medical Home Model program (Unique RHP Project Identifier number 126675104.2.2) under development across JPS Health Network's ambulatory care sites will also augment the CHF clinic. Many patients are admitted through the emergency department without a primary care provider. Patients discharged from the emergency department or hospital that are followed in the CHF clinic will also be assigned a primary care provider during their first post hospital visit to improve the coordination of care. In addition, through the use of the EMR our primary care providers will be able to access all documentation from the CHF clinic which will improve clinical coordination. This project also will work alongside two additional JPS Health Network

projects, our call center project (126675104.1.2), and our project to improve patient experience (126675104.2.11).

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as JPS Health Network congestive heart failure patients. The percentage of the population expected to be positively impacted by the project is 7%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her quality of life is significantly improved.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, the - dependence on the community is not significantly improved.

126675104.2.4	2.12.1	2.12.1 (A-G)	Coordinated CHF Program
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.*3.19* 126675104.3.20	IT-3.2 IT-6.1	Congestive Heart Failure 30-Day readmission rate 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]**:** Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions Metric 1 [P-1.1]**:** Care transitions protocols Baseline/Goal: Development of necessary CHF protocols Data Source: Documentation of protocols Milestone 1 Estimated Incentive Payment *(maximum amount):* $88,911 **Milestone 2** [P-5]: Using a validated risk assessment tool, create a patient identification system. Metric1 [P-5.1]:Patient stratification system Baseline/Goal: identify 80% of target CHF population Data Source: EMR medical records Milestone 2 Estimated Incentive	**Milestone4** [P-2]:Implement standardized care transition processes Metric 1 [P-2.1]: Care transitions policies and procedures. Baseline/Goal: 100% adherence to necessary CHF protocols Data Source: EMR or program records Milestone 4Estimated Incentive Payment *(maximum amount):* $272,803	**Milestone 5** [P-12]: 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. Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: participate in two meetings per year Data Source: Learning Collaborative meeting agendas and meeting minutes Milestone 5Estimated Incentive Payment *(maximum amount):* $72,959 **Milestone 6** [I-10]: Identify the top chronic conditions (e.g.,, heart failure and pneumonia) and other patient	**Milestone** 9 [I-11]:Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [I-11.1]**:** Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Baseline/Goal: 90% of CHF patients Data Source: EMR Milestone 9Estimated Incentive Payment *(maximum amount):* $120,541 **Milestone 10** [I-12]:Reduce the percentage of high users of ED services with ambulatory care sensitive conditions Metric 1 [I-12.1]: Identify high users with ambulatory care sensitive conditions. Baseline/Goal: 40% reduction in

126675104.2.4	2.12.1	2.12.1 (A-G)	Coordinated CHF Program	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.*3.19* 126675104.3.20	IT-3.2 IT-6.1	Congestive Heart Failure 30-Day readmission rate 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)**
Payment *(maximum amount):* $88,911 **Milestone 3** [P-7]:Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program Metric 1 [P-7.1]: Documentation of the staffing plan. Baseline/Goal: Develop a plan to fulfill 100% of national RN staffing criteria Data Source: documentation of staffing plan Milestone 3 Estimated Incentive Payment *(maximum amount):* $88,910			characteristics (e.g.,, medical home assignment and demographics such as age) or socioeconomic factors (e.g.,, homelessness) that are common causes of avoidable readmissions Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in highest rates of re-admissions. Baseline/Goal: 80% of CHF patient population Data Source: EMR Milestone 6 Estimated Incentive Payment *(maximum amount):* $72,959 **Milestone** 7 [I-11]:Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [I-11.1]**:** Number over time of those patients in target population receiving	users with ambulatory care sensitive conditions Data Source: EMR Milestone 10 Estimated Incentive Payment *(maximum amount):* $120,541

126675104.2.4	2.12.1	2.12.1 (A-G)	Coordinated CHF Program	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.*3.19* 126675104.3.20	IT-3.2 IT-6.1	Congestive Heart Failure 30-Day readmission rate 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)**
			standardized, evidence-based interventions per approved clinical protocols and guidelines Baseline/Goal: 60% of CHF patients Data Source: EMR Milestone 7Estimated Incentive Payment *(maximum amount):* $72,959 **Milestone 8** [I-12]:Reduce the percentage of high users of ED services with ambulatory care sensitive conditions <u>Metric 1</u> [I-12.1]: Identify high users with ambulatory care sensitive conditions. Baseline/Goal: 20% reduction in users with ambulatory care sensitive conditions Data Source: EMR Milestone 8 Estimated Incentive Payment *(maximum amount):* $72,959	

126675104.2.4	2.12.1	2.12.1 (A-G)	Coordinated CHF Program	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.*3.19* 126675104.3.20	IT-3.2 IT-6.1	Congestive Heart Failure 30-Day readmission rate 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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $266,732	Year 3 Estimated Milestone Bundle Amount: $272,803		Year 4 Estimated Milestone Bundle Amount: $291,836	Year 5 Estimated Milestone Bundle Amount: $241,082
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$1,072,454				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.12.1 – Implement/Expand Care Transitions Programs – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions

Unique Project ID: 126675104.2.5

Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.

Intervention: The project purpose is to implement a comprehensive, safe and effective discharge planning and discharge support program. Interventions will include hospital visits, home visits, care transitioning to various care settings, patient/family role coaching, preparing for doctor's visits, education related to medications, responding to red flags, obtaining follow up appointments, etc. This project is a new initiative.

Need for the project: All counties in Region 10 identified more care coordination as a system cap and need. EDs are over used. There were 1.1 million visits to hospital EDs in 2010, with a rate of 447.5 visits per 1000 persons. The 2007 national ED visit rate was 390.5 per 1000 persons, increasing 23% since 1997, but lower than the ED visit rate of Region 10.

Target population: Medicaid and uninsured patients discharged from JPS Health Network inpatient or ED settings that are transitioning to a medical home. Estimated number of patients to be served over the waiver period: 5,000 patients will receive care coordination from trained staff that will aid in decreasing unnecessary hospital readmissions and ED visits; most of which are preventable and come at a cost both to the patient's health and function. Patients will receive personalized coaching and training/education specifically designed to help them better manage their health.

Category 1 and 2 expected patient benefits: Care coordination services that benefit the patient: discharge planning (hospital visits), support post-discharge (home visits), patient/family education, assistance with coordinating appointments/care, medication management, self-care management, health maintenance, etc. The project seeks to provide to each patient, at least four (4) care coordination services. 3,500 patients served and included in a registry in DY4 and 5,000 patients in DY5. The volume of services /visits in DY4 is expected to be at least 14,000 and in DY5 the volume of services/visits is 20,000.

Category 3 outcomes: IT- 3.1 All cause 30 day readmission rate. 10% reduction over baseline (< 1850 admission encounters) in DY4 and in DY5, 15% reduction (<1750 admission encounters). IT-9.2 ED appropriate utilization: 5% - decrease in ED utilization - over baseline in DY4 and 10% - decrease in ED utilization - over baseline in DY5.

Project Option 2.12.1 – Implement/Expand Care Transitions Programs – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions

Unique Project ID: 126675104.2.5
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
JPS Health Network proposes to create a network-wide care transitions program to reduce avoidable inpatient admissions and readmissions, reduce inappropriate emergency department (ED) utilization and connect patients in need of primary and preventive health care to their medical home. The program will provide intensive case management to avoid all-cause readmissions, ensure effective care coordination/navigation, promote effective transfer to post acute care agencies, improve access to preventive health care and discharge planning with post discharge support, based on the evidenced-based model, **The Care Transitions Intervention™** program, developed by Dr. Eric Coleman.[224] The case management staff will work with an interdisciplinary team to identify the most appropriate transition care setting.

Three major teams will be established and all will utilize an integrated electronic medical record(EMR) so that continuity of care in enabled. (1) The inpatient care management team will lead care coordinating transitions with physicians, nurses, social workers, and other members of the health care team to facilitate the progression of care from hospital admission through discharge. Prior to discharge, early in the course of care, the team will complete an initial discharge assessment to include issues related to funding, medical home assignment, psychosocial needs, and ongoing medical needs. The team will function as patient advocates as they collaborate with community agencies to aid in transitioning patients to long-term care facilities, home care, hospice, etc. Additionally the staff will assist high risk, complex patients by reinforcing discharge plans and initiate a collaborative hand-off to the medical home health

[224] A proven method for reducing avoidable readmissions is to improve transitional care, which ensures proper coordination and continuity of care as patients move between various locations or levels of care within one organization. A leading model for this work is The Care Transitions Intervention ™, which has been adopted by over 170 leading health care organizations nationwide. Through this approach, Eric Coleman, MD, a nationally recognized readmissions expert, says that there are four pillars that provide a core set of medical directions that the patient should have: medication self-management, follow-up appointment with the primary care physician or specialist, a knowledge of "red flag" or warning signs of symptoms and how to respond to them, and a personal health record that is a portable core set of medical directions including a medication list and associated allergies, an advance directive, treatment preference, and room for patient questions and concerns.
In addition to these four pillars, studies show that care transitions intervention coaching can result in a significant reduction in 30-day hospital readmits, as well as a potential reduction in 90-day and 180-day readmits Care transitions coaches could help patients by modeling behavior to resolve discrepancies, respond to red flags and obtain a timely follow-up appointment, and also help the patient practice for their next encounter with his/her provider and identify two or three questions to discuss. Enhancing the role of patients and caregivers, measuring the quality and safety of care transitions, and using health information technology to promote safe care transitions also play a role in preventing avoidable readmissions. For more information, please see: http://www.caretransitions.org.

coach, home care, community homeless projects, federally qualified health centers (FQHCs), skilled care facilities, etc. The program will identify a patient's need for a primary care home and will help establish primary care linkages. If the patient requires intensive care management a hand-off will also be completed to the outpatient care management team. (2) Outpatient Care Management team will reinforce **The Care Transitions Intervention™** model and provide case management until the patient is well established in primary care and refer to community resources as needed. The foundational components of the transitions intervention model are: medication self-management, follow-up appointment with the primary care provider (PCP) or specialist, warning signs or symptoms and how to respond to them, and a personal portable health record. The standards of practice and scope of services of the case manager are those outlined by the American Case Management Association.[225] Patient risk stratification and identification tools will be used to inform case management staff of urgency and intensity for follow-up. Registries will aid providers in addressing acute, chronic and preventive care needs for patients empaneled in the medical homes. Patients in the registries will benefit from a care management team that will reach out to them when gaps in care are identified. An individualized care management plan will be developed to aid the patient in achieving their personal health goals. Patients will benefit from receiving at least four (4) care coordination services. For the 3,500 patients that will be included in the registry in DY4, the volume of services /visits is expected to be at least 14,000 and in DY 5 the 5,000 patients in the registry will receive at least 20,000 services/visits. The registry patients will also benefit from receiving care based on standardized protocols. These registries, along with the EMR, will also support establishing an integrated information system so that continuity of care for patients is enabled. (3) ED Care Management Team will facilitate patient throughput from the ED to the appropriate care setting. The team will serve as a point of contact for referring patients to community resources and assisting with accessing clinical and support care services. This team will provide post discharge contact/follow-up. The team will also provide ED discharged patients with care coordination and hand-off to the most appropriate care setting. If the patient is admitted to the hospital, the ED transition staff will hand off to the inpatient care management team.

Goals and Relationship to Regional Goals:

Project Goals:

Project goals are to utilize a best practice model to design and implement a comprehensive discharge planning and discharge support program that systematically helps high risk patients' access health care resources appropriately thereby decreasing potentially avoidable inpatient admissions, reducing ED encounters and increasing use of the medical home. The project will be specific to the population served and will conduct an analysis of key drivers of 30-day hospital readmissions and the development of a system that will identify those potentially at risk for needing acute care services within 30-60 days. A community-based agency team will be

[225] American Case Management Association, Standards of Practice and Scope of Services for Hospital/Health System Case Management. http://www.acmaweb.org.

developed to support the transitions across the continuum and provide a consistent, safe and effective transition process from one provider to another with a strong emphasis on engaging patients and improving their access to the medical home for on-going primary and preventive health care instead of the ED. A quality improvement process will identify changes that need to be implemented. This project will provide patients with services to improve disease self-management and reduce errors and complications with serious medical consequences.

This project meets the following Regional goals:
This project meets a number of Regional goals aligned with the Waiver and the Institute for Healthcare Improvement's Triple Aim. Through the use of effective and efficient intensive case management services in the ED, inpatient and outpatient settings this program will improve the patient experience, improve the health of the population, and will reduce the cost of care by transitioning patients to the right care in the right setting.

Challenges: Patients seeking services within the JPS Health Network system often present with multiple disease processes and significant psychosocial barriers that impact their ability to seek health care consistently and timely. Upon discharge from the ED and the hospital, patients often leave without fully understanding how to take their medications, the discharge plans or follow-up care instructions. As a result, many patients are readmitted within 30 days. A 2012 patient survey revealed that 33% of the patients perceive they can "never access care" or only "sometimes access care" in the primary care clinics. JPS Health Network has an extreme caseload size at this time, which makes effective and efficient discharge planning very difficult. (Currently, case managers cover between 36-54 beds at JPS Health Network except in Women's services where there are approximately 126 beds to cover. However, the American Case Management Association 2011 hospital survey reveals that in 60% of the hospitals (same size as JPS Health Network) case managers have an average bed coverage of 25 or less.[226]) Additionally, JPS Health Network case managers cover beds on multiple floors which further impacts their ability to be readily available to assess, evaluate and initiate care transition in a timely manner. The project addresses these challenges by providing an evidence-based program for care transitions and by hiring staff to implement the program.

5-Year Expected Outcome for Provider and Patients:
By the end of the Waiver period, we will reduce the all-cause readmission rate by 15% of the baseline validated in DY2

Starting Point/Baseline:

[226] American Case Management Association, 2011 National Hospital Case Management Survey. Retrieved from http://www.acmaweb.org

JPS Health Network does not have an evidence-based care transitions program. Discharge planning is not comprehensive and post discharge support is not consistent. There are no established transitions of care discharge planning, hand-off processes, guidelines and policies/procedures. Of the 32,833 patients discharged from JPS Health Network in FY 2011, a total of 2,948 patients were identified as having diabetes, a potentially preventable admission diagnosis. The same analysis also showed that 71% of inpatients are admitted from the ED. FY 2011 data also showed that over 37,000 unique patients had at least one potentially avoidable ED encounter and; 1,352 unique patients had four or more inpatient or ED encounters. This subset of patients also had a total of 1,039 inpatient admissions with 161 potentially avoidable admissions. Current project baselines will be validated in DY2.

Rationale:
JPS Health Network seeks to improve clinical outcomes and reduce cost of care by providing well coordinated, accessible, and standardized care. The Region 10 community health needs assessment cited ED overuse, reduced inpatient capacity and impaired patient flow as significant barriers. Admissions and readmissions are major contributors to both reduced inpatient capacity and impaired patient flows; JPS Health Network has a readmission rate of 13% for its low-income, uninsured population. Milestones for this project include: (1) Establish a process for hospital based case managers to follow up with identified patients hospitalized that addresses the top chronic conditions and provides standardized discharge instructions and patient education. Topics will include activity, diet, medications, follow up care, etc.; (2) Develop a staffing plan; (3) Create a patient identification system using a validated risk assessment tool; (4) Implement a case-management-related registry; (5) Implement standard care transition processes in specified patient populations; and, (6) Increase the number or percentage of patients in the case-management-related registry. These milestones and the associated metrics create an evidence-based program with standardized protocols that align with the Hospital Readmissions Reduction Program, under the Affordable Care Act.

Project Components: All required core components will be included in the project. Additionally, core components C, D and E are also addressed as milestones.

a. A review of best practice models such as RED, STAAR, BOOST, Coleman, etc. will be completed. From the review a best practice model will be chosen as the infrastructure for the project. Interventions from other best practice models will also be used if deemed to be effective with the targeted populations.
b. Care Management staff will complete an assessment interview on readmitted patients to identify reasons (key drivers) for readmissions and conduct chart reviews using an approved tool. This data analysis of key drivers will be used to develop strategies and interventions specific to the population.
c. EPIC (electronic medical record) and a provider health record hotline will be used to aid in integrating information health systems so that continuity of care, communication and coordination of care across the continuum is enabled. Agencies that are providing post-hospital care will be provided these avenues of accessing necessary information.

d. Population risk management data and inpatient risk assessment information will be analyzed to identify patients most at risk for needing acute care within 30-60 days. The patients identified through this process will be enrolled in the care transition program and given special attention related to discharge planning, discharge support after leaving the hospital setting, etc. Patient registries and defined standardized protocols will be used to develop a systematic process for care transition.
e. The Care Management team will initiate the discharge planning program and complete a discharge assessment to include issues related to funding, medical home assignment, psychosocial needs, and ongoing medical needs. The program will also include patient/family education related to medication and self-management, follow up appointments, warning signs, etc. If the patient requires intensive care management a hand-off will be completed to the Outpatient Care Management team that will reinforce the program evidence-based care transitions model and provide discharge support and care management until the patient is well established in primary care.
f. A community-based cross-continuum team will be developed to support care transitions and provide a consistent, safe and effective process from one provider to another with a strong emphasis on engaging patients and improving their access to the medical home for on-going primary and preventive health care instead of the ED or readmission. The team will be comprised of representatives from various community clinics, hospitals, home health agencies, etc.
g. A comprehensive quality improvement program will be implemented. EMR registries, risk stratification, patient identification processes, and dashboard reporting are designed into the project as mechanisms for consistent monitoring and improvement. Learning collaboratives, plan-do-study cycles, etc. are also included in the project.

Unique community need identification numbers the project addresses:

- CN11 – Need for more care coordination
- CN10 – Overuse of emergency department (ED) services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and has not received any other federal funding.

Related Category 3 Outcome Measures:
Outcome Measure 1: IT-3.1 All-cause 30-day readmission rate NQF 1789 (Stand-alone measure) – All JPS Health Network patients enrolled in case management registry
Rationale: This outcome measure was chosen because JPS Health Network does not yet have a systematic process to reduce the risk for potentially preventable hospital readmissions. This measure has also been recognized as an opportunity for improvement at the national (Affordable Care Act) and local level (needs assessment). The Region 10 community health needs assessment indicated there are inpatient capacity issues and impaired patient flow concerns.

These problems correlate with excessive admissions and readmissions. CMS supports the link between care transitions program and the reduction of readmissions.[227] By DY4, it is expected that readmissions will be reduced by 10% and at the end of the Waiver period by 15%.

Outcome Measure 2: IT-9.2 ED-appropriate utilization
Rationale: This outcome measure was chosen because JPS Health Network does not yet have a systematic process to reduce inappropriate ED utilization. The Region 10 community health needs assessment indicated that regional stakeholders felt their patient population had to resort to the ED for routine care because of access and capacity issues. These problems correlate with excessive admissions and readmissions. By the end of the waiver, when a systematic process has been established, it is expected that ED appropriate utilization will be increased.

Relationship to Other Projects:
This project supports the following projects through hand-off collaboration and coordination of care interventions: Community Connect, Care Connection for the Homeless, MedStar and Patient-Centered Medical Home implementation. It will target patients who receive care in the ED rather than a more appropriate delivery setting as well as inpatient readmissions. This project also supports the primary and preventive care interventions of the Patient-Centered Medical Home with a focus on patients with diabetes. This program will also work closely with the JPS Health Network Congestive Heart Failure Program to ensure that the Congestive Heart Failure 30-day readmission rate is captured and valued in that project. The Care Transition project will refer (hand-off) patients to Community Connect which will reinforce efforts to decrease the inappropriate use of the ED and provide primary care. Care Connection for the Homeless will provide care transition and delivery to the homeless population and will accept collaborative referrals. Patient-Centered Medical Home implementation is designed to establish fourteen (14) medical homes intended to provide primary and preventive health care. The Care Transition project will inform the medical home provider when there are gaps in care for the targeted population and make medical appointments for patients to receive health care. The MedStar program will provide nurse triage and by way of referral provide care management and support to avoid admissions and readmissions.

The Category 4 Reporting domain is RD-2.7- All-Cause: 30-day readmissions

By implementing The Care Transitions Intervention™ evidence-based model, the project will aid in reducing avoidable readmissions.

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

[227] Centers for Medicare and Medicaid Services (CMS) office of Research, Development, and Information, National Conference on Care Transitions Transcript. Retrieved from http://www.cms.gov/medicare/demonstration-projects/demoprojectsevalrpts/downloads/cctp transcript.pdf

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as discharged patients from JPS Health Network inpatients or ED settings. The percentage of the population expected to be positively impacted by the project is 15%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, - because their instances of being readmitted to the ED or an inpatient bed will be reduced.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, dependence on the community and the cost of care are significantly reduced.

126675104.2.5	2.12.1	***2.12.1 (A-G)***	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.21 126675104.3.22	IT-3.1 IT-9.2	*All-cause 30-day readmission rate* 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-3]: Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which addresses activity, diet, medications, follow-up care, weight and worsening symptoms; and where appropriate additional patient education and/or coaching as identified during discharge. This project will use The Care Transitions Intervention model. The project will impact current staffing of 31 positions. Metric 1 [P-3.1]: Care transitions protocols Baseline/Goal: JPS Health Network does not have a care transitions program or protocols/ By end of DY2 Care transition materials for discharge instructions and patient education will be complete. Data Source: Care transitions protocols	**Milestone 3** [P-5]: Using a validated risk assessment tool, create a patient identification system. Metric 1 [P-5.1]: Patient stratification system (reports for ED utilizers, gaps in preventive health care and at-risk patients for readmissions within 30 days). Baseline/Goal: JPS Health Network does not use a validated risk assessment tool/ By end of DY3 a validated risk assessment tool will be used. Data Source: Risk assessment tool Milestone 3Estimated Incentive Payment: $1,070,389 **Milestone 4** [P-9]**:** Implement a case-management-related registry Metric 1 [P-9.1]: Documentation of registry implementation, registry reports and EMR reports that support		**Milestone 5** [I-13]**:** Increase the number or percent of patients in the case-management-related registry Metric 1 [I-13]**:** Increase in the number or percentage of patients in the case-management-related registry; Note: Patients may be targeted from ED and inpatient areas Goal: 3,500 patients will be in the case management registry by DY4. (3,500 is 14% of the population) Data Source: EMR, registries Milestone 5 Estimated Incentive Payment: $1,145,067 **Milestone 6** [I-14]**:** Implement standard care transition processes in specified patient populations. Specified population- 3,500 patients	**Milestone 7** [I-13]: Increase the number or percent of patients in the case-management-related registry Metric 1 [I-13]: Increase in the number or percentage of patients in the case-management-related registry; Note: Patients may be targeted from ED and inpatient areas Goal: 5,000 patients will be in the case management registry by end of DY5. (5,000 is 20 % of the population) Data Source: EMR, registries Milestone 7 Estimated Incentive Payment: $945,925 **Milestone 8** [I-14]: Implement standard care transition processes in specified patient populations. Specified population- 5,000 patients

126675104.2.5	2.12.1	***2.12.1 (A-G)***	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.21 126675104.3.22	IT-3.1 IT-9.2	*All-cause 30-day readmission rate* 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 Estimated Incentive Payment: $1,046,567 **<u>Milestone 2</u>** [P-7]**:** Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program. Current hospital based case management staff is 31. Plan to hire 4 additional staff (2 for the ED and 2 for the inpatient setting). <u>Metric 1</u> [P-7.1]**:** Documentation of the staffing plan. <u>Baseline/Goal</u>: Completion of written staffing plan. <u>Data Source:</u> Staffing plan with increase of case management staff. Milestone 2 Estimated Incentive Payment: $1,046,566	an integrated information systems. Baseline/Goal: JPS does not have a standardized registry process for case managed patients by end of DY3 case management registry reports will be established for the medical home population Data Source: Registry reports demonstrating case management functionality Milestone 4 Estimated Incentive Payment: $1,070,388	<u>Metric 1</u> [I-14.1]: Measure adherence to processes: Goal: By end of DY4 process adherence will be measured to determine if patients are receiving care according to standardized protocols in the specified populations. 50% (1,750) of registry patients will receive care according to protocols. Data Source: EMR, registries Milestone 5 Estimated Incentive Payment: $1,145,067	Metric 1 [I-14.1]: Measure adherence to processes: Goal: By end of DY5 process adherence will be measured to determine if patients are receiving care according to standardized protocols in the specified populations. 75% (3,750) of registry patients will receive care according to protocols. Data Source: EMR, registries Milestone 8 Estimated Incentive Payment: $945,925

126675104.2.5	2.12.1	***2.12.1 (A-G)***	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.21 126675104.3.22	IT-3.1 IT-9.2	*All-cause 30-day readmission rate* 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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,093,133	Year 3 Estimated Milestone Bundle Amount: $2,140,777		Year 4 Estimated Milestone Bundle Amount: $2,290,134	Year 5 Estimated Milestone Bundle Amount: $1,891,850
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $8,415,894				

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 2.15.1 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services
Unique Project ID: 126675104.2.6
Performing Provider Name/TPI: JPS Health Network / 126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: The goal of this project is to provide more fully integrated behavioral health services embedded within the primary care medical home so that patients receive whole-person care through their medical home team. Behavioral health care will be integrated into the fabric of primary care services. Clinical algorithms will be developed and implemented in primary care to ensure that those patients with high medical needs but low behavioral health needs can still receive quality medical interventions for depression and anxiety. This project is a new initiative that will be implemented in our four clinics with existing co-located behavioral health services to increase the level of integration and provide new components of integrated care.
Need for the project: This project addresses the following community needs: a) CN.4 Lack of access to mental health services, b) CN.5 Insufficient integration of mental health care in primary care medical care system, and c) CN.11 Need for more care coordination.
Target population: The population who will be served by both primary and behavioral health care in an integrated fashion is a combined total of 5,567 for all 4 years (DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670). Medicaid and the uninsured of our service area will benefit from behavioral healthcare being integrated into the fabric of the primary care services as evidenced by utilization of the Four-Quadrant model, clinical algorithms, both physical and behavioral healthcare at locations, treatment plans with primary care and behavioral health expertise, and depression screening being commonplace in clinics where behavioral health services are co-located.
Category 1 or 2 expected patient benefit: Milestones P-3.1, P-3.2, P-3.3, P-6.1, P-6.2, P-X1.1, P-X2.1, P-X2.2, PX2.3, P-X3.1, I-8.1, and I-9.1 were selected. Each milestone selected was due to their natural progression to project implementation or a natural result of implementing integrated care components.
Category 3 outcomes: Outcomes IT-1.8, IT-1.9, IT-1.10, and IT-1.11 were selected. There is an evidence base to suggest that integrated care will have positive impact on each of those outcome areas.

Project Option 2.15.1 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services
Unique Project ID: 126675104.2.6
Performing Provider Name/TPI: JPS Health Network / 126675104

Project Description:
This project will utilize aspects of the Four Quadrant model[228], IMPACT model[229], and Wagner's Chronic Care Model[230] as a foundation to ensure patients receive appropriately integrated behavioral health care. This project will develop and implement a set of standards to be used for integrated services to ensure effective information sharing and proper handling of referrals of behavioral health clients to physical health providers and vice versa. Additionally, five embedded behavioral health specialists who will be masters' level social workers (LMSWs) or registered nurses (RNs) with experience in psychiatric service delivery will be established. The embedded behavioral health care managers will serve five primary roles: (1) be the liaison with primary care to ensure integrated care, (2) provide immediate access to a behavioral health provider by delivering behavioral health in the primary care setting on a stat basis, (3) provide brief, solution focused counseling services in primary care settings, (4) manage the referral process and case load balance between primary care referrals and stable behavioral health patients transitioning back to primary care providers as appropriate, and (5) serve as a behavioral health care manager as needed. The five embedded behavioral health specialists will be located in primary care clinics where we have co-located outpatient behavioral health services and one behavioral health specialist will serve as a resource to JPS Health Network satellite and clinics currently without current co-located services. The minimum number of patients who will be served by both primary and behavioral health care in an integrated fashion is a combined total of 5,567 for all 4 years (DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670). In addition, this project will improve the competency of primary care providers in screening, identification and

[228] The Four Quadrant model is a model for the proposed integration of clinical mental health and behavioral health services. The emphasis is on the prevalence of concurrent disorders (e.g., depression and alcoholism). The Four Quadrant model is based on the 1998 consensus document on mental health and substance abuse/addiction integration service. The severity for each disorder is divided into Four Quadrants: (1) Low mental health – low substance abuse, served in primary care; (2) High mental health – low substance abuse, served in the mental health system by staff who have substance abuse competency; (3) Low mental health – high substance abuse, served in the substance abuse system by staff who have mental health competency; and (4) High mental health – high substance abuse, served by a fully integrated mental health and substance abuse program. The Four Quadrant model is not intended to be prescriptive about what happens in each quadrant, but to serve as a conceptual framework for collaborative planning in each local system.

[229] The IMPACT model has five key components: (1) collaborative care, (2) depression case manager, (3) designated psychiatrist, (4) outcome measurement, and (5) stepped care. For more information, please see the IMPACT website at the University of Washington at http://impact-uw.org/about/key.html.

[230] See http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2 for detailed information about the Chronic Care Model.

treating depression and anxiety by developing medication algorithms utilizing best practices and evidence-based resources.[231]

Goals and Relationship to Regional Goals:
Project Goals: The goal of this project is to provide more fully integrated behavioral health services embedded within the primary care medical home so that patients receive whole-person care through their medical home team. Behavioral health care will be integrated into the fabric of the primary care services. Clinical algorithms will be developed and implemented in primary care to ensure that those patients with high medical needs but low behavioral health needs can still receive quality medical interventions for depression and anxiety.

Challenges:
Currently, JPS Health Network has co-located behavioral services in four locations, but there is no significant coordination or integration of services. JPS Health Network lacks a coordinated system of care for individuals with both physical and mental health problems that results in fragmented and uncoordinated care efforts. Patients often remain in treatment with a psychiatrist because they have historically received medication refills from this setting while primary care patients who increasingly need integrated services cannot be served due to limited specialty psychiatric capacity. Additionally, primary care providers lack the time or knowledge to effectively address behavioral health issues outside an effective team.[232]

5-Year Expected Outcome for Provider and Patients:
At the end of the Waiver period, behavioral health care will be integrated into the fabric of the primary care services by utilizing evidence-based strategies and patients will be assigned appropriate interventions by a clinically integrated team by utilizing the Four-Quadrant model based on their needs. At least eight providers will achieve Level 4 integration with 6 of those providers achieving Level 5 integration. Over 3.5% (or 5,567) of patients will receive both physical and behavioral health care at established locations and 1% (or 1,590) will have treatment plans implemented with both primary care and behavioral health expertise. Depression screening for more than 5000 primary care patients will occur in clinics where behavioral health services are co-located. The target percentage of patients screened will be reassessed - in DY3.

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[231] Primary care physicians who will retain management of identified behavioral health needs can utilize the project that provides virtual psychiatric and clinical guidance for assistance to medication management strategies, evidence-based treatments, and timely communication with psychiatrists as necessary.

[232] The Institute of Medicine found a strong link between behavioral health issues and general health, especially chronic illnesses. Behavioral health patients who have significant chronic physical illnesses often go untreated and suffer poorer health outcomes than patients without behavioral health diagnoses. Additionally, patients with both behavioral and physical conditions generate significantly higher medical costs than patients with only one set of conditions, and treatment of the behavioral health conditions lowers those costs, particularly if diagnosed early. People with chronic mental illnesses and comorbid physical health problems such as cardiovascular or pulmonary disease, diabetes, or arthritis many times present first in primary care. Mental health problems exacerbate the disability associated with physical disorders as evidence by research documenting people with serious mental illness treated by the public mental health system die on the average 25 years earlier than the general population; they live to 51, on average, compared with 76 for Americans overall. Additionally, they are 3.4 times more likely to die of heart disease, 6.6 times more likely to die of pneumonia and influenza, and 5 times more likely to die of other respiratory ailments. Other research has found that 60% of premature deaths in persons with schizophrenia were due to medical conditions such as pulmonary disease, and infectious and cardiovascular diseases.

Starting Point/Baseline:
The current system would be described as having Level 3 integration – Basic Collaboration On-Site. In FY 2011, 2.69% (or 4,273) of JPS Health Network patients had encounters in both behavioral health and primary care locations. None of these patients had treatment plans developed with joint expertise. Additionally, there are no protocols guiding the treatment and/or referral processes. Having embedded behavioral health specialists will result in an increase in routine visits from the baseline established in DY2 and an increase or decrease use of specialty care according to practice guidelines from the baseline establish in DY2. (Note: JPS Health Network must establish a baseline to determine if the measure should be an increase or decrease).

Rationale:
This project was selected because JPS Health Network treats a large group of patients whose care is complicated by co-occurring mental health problems. AHRQ research highlights the significant evidence base available supporting the integration of behavioral health care with primary care: The studies reviewed tended to show positive results for symptom severity, treatment response, and remission when compared to usual care. Anxiety disorder studies also exhibited a consistently similar pattern.[233] AHRQ's statement aligns with the significant evidence base supporting integrated care as a best practice.[234,235]

Project Components:
Core Component A - The focus of this project is to enhance the level of integration from Level 3 to Levels 4 or 5 at each site, not to establish co-location.
Core Component B - Provider agreements will not need to be developed as this project will target inner-organization integration and agreements that already exist and allow for co-scheduling and information sharing.
Core Component D - Additional providers or provider days will be recruited or identified as necessary to accomplish project goals.

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[233] Evidence Report Technology Assessment #173 – Integration of Mental Health/Substance Abuse and Primary Care – Agency for Healthcare Research and Quality, 2008. Publication No. 09-E003.
[234] Supporting research includes:
- An Evaluation of the Collaborative Care Model of Integrated Health Care in Texas: An Executive Summary – Hogg Foundation for Mental Health, 2010.
- Connecting Body and Mind: A Resource Guide to Integrated Care in Texas and the United States – Hogg Foundation for Mental Health, 2008.
[235] Data from the epidemiological survey, National Comorbidity Survey Replication, from 2001-2003 found that 25% of American adults meet at least one diagnosis for mental illness at any given time and more than half of those report one or more chronic medical conditions. This same survey found that more than 68% of adults with a pre-existing mental disorder reported having at least one general medical condition.235 There is also significant evidence reported by SAMHSA that supports the use of integrated care as evidence-based and best practice. This evidence is contained on the SAMHSA-HRSA Center for Integrated Solutions website.

Core Component E - We will train both physical and behavioral health providers in protocols, communication, and treatment through a team approach with attending physicians as well as primary care and psychiatry resident physicians with regular consultative meetings, case conferences, and shared treatment plans.
Core Component F - Our organization already uses an EMR among primary and behavioral health care providers -. However, we will still ensure the data reporting, communication, and collection tools are available to facilitate effective integrated care.
Core Component G - There is no need for further exploration of legal agreements as we already have a provider agreement established.
Core Component H - There is no need for arrangement of utilities so those components will not be addressed.
Core Component I - The components related to data collection - are already identified as milestones within the project.
Core Component J - The components related quality improvement is already identified as milestones within the project.

Milestones include (1) the development and implementation of a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa; (2) identification of the number and types of referrals that are made between providers at the location; (3) evaluation and continuously improved integration of primary and behavioral health services with demonstrated plan, do, study act quality improvement cycles; (4) development and implementation of data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings; (5) eight providers will achieve Level 4 of interaction (close collaboration in a partially integrated system) and six providers will achieve Level 5 of interaction (close collaboration in a fully integrated system); (6) 3.5% of Individuals receiving both physical and behavioral health care at the established locations and (7) 1% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise. Additionally, custom milestones and improvement targets have been created to accommodate the desired outcome of implementing a common practice of screening primary care patients for depression.

Unique community need identification numbers the project addresses:

- CN.5 – Insufficient integration of mental health care in the primary care medical care system
- CN.4 – Lack of access to mental health services
- CN.11 – Lack of care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This is a new initiative and we have not received any other federal funding for its implementation.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) was selected because CMS has stated the evidence is adequate to conclude that screening for depression in adults, which is recommended with a grade of B by the U.S. Preventive Services Task Force (USPSTF), is reasonable and necessary for the prevention or early detection of illness or disability, and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.[236] Compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up. The virtual psychiatric and clinical guidance service will improve depression screening and the effectiveness of follow-up plans as well as treatment.

-**IT-1.10 Diabetes care: HbA1c poor control (>9.0%)17- NQF 0059** was selected because integrated care will be utilized to improve the identification of patients with diabetes and behavioral health issue to improve adherence to treatment plans and foster better patient engagement.

IT-1.11 Diabetes care: BP control <140/80mm Hg)18 – NQF 0061 was selected because integrated care will be utilized to improve the identification of patients with diabetes and behavioral health issue to improve adherence to treatment plans and foster better patient engagement.

Relationship to Other Projects:

- Project 126675104.1.1 – This project's purpose is to establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the Region where access to care is likely to be limited. New patients will benefit from integrated care projects aimed at improving whole health.
- Project 126675104.2.7 – Established to design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders (Behavioral Health Discharge Management Program). BH Discharge Care Managers will be able to utilize the integrated services as a tool to better manage patients post-discharge.
- This project is related to RD-1.3 Potentially preventable admissions Behavioral Health and Substance Abuse Admission rate (based on other selected PPA primary diagnoses). This reporting measure was selected because it is anticipated this project will reduce

[236] Centers for Medicare and Medicaid Services (CMS) http://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?&NcaName=Screening%2520for%2520Depression%2520in%2520Adults&bc=ACAAAAAAIAAA&NCAId=251.

potentially preventable admissions by behavioral health patients for medical conditions by improving the care and adherence to treatment recommendations through integration of care.

- Project 126675104.2.2– Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards. The behavioral health expertise and team members will work in a collaborative and integrated fashion to contribute and build upon the successes of the JPS Health Network Patient-Centered Medical Home (PCMH) model. The projects will work to gain synergy but will focus on the unique improvements and outcomes established for each project.

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

This integrated care project will collaborate with MHMR of Tarrant County's projects. It is anticipated the substance use disorder treatment and detox expansion will be utilized significantly as patients with these issues are more readily identified because of the integration of care. In fact, it is anticipated MHMR employees will provide SBIRT services to the patients who receive primary care services within the JPS Health Network integrated care clinics. The JPS Health Network and MHMR integrated health projects will each serve distinct client populations. The MHMRTC project will only serve those clients registered to receive behavioral health services with MHMR while bringing a primary care team into the MHMR clinic for a comprehensive model of care. The JPS Health Network project will serve clients registered to receive primary care or behavioral health services with JPS. Each entity offers a distinct array of mutually exclusive services for this project.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as primary care patients needing embedded behavioral health services and all behavioral health outpatients in the JPS Health Network. The percentage of the population expected to be positively impacted by the project is 26%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to

determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her quality of life is significantly improved through the proper management of depression, diabetes control, and diabetics with blood pressure.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her potential dependence on the community is significantly decreased.

Specifically, 5567 patients (DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670) receiving *both primary and behavioral health care in an integrated fashion* will be positively impacted in the following quantifiable ways:

- Increase percentage of primary care patients screened for depression in primary care clinics where behavioral health services are co-located by 5500 patients over life of project
- Increase percentage of individuals receiving both physical and behavioral health care at the established locations by 3% over life of project
- Increase percentage of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise by 1% over life of project
- Improve baseline percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg by a percentage to be determined in DY3.
- Improve baseline percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg by a percentage to be determined in DY3.
- Increase in patients screened for clinical depression using a standardized tool AND follow-up plan is documented by a percentage to be determined in DY3.

126675104.2.6	***2.15.1***		*Integrate Primary and Behavioral Health Care Services*	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.23* *126675104.3.24* *126675104.3.25*	IT-1.8 IT-1.10 IT-1.11	Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) Diabetes care: *HbA1c poor control (>9.0%)17- NQF 0059* Diabetes care: *BP control <140/80mm Hg)18 – NQF 0061*	
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 and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. Metric 1 [P-3.1]: Number and types of referrals that are made between providers at the location Baseline/Goal: Establish number of behavioral health referrals are made using the set of standards between providers at location Data Source: Review of referral data and survey result Metric 2 [P-3.2]**:** Number of referrals that are made outside of the location Baseline/Goal: Report indicating number of referrals made outside of the location Data Source: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results	**Milestone 3** [P-X]: Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings. Metric 1 [P-X.1]: Utilize a Integrated Care Utilization Tracking Report to inform practice Baseline/Goal: Create Integrated Care Utilization Tracking Report Data Source: EMR Milestone 3 Estimated Incentive Payment: $1,310,166 **Milestone 4** [P-6]**:** Develop integrated behavioral health and primary care services within co-located sites. Metric 1 [P-6.1]: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system).		**Milestone 6** [P-X3]**:** Depression Screening in primary care clinics where behavioral health services are co-located. Metric 1 [P-X3.1]: Increase in percentage of primary care patients screened for depression in primary care clinics where behavioral health services are co-located. Baseline/goals: 2500 patients will be screened for depression Data Source: EMR, Project Documentation Milestone 6 Estimated Incentive Payment: $1,401,573 **Milestone 7** [I-8]**:** Integrated Services Metric 1 [I-8.1]: 3% of Individuals receiving both physical and behavioral health care at the established locations. Goal: 3% of individuals receiving both physical and behavioral health care in	**Milestone 9** [P-X4]**:** Depression Screening in primary care clinics where behavioral health services are co-located. Metric 1 [P-X4.1]: Increase in percentage of primary care patients screened for depression in primary care clinics where behavioral health services are co-located. Baseline/goals: 3000 patients will be screened for depression Data Source: EMR, Project Documentation Milestone 9 Estimated Incentive Payment: $1,157,821 **Milestone 10** [I-8]**:** Integrated Services Metric 1 [I-8.1]: 3.5% of Individuals receiving both physical and behavioral health care at the established locations. Goal: 3.5% of individuals receiving both physical and behavioral health care in

126675104.2.6	***2.15.1***		*Integrate Primary and Behavioral Health Care Services*	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.23* *126675104.3.24* *126675104.3.25*	IT-1.8 IT-1.10 IT-1.11	Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) Diabetes care: *HbA1c poor control (>9.0%)17- NQF 0059* Diabetes care: *BP control <140/80mm Hg)18 – NQF 0061*	
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)**
Metric 3 [P-3.3]: Number of referrals which follow the established standards Baseline/goals: Report indicating number of referrals which follow the established standards Data Source: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results Milestone 1 Estimated Incentive Payment: $1,921,511 **Milestone 2** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services. Metric 1 [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles. (Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement))	Baseline/goals: 8 providers achieving Level 4 of interaction Data Source: EMR, Training logs, treatment plans, referral patterns, encounter data, patient problem lists Metric 2 [P-6.2]: Number of providers achieving Level 5 of interaction (close collaboration in a fully integrated system) Baseline/goals: 6 providers achieving Level 5 of interaction Data Source: EMR, Training logs, treatment plans, referral patterns, encounter data, patient problem lists Milestone 4 Estimated Incentive Payment: $1,310,166 **Milestone 5** [P-X2]**:** Establish the tools and processes necessary to commonly screen for depression in primary care clinics where behavioral health services are		established locations Data Source: Project data; claims and encounter data; medical records Milestone 7 Estimated Incentive Payment: $1,401,573 **Milestone 8** [I-9]**:** Coordination of Care Metric 1 [I-9.1]: 0.5% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Goal: 0.5% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Data Source: Project data; claims and encounter data; medical records Milestone 8 Estimated Incentive Payment: $1,401,573	established locations Data Source: Project data; claims and encounter data; medical records Milestone 10 Estimated Incentive Payment: $1,157,821 **Milestone 11** [I-9]**:** Coordination of Care Metric 1 [I-9.1]: 1% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Goal: 1% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Data Source: Project data; claims and encounter data; medical records Milestone 11 Estimated Incentive Payment: $1,157,822

126675104.2.6	***2.15.1***		*Integrate Primary and Behavioral Health Care Services*
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.23* *126675104.3.24* *126675104.3.25*	IT-1.8 IT-1.10 IT-1.11	Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) Diabetes care: *HbA1c poor control (>9.0%)17- NQF 0059* Diabetes care: *BP control <140/80mm Hg)18 – NQF 0061*

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)
Baseline/goals: Quarterly Performance Improvement (PI) Report to standing departmental PI Committee Data Source: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g., how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 2 Estimated Incentive Payment: $1,921,512	co-located. Metric 1 [P-X2.1]: Screening tool and processes are in place for primary care screening of depression Baseline/goals: Screening tool implemented Data Source: EMR, Project Documentation Metric 2 [P-X2.2]: Establish baseline percentage of primary care patients screened in primary care clinics where behavioral health services are co-located. Baseline/goals: Screening Report identifying baseline percentage Data Source: EMR, Screening Report, Project Documentation Metric 3 [P-X2.3]: Establish improvement target of primary care patients screened in primary care clinics where behavioral health services are co-located. Baseline/goals: Improvement target Data Source: EMR, Screening Report, Project Documentation		

126675104.2.6	***2.15.1***		*Integrate Primary and Behavioral Health Care Services*	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.23* *126675104.3.24* *126675104.3.25*	IT-1.8 IT-1.10 IT-1.11	Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) Diabetes care: *HbA1c poor control (>9.0%)17- NQF 0059* Diabetes care: *BP control <140/80mm Hg)18 – NQF 0061*	
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 5 Estimated Incentive Payment: $1,310,166			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $3,843,023	Year 3 Estimated Milestone Bundle Amount: $3,930,498		Year 4 Estimated Milestone Bundle Amount: $4,204,719	Year 5 Estimated Milestone Bundle Amount: $3,473,464
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $15,451,704				

Project Summary Template to be completed for each Category 1 and 2 project
Project Option 2.17.1 – Behavioral Health Discharge Management Program

Unique Project ID: 126675104.2.7
Performing Provider Name/TPI: JPS Health Network / 126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: This project will create a comprehensive Behavioral Health Discharge Management Program based on evidence-based models. Psychiatric professionals will be responsible for proactive pre- and post-discharge interaction, intervention, and coordination with patients discharged from Trinity Springs Pavilion (JPS' 96 bed psychiatric facility) as they return to the community. This project is a new initiative
Need for the project: This project addresses the following community needs: a) CN.4 Lack of access to mental health services, b) CN.5 Insufficient integration of mental health care in primary care medical care system, c) CN.10 Overuse of emergency department (ED) services, and d) CN.11 Need for more care coordination.
Target population: All patients discharging from Trinity Springs Pavilion (96 bed inpatient psychiatric hospital) - 4,923 inpatient discharges annually (14,769 for DY3, DY4, and DY5). This project will provide greater management that will result in improved post-discharge engagement and treatment adherence, the rate of readmission for psychiatric services and the general availability inpatient and intensive services for the significant volume of Medicaid and Uninsured psychiatric patient discharging from TSP.
Category 1 or 2 expected patient benefits: Milestones P-1.1, P-2.1, P-2.2, P-2.3, P-2.4, P-2.5, P-2.6, P-2.7, P-3.1, P-4.1, P-5.1, P-6.1, P-7.1, P-8.2, P-9.1, P-10.1, P-10.2, P-10.3, P-11.1, P-12.1, P-13.1, P-15.1, P-27.1, P-29.1, P-X.1, P-X.2, I-36.1, I-38.1, I-40.1, I-42.1 were selected. All core project components are included in this project. Each was selected due to their natural progression to project implementation. The improvement milestones selected are all considered to be indicative of improved transition management.
Category 3 outcomes: Outcomes IT-3.8, IT-9.1, IT-9.2 were selected. There is an evidence base to suggest that improved transition management will have positive impact on each of these outcome areas.

Project Option 2.17.1 – Behavioral Health Discharge Management Program

Unique Project ID: 126675104.2.7
Performing Provider Name/TPI: JPS Health Network / 126675104
Project Description:
This project creates a comprehensive Behavioral Health Discharge Management Program based on evidence-based models. Psychiatric professionals will be responsible for proactive pre- and post-discharge interaction, intervention, and coordination with patients discharged from an inpatient facility as they return to the community. The project uses engagement strategies specific to broad diagnostic categories (i.e., major depressive disorder, schizophrenia, bipolar disorder, etc.) and which involve motivational interviewing techniques to encourage engagement, follow-up participation, medication adherence and identification of red flags necessitating additional assistance. We will utilize patient experience of care councils and peer specialists to inform and improve the discharge and recovery process. This project also will use technology to implement electronic communications to patients with appointment reminders, medication reminders, treatment adherence encouragement, and recovery oriented messages. The program targets patients discharged from Trinity Springs Pavilion (TSP) – 4,923 individuals in 2011. Patients discharging from TSP will experience improved outpatient follow-up within seven and 30 days post-discharge in order to reduce behavioral health readmissions to TSP. JPS Health Network behavioral health services include the Psychiatric Emergency Center (PEC), which provides crisis counseling, triaging and referrals, and TSP, an inpatient 96-bed psychiatric hospital for patients 13 and older in Fort Worth, Texas.

Goals and Relationship to Regional Goals:
Project Goals:
After implementing an effective Discharge Management Program for behavioral health patients, we will improve care transitions and coordination of care from inpatient to outpatient, postacute care, and home care settings so that patients will experience postdischarge community engagement and stability, reducing the risk of readmission due to their conditions worsening.
This project meets the following Regional goals:
This project addresses important Regional goals of improving access to behavioral health services and better coordination of behavioral health care services.

Challenges:
Our current system of placing discharge calls to some patients does not provide the level of discharge support needed by psychiatric patients to establish and/or maintain early efforts at recovery. Additionally, there are no targeted interventions based on level of risk. Patients with a psychiatric illness often have difficulty maintaining stability when discharged from inpatient services. This difficulty is reflected in our readmission rate. Additionally, navigating through the mental health system is difficult for patients suffering from mental illness and their families.

Approximately 40% of inpatients are involuntarily admitted to TPS after being brought to JPS Health Network on an Application for Emergency Detention. This results in mandatory treatment for patients who never made the initial decision to seek treatment. All of these factors create significant barriers or challenges to effective transitions to community-based treatment and follow-up levels of care. Our program has high rates of patients who do not keep follow-up appointments or who do not maintain engagement with outpatient treatment providers postdischarge.

5-Year Expected outcome for Provider and Patients:
This project will increase adherence to seven- and 30-day appointment attendance and reduce 30-day behavioral health readmissions by implementing a transition management program focused on psychiatric patients discharging from an inpatient psychiatric facility. Expected outcomes include improvements in the percent of patients discharged who receive clinician follow-up and treatment; percentage of patients /families provided with appropriate education upon discharge; increased percentages of high risk patients[237] discharged with customized care plans; and improvement in both the seven-day and 30-day follow up after hospitalization rates. Actual improvement targets will be established in DY3. By reducing readmissions and non-adherence rates we will improve appropriate utilization of the limited behavioral health services available. This project will improve access to mental health services by reducing potentially avoidable utilization, improving integrated care with primary care providers, reducing overuse of psychiatric emergency department services, and enhancing coordination of care.

Starting Point/Baseline:
Currently no formal discharge/transition management program is in place. We conduct multidisciplinary case conferences for high utilizer patients with frequent readmissions, but these activities are retrospective discussions rather than a proactive identification of factors and interventions. In 2011, 4,923 individuals were discharged from TSP, our system's inpatient psychiatric facility.

Rationale:
This project was selected because of the significant volume of unmanaged psychiatric patient discharges that result in limited postdischarge engagement and treatment adherence, the rate of readmission for psychiatric services, and the general limited availability of inpatient and intensive services. We will adapt evidence-based models that document reduced readmissions, sustained improvement, and cost reduction. We also anticipate this project will reduce no show rates and psychiatric emergency center visits. Technology interventions will be incorporated because of the evidence supporting their efficacy. We have identified a few models that could be adapted and modified to meet the needs of a psychiatric population, including one model that has

[237] For the purposes of this project, "High Risk Patients" are defined in process milestone 5.

been implemented in over 600 facilities across the U.S. that implements a "transition coach" for patients in the program over four weeks.[238]

Project Components:

This project includes all core project components. They will be executed sequentially as we move from pre-implementation to go-live. They will form the basis of a project plan built upon carefully selected milestones and metrics. The improvement milestones selected encourage improved family and patient communication, customized care plans, assessment and follow-up as well as follow-up after hospitalization. In DY2, we will complete the Core Component A by developing a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports as indicated by the process milestone. Core Component B will be completed by conducting an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient and provider interviews. The program will collect information and/or analyze data on factors contributing to preventable readmissions within 30 days. Staff will conduct a minimum of 10 interviews with patient/family members regarding preventable 30-day hospital readmissions. A baseline metric will be determined for all causes of 30-day readmissions. To complete Core Component C we will also identify baseline mental health and substance abuse conditions at high risk for readmissions, (example include schizophrenia, bipolar disorder, major depressive disorder, chemical dependency). The team will identify key factors that increase the likelihood of preventable 30-day readmissions for individuals with mental health and substance use disorders. We will ensure Core Component D is met by reviewing best practices for improving care transitions from a range of evidence-based or evidence-informed models. Evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions will be identified. A written operations manual will be developed for care transitions intervention with administrative protocols and clinical guidelines. The manual will identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions as required by Core Component E. We will develop a plan for a hospital care transition process. We will conduct a study to determine feasibility of providing a wellness,

[238] A proven method for reducing avoidable readmissions is to improve transitional care, which ensures proper coordination and continuity of care as patients move between various locations or levels of care within one organization. A leading model for this work is The Care Transitions Intervention ™, which has been adopted by over 170 leading health care organizations nationwide. Through this approach, Eric Coleman, MD, a nationally-recognized readmissions expert, says that there are four pillars that provide a core set of medical directions that the patient should have: medication self-management, follow-up appointment with the primary care physician or specialist, a knowledge of "red flag" or warning signs of symptoms and how to respond to them, and a personal health record that is a portable core set of medical directions including a medication list and associated allergies, an advance directive, treatment preference, and room for patient questions and concerns. In addition to these four pillars, studies show that care transitions intervention coaching can result in a significant reduction in 30-day hospital readmits, as well as a potential reduction in 90-day and 180-day readmits Care transitions coaches could help patients by modeling behavior to resolve discrepancies, respond to red flags and obtain a timely follow-up appointment, and also help the patient practice for their next encounter with his/her provider and identify two or three questions to discuss. Enhancing the role of patients and caregivers, measuring the quality and safety of care transitions, and using health information technology to promote safe care transitions also play a role in preventing avoidable readmissions. For more information, please see: http://www.caretransitions.org.

self -management and peer support program for patients with high-risk diagnoses. We will conduct a baseline study and annual reassessments of high risk patients readmitted to the hospital in less than 30 days to determine interval between hospital discharge and visit to PCP/Behavioral Health provider. A study of at least 250 high-risk patients readmitted in less than 30 days to the hospital in a given year will be developed using internal hospital records and documentation as the data source. A Patient Experience of Care Council will be created, (including patient/caregiver representation) to provide advice to JPS Health Network on factors influencing care transition and strategies for improving care transition. In DY3, - pilot programs will be implemented involving inpatient and community behavioral health providers as required in Core Component F-. Peer Specialist Positions will be developed with the focus on providing emotional support and practical guidance regarding the discharge and recovery process in a manner consistent with the feasibility study completed in DY2. Consistent with Core Component G, we will conduct quality improvement for project using methods such as rapid cycle improvement. Activities will include, but will not be limited to, identifying "lessons learned" and identifying key challenges associated with expansion of the project, including special considerations for safety - net populations. Benchmarks and targets for improvement milestones in DY4 and DY5 will also be established. In the fourth and fifth year, the focus will be on assessment and follow-up. There will be an increase in targeting discharged inpatient population members and making clinician follow-up calls to review treatment plans and assess compliance. The plan includes an increase in the number of patients receiving follow-up after hospitalization for mental illness within seven and 30 days. In DY4 and DY5, we will work to increase the percentage of patients/families who are provided appropriate education upon discharge and the percentage receiving customized care plans. We will establish actual improvement percentages in DY3.

- **Unique community need identification numbers the project addresses:**
  CN.4 – Lack of access to mental health services
- CN.5 – Insufficient integration of mental health care in the primary care medical care system
- CN.10 – Overuse of emergency department (ED) services
- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This is a new initiative and has not received any other federal funding

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

IT-3.8 Behavioral Health /Substance Abuse 30-day readmission rate was selected because utilization of transition management will enhance stability in the community and adherence to outpatient visits for patients which reduces 30-day behavioral health readmission rates. Dropping out of treatment after a psychiatric hospitalization increases the likelihood of rehospitalization

from one in 10 to one in four.[239] This measure also directly impacts our identified community needs. There is limited access to mental health services (CN.4) and readmissions result in avoidable utilization of the very limited resources available.

IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons was selected because 98% of adults and children receiving public community-based mental health services have avoided multiple hospital readmissions.[240] Admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency department, and inpatient services. Interventions that can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

IT-9.2 ED appropriate utilization was selected because 97% of adults and children receiving public community-based mental health services have avoided a crisis episode.[241] JPS Health Network experiences over 24,000 psychiatric emergency visits per year. The transition management program will ensure patients engage in their individualized care plan enhancing stabilization and service utilization outside of the emergency system. This measure also directly impacts our identified community needs. There overuse of the emergency department services (CN.10). Improve transition management will result in reduced utilization of the emergency services because patients will remain more stable in community-based services.

Relationship to Other Projects:

Project 126675104.1.1 – Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the State where access to care is likely to be limited. Extended operating hours allow for greater flexibility with patient engagement and follow-up services. The additional hours and services added to the continuum allow for greater targeted interventions with the Discharge Management Team. This project essentially becomes a tool for the DC Management Team to utilize to help accomplish the Category 3 goals.

Project 126675104.2.23 – Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care). Utilizing expanded community-based settings (PHP and IOP) allows for greater flexibility with patient engagement and follow-up services. The addition to the continuum allows

[239] Mitchell, A. J., & Selmes, T. (2007). Why don't patients attend their appointments? Maintaining engagement with psychiatric services. Advances in Psychiatric Treatment, 13, 423-434.

[240] Department of State Health Services Behavioral Health Data Book, FY 2010, 4th Quarter, Figures 1.6, 1.7, 1.9, 2.6, 2.7.

[241] Department of State Health Services Behavioral Health Data Book, FY 2010, 4th Quarter, Figures 1.6, 1.7, 1.9, 2.6, 2.7.

for greater targeted interventions with DC Management Team. This project essentially becomes a tool for the DC Management Team.
Project 126675104.2.6 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services. Having embedded care managers in the clinics allows a quick intervention component to the available services. This can be quickly directed toward a patient needing postdischarge assistance and might proactively be engaged as a tool for particularly high-risk patients. Additionally, patients who present with co-occurring medical conditions can be linked to the primary care side of the equation reducing potential readmissions in other sites.

This project will collaborate with MHMR of Tarrant County on interrelated projects such as telemedicine, expanded behavioral health services, RN case management and detox expansion. As this project helps patients transition from inpatient to community-based services each of these community resources will be critical to ensure the patient's continue to progress across a fully developed continuum.

This project will impact RD-2.3 – Behavioral health and Substance Abuse: 30-Day Readmissions. It is expected this project will improve follow-up rates after hospitalization for mental illness. This is expected to reduce behavioral health 30-day readmissions.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as 4923 patients being discharged from Trinity Springs Pavilion. The percentage of the population expected to be positively impacted by the project is 13%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her ability to sustain a normal lifestyle is significantly improved.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, the threat and dependence on the community are significantly reduced.

Specifically, 14,769 patients (4923 annually for DY3, DY4, and DY5) discharging from Trinity Springs Pavilion will receive transition management services will be positively impacted in the following quantifiable ways:

- Increase number of the patients / families who are provided with appropriate education upon discharge by 75% over life of project.
- Increase number of High Risk Patients who are discharged with customized care plans by 60% over life of project.
- Increased patients who have been discharged and have received 3 attempted clinician follow-up calls to review treatment plans and assess compliance by 75% over life of project.
- Increased number of patients receiving follow-up after hospitalization for mental illness within 7 and 30 days by 5% and 7.5% over life of project.
- Reduction in behavioral health/substance abuse 30-day readmission rate to be determined in DY3.
- Decreased mental health admissions and readmissions to criminal justice settings such as jails or prisons to be determined in DY3.
- Reduced emergency department visits for behavioral health conditions to be determined in DY3.

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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]: Establish Task Force or Team to support or lead project. Metric 1 [P-1.1]: Establishment of Task Force or Team Baseline/Goal: Establish cross continuum team Data Source: Project Documentation Milestone 1 Estimated Incentive Payment: $202,645 **Milestone 2** [P-2]: Collect information and /or analyze data on factors contributing to preventable readmissions within 30-days. Metrics may include: Metric 1 [P-2.1]: Conduct a minimum of 10 interviews with patient/family members regarding an occurrence of a preventable 30 -day hospital readmission Baseline/Goal: 10 Interview Reports	**Milestone 14** [P-8 -]**:** Pilot test care management/ intervention approaches at selected provider sites (inpatient or outpatient). Metric 1 [P-8.1 -]. Implementation of pilot program involving inpatient and community behavioral health providers, including number of patients served by the pilot Baseline/Goal: 2 Completed pilots Data Source: Detailed implementation plan; program records Milestone 14 Estimated Incentive Payment: $449,058 **Milestone 15** [P-9 -]**:** Analyze pilot test results Metric 1 [P-9.1 -]: Analyze pilot report Baseline/Goal: Analysis of 2 pilots	**Milestone 20** [I-36] -: Patient / Family Communication Metric 1 [I-36.1] -: X% increase in patients / families who are provided with appropriate education upon discharge Baseline/Goal: 50% of patients/families will receive appropriate education upon discharge Data Source: EMR Milestone 20 Estimated Incentive Payment: $720,581 **Milestone 21** [I-38] -: Customized Care Plans Metric 1 [I-38.1] -: Increase in High Risk Patients who are discharged with customized care plans Baseline/Goal: Current is zero percent/goal is 50% Data Source: EMR	**Milestone 24** [I-36] -: Patient / Family Communication Metric 1 [I36.1] -: X% increase in patients / families who are provided with appropriate education upon discharge Baseline/Goal: 75% of patients/families will receive appropriate education upon discharge Data Source: EMR Milestone 24 Estimated Incentive Payment: $595,263 **Milestone 25** [I-38] -: Customized Care Plans Metric 1 [I-38.1] -: 60% increase in High Risk Patients who are discharged with customized care plans Baseline/Goal: Current is zero percent/Goal is 60% Data Source: EMR

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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)**
Data Source: Project Documentation, Interview notes Metric 2 [P-2.2]: Review interview data conducted by multidisciplinary team Baseline/Goal: Interview Summary Report Data Source: Project Documentation, Interview Notes Metric 3 [P-2.3]: Improve electronic reporting of readmission data Baseline/Goal: Improvement Project PDSA report Data Source: Project Documentation, PI Meeting minutes Metric 4 [P-2.4]: Develop an electronic report on readmission data Baseline/Goal: 7 and 30-day readmission report Data Source: Project Documentation, EMR	Data Source: Evidence of how pilot test results were used in rapid-improvement to inform the scaled-up plans for a hospital care transition process or community-based program for high-risk patients Milestone 15 Estimated Incentive Payment: $449,058 **Milestone 16** [P-29 -]**:** Develop peer specialist positions that focus on providing emotional support and practical guidance regarding the discharge and recovery process. Techniques could include: teaching patients techniques, such as keeping wellness journals or recovery inventories; meeting with patients individually and in recovery support groups, conducting panel presentations to provide the patient perspective to physicians, nurses, medical and nursing students and other hospital staff; conducting	Milestone 21 Estimated Incentive Payment: $720,581 **Milestone 22** [I-40] **-:** Assessment and Follow-up Metric 1 [I-40.1] -: XX% increase in target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance. Goal: 75% of patients discharged to home will receive at least 3 attempted follow-up calls to review treatment plans and assess compliance Data Source: Medical Records; Project Data; Clinician Logs, Discharge Call Manager Milestone 22 Estimated Incentive Payment: $720,581 **Milestone 23** [I-42] **-:** Follow-up After Hospitalization	Milestone 25 Estimated Incentive Payment: $595,263 **Milestone 26** [I-40] **-:** Assessment and Follow-up Metric 1 [I-40.1] -: XX% increase in target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance. Goal: 90% of patients discharged to home will receive at least 3 attempted follow-up calls to review treatment plans and assess compliance Data Source: Medical Records; Project Data; Clinician Logs, Discharge Call Manager Milestone 26 Estimated Incentive Payment: $595,263 **Milestone 27** [I-42] **-:** Follow-up

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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)**
Metric 5 [P-2.5]: Chart review Reports Baseline/Goal: Chart Review Reports Data Source: EMR, Project Documentation Metric 6 [P-2.6]: Determine baseline metric for all-cause 30-day readmission Baseline/Goal: 30-Day Readmission Report Data Source: EMR Metric 7 [P-2.7]: Identification of key factors that increase the likelihood of preventable 30-day readmissions for individuals with mental health and substance use disorders Goal: Key Factor Report Data Source: EMR Milestone 2 Estimated Incentive Payment: $202,645	evidence-based self-help training sessions with patients. (Examples of EBPs include Wellness Recovery Action Planning (WRAP), Chronic Disease Self-Management) Metric 1 [P-29.1 -]: 5 position postings and hiring roster a. Internal personnel records Baseline/Goal: 8 Peer Support employees Data Source: Human Resource Records Milestone 16 Estimated Incentive Payment: $449,058 **Milestone 17** [P-X1 -]: Establish baseline and improvement targets for I-36.1 – Patients / families who are provided with appropriate education upon discharge Metric 1 [P-X1.1 -]: Baseline percentage for 1-12.1 Baseline/goal: Establish baseline	-Metric 1 [I-42.1]: XX% increase in number of patients receiving Follow-Up After Hospitalization for Mental Illness within 7 and 30 days (NQF#-576) Goal: 2.5% more patients will have f/u within 7 days Data Source: Project Data; Encounter/ Claims Data; Medical Records Metric 2 [I-42.2]: XX% increase in number of patients receiving Follow-Up After Hospitalization for Mental Illness within 7 and 30 days (NQF#-576) Goal: 7.5% more patients will have f/u within 30 days Data Source: Project Data; Encounter/ Claims Data; Medical Records Milestone 23 Estimated Incentive Payment: $720,582	After Hospitalization -Metric 1 [I-42.1]: XX% increase in number of patients receiving Follow-Up After Hospitalization for Mental Illness within 7 and 30 days (NQF#-576) Goal: 5% more patients will have f/u within 7 days Data Source: Project Data; Encounter/ Claims Data; Medical Records Metric 2 [I-42.2]: XX% increase in number of patients receiving Follow-Up After Hospitalization for Mental Illness within 7 and 30 days (NQF#-576) Goal: 7.5% more patients will have f/u within 30 days Data Source: Project Data; Encounter/ Claims Data; Medical Records Milestone 27 Estimated Incentive Payment: $595,262

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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 3 [P-3]: Identify baseline high-risk patients analyzing Diagnoses, Diagnostic-related Groups (DRGs) and /or other data elements regarding 30-day readmissions for acute care and home care patients. (Examples of other data elements include but are not limited to age, social support, co-occurring behavioral health conditions, and housing status) <u>Metric 1</u> [P-3.1]: Documentation of chart review Goal: Identify predictors of readmission Data Source: Patient Medical Record Milestone 3 Estimated Incentive Payment: $202,645 **Milestone 4** [P-4]: Hire clinician(s) with care transition/disease management expertise.	Data Source: EMR <u>Metric 2</u> [P-17.2.]: Improvement percentage for 1-12.1 for DY4 and DY5 Baseline/goal: Establish Improvement Target Data Source: EMR Milestone 17 Estimated Incentive Payment: $449,058 **Milestone 18** [P-X2 -]: Establish baseline and improvement targets for I-40.1 – Target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance. <u>Metric 1</u> [P-X2.1 -.]: Baseline percentage for I-40.1 Baseline/goal: Establish baseline Data Source: EMR, Discharge Call Manager		

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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)**
Metric 1 [P-4.1]: Position offer letters Goal: Hire 3 care transition discharge manager Data Source: Human Resource Records Milestone 4 Estimated Incentive Payment: $202,645 **Milestone 5** [P-5]: Develop an assessment tool to identify patients who are at high risk for readmission. Metric 1 [P-5.1]: Multidisciplinary committee approves assessment tool Goal: Approved identification tool. Data Source: Tool – Project Documentation Milestone 5 Estimated Incentive Payment: $202,645	Metric 2 [P-X2.2 -.]: Improvement percentage for 1-40.1 for DY4 and DY5 Baseline/goal: Establish Improvement Target Data Source: EMR, Discharge Call Manager Milestone 18 Estimated Incentive Payment: $449,058 **Milestone 19** [P-X3 -]: Establish baseline and improvement targets for I-42.1 – increase in number of patients receiving Follow-Up After Hospitalization for Mental Illness within 7 and 30 days. Metric 1 [P-X3.1 -.]: Baseline percentage for I-42.1 Baseline/goal: Establish baseline Data Source: EMR, Discharge Call Manager, Encounter data Metric 2 [P-X3.2 -.]: Improvement percentage for 1-42.1 for DY4 and			

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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 6 [P-6]: Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions. Metric 1 [P-6.1]: Selection of an evidence-based framework Goal: Framework selected Data Source: Project documentation Milestone 6 Estimated Incentive Payment: $202,645 **Milestone 7** [P-7]: Develop operations manual for care transitions intervention with administrative protocols and clinical guidelines. Metric 1 [P-7.1]: Development of operations manual Goal: Operations Manual Data Source: Project documentation	DY5 Baseline/goal: Establish Improvement Target Data Source: EMR, Discharge Call Manager, Encounter data. Milestone 19 Estimated Incentive Payment: $449,057			

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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 7 Estimated Incentive Payment: $202,645 **Milestone 8** [P-10 -]: Develop plan(s) for a (1) hospital care transition process or (2) community-based aftercare / follow-up program for high-risk patients, or (3) to provide care management tools and health information exchanges with postacute providers. Metric 1 [P-10.1 -]: Care management tool and Plan Goal: Develop Care Management Tool and Plan Data Source: Project Documentation Metric 2 [P-10.2 -]: Transition Process Improvement Plan Goal: Transition PI Plan and Improvement plan Data Source: Project			

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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)**
Documentation Metric 3 [P-10.3 -]: Community-based aftercare plan Goal: Transition Aftercare Plan Data Source: Project Documentation Milestone 8 Estimated Incentive Payment: $202,645 **Milestone 9** [P-11 -]: Evaluate and continuously improve care transitions programs Metric 1 [P-11.1 -]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: PI Program for project Data Source: PDSA documentation and PIRC minutes Milestone 9 Estimated Incentive Payment: $202,645				

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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 10 [P-12 -]: Conduct study to determine feasibility of providing a wellness, self-management and /or peer support program on hospital campus for patients with high-risk diagnoses. Metric 1 [P-12.1 -]: Hospital program plan Goal: Feasibility Study Report Data Source: Project Documentation Milestone 10 Estimated Incentive Payment: $202,645 **Milestone 11** [P-13 -]: Conduct baseline study and annual reassessments of high-risk patients readmitted to hospital < 30 days to determine interval between hospital discharge and visit to PCP/ behavioral health provider.			

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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)**
Metric 1 [P-13.1 -]: Study of at least 250 high risk patients readmitted in less than 30 days to hospital in a given year Goal: Baseline Study Summary of 250 discharges Data Source: Patient Medical Record Milestone 11 Estimated Incentive Payment: $202,645 **Milestone 12** [P-15 -]: Educate appropriate clinical staff on key contributing factors to preventable readmissions. Metric 1 [P-15.1 -]: 75% of key clinical staff completing educational sessions Goal: 75% of social workers, inpatient physicians, program managers, and physician leaders Data Source: Project Documentation			

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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 12 Estimated Incentive Payment: $202,645 **Milestone 13** [P-27 -]: Creation of Patient Experience of Care Council, (including patient / caregiver representation) to provide advice to Regional Healthcare Partnership on factors influencing care transition and strategies for improving care transition. Metric 1 [P-27.1 -]: Council creation meeting minutes Goal: 8+ member council Data Source: Patient Experience of Care Council Minutes Milestone 13 Estimated Incentive Payment: $202,643			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):*	Year 3 Estimated Milestone Bundle Amount: $2,694,347	Year 4 Estimated Milestone Bundle Amount: $2,882,325	Year 5 Estimated Milestone Bundle Amount: $2,381,051

126675104.2.7	***2.17.1***		Behavioral Health Discharge Management Program	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.26 126675104.3.27 126675104.3.28	*IT-3.8* *IT-9.1* *IT-9.2*	Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons 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)**
$2,634,383				
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $10,592,107				

Project Summary

Project Option 2.9.1– Establish/Expand a Patient Care Navigation Program– MedStar Patient Navigation
Unique Project ID: 126675104.2.8
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: This project will navigate patients at risk for potentially preventable emergency department (ED) visits and hospital admissions to more safe and effective settings for their healthcare needs. This project dramatically expands a short-cycle tested, limited-enrollment, pilot project that has resulted in exceptional results for the target population.
Need for the project: The pilot Patient Navigation project has only been able to reach 528 patients at risk for potentially preventable ED visits. Not only have the enrollee's experienced dramatic improvement in health status, but the program has saved nearly $1.7 million in healthcare expenditures (over $3,000 per patient enrolled).
Target population: Medically underserved Medicaid indigent patients and uninsured that are at risk for potentially preventable ED visits and hospital admissions. We anticipate enrolling a total of 6,525 patients in this program over the reporting period.
Expected patient benefit: Improved health status through navigation away from uncoordinated/episodic ED use to their patient-centered medical home and reduced expenditures by Medicaid through reduced ED visits and hospital admissions.
Category 1 or 2 expected patient benefit:

- I-8.1: -Reduction in ED use by identified ED frequent users receiving navigation services. This project is anticipated to reduce ED usage by 2,082 visits for the 911 Nurse Triage and High Utilization Group programs.
    - ED visits for the 911 Nurse Triage program will be reduced by 1,920 visits (by 30% in DY3-450 pt. visits, reduced by 35% in DY4-630 pt. visits, and reduced by 40% in DY5-840 pt visits).
    - ED visits for the High Utilization Group (HUG) program will be reduced by162 visits (by 30% in DY3-30 pt visits, reduced by 35% in DY4-52 pt visits, and 40% in DY5-80 pt. visits).
    - Four programs will be served under this model: 911 Nurse Triage will enroll 5,400 pts (DY 3 – 1500 pts, DY 4 – 1800 pts and DY5 – 2100 pts); Observation Admission Avoidance will enroll 450 pts (DY 3-100 pts, DY 4-150 pts and DY5-200 pts); CHF Program – will enroll 225 (DY 3-50 pts, DY 4-– 75 pts, and DY5-100 pts); and the High Utilization Group (HUG) will enroll 450 pts (DY 3 – 100 pts, DY 4 – 150 pts, and DY5 – 200 pts).

Category 3 outcomes:
IT 3.2: CHF 30 Day Readmission Rate-113 CHF program patients will experience no PPR during the 30-day post-discharge time frame throughout the reporting period (DY 3 – 25 pts, DY 4 – 38 pts, and DY5 – 50 pts- IT 2.11: Ambulatory Care Sensitive Conditions Admission Rate

- This program will reduce the number of PPA by 5% from established baseline in DY3, will reduce the number of PPA by 10% from established baseline in DY4, and reduce the number of PPA by 15% from established baseline in DY5. This is estimated to be an impact of 50 patients during the reporting period.
- Observation Avoidance Program will enroll 450 patients (DY3-100pts, DY4-150 pts, and DY5 200pts).

Project Option 2.9.1– Establish/Expand a Patient Care Navigation Program– MedStar Patient Navigation

Unique Project ID: 126675104.2.8
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
In the past three years MedStar[xxvi] initiated four pilot patient navigation projects on a limited basis. These programs have significantly reduced the incidence of ED visits and PPRs for congestive heart failure (CHF) and ambulatory care sensitive conditions (ACSC). JPS Health Network and MedStar plan on expanding these programs to allow more patients to be served and result in more dramatic improvement in patient outcomes, ED utilization and potentially preventable readmissions.

The MedStar Patient Navigation program has four components:
911 Nurse Triage Program:
The 911 Nurse Triage components will screen low-acuity 911 calls and send the callers to a specially trained RN in the 911 call center. The RN who works with these low-acuity callers to find them resources other than an ambulance transport to the ED. To date, the limited scope, pilot 911 Nurse Triage project has been successful in referring 38% of patients enrolled in the program to dispositions other than an ambulance trip to the emergency department.

An analysis of current 911 calls reveals that 5-10% of all 911 calls are calls with very low-acuity patient complaints. Typically, these calls have resulted in an ambulance response and subsequent transport to a local emergency department. This leads to uncoordinated care for the patient and high cost to the system. The average Patient Charge (APC) for an ambulance transport is $1,500 and the APC for an ED visit is $2,400 for a cost per episode of care of $3,900.
A very limited pilot program launched by JPS Health Network and MedStar in June 2012 with a 911 Triage Nurse on duty M-F, 9a – 5p. Of the 200 patients referred to this program since June, of low acuity calls referred to a specially trained RN in the MedStar Call Center 76 patients have been effectively navigated to resources other than an ambulance response and subsequent transport to an emergency department. In many cases, these patients have been navigated to a PCMH for coordinated care at reduced costs. Expanding this program to 24/7 will have significant impact on up to 24 patients per day, versus the current 6 patients per day.

The **High Utilization Group (HUG) Program:**
The High Utilization Group (HUG) component targets patients with four or more ED visits/admissions in the past year and provides program enrollees with in-home education; medication reconciliation, environmental assessment and mitigation, and connection to other resources to help them better manage their medical conditions in settings other than the ED. To date, the limited pilot project has reduced PPA to EDs by 56% for enrolled patients.

MedStar has been conducting a Community Health Program for 3 years to address frequent 911 users. To date, the program has enrolled over 150 patients with a 46% reduction in 911 and ED use during the patient's enrollment and 85% sustained reduction in 911 and ED use up to 12 months post-graduation from the program.

JPS Health Network has identified 778 patients who have used the ED 4 or more times in 12 months in FY11. Under this DSRIP project, we plan to enroll these 450 patients into the HUG program in an attempt to achieve similar results as the frequent 911 users.

CHF Program:

In-Home Congestive Heart Failure (CHF) Management component provides in-home education, medication reconciliation, environmental assessment and mitigation, and medical intervention (in-home diuresis) in coordination with the patient's PCP for patients at risk for potentially preventable admissions (PPRs) for CHF. To date, the limited scope pilot project has demonstrated a 46% reduction in PPR for CHF for enrolled patients.

Observation Admission Avoidance Program:

The Observational Admission Avoidance component targets patients who are at risk for an observation only admission until they can be seen by their PCP or a specialist, and provides them with in-home assessment, evaluation and any necessary treatments to assure they are safe at home and help assure they attend their follow-up PCP/specialist appointment. To date, no patients enrolled in this limited scope, pilot project have experienced a PPR to the ED prior to their PCP/specialist appointment for enrolled patients.

Under the pilot, only 528 patients in the past 24 months were enrolled due to limited funding. This DSRIP project will significantly expand these 4 programs. Under the Waiver, MedStar will expand the Patient Navigation program and enroll an estimated 6,525[xxvii] patients, which will have a greater impact on patient outcomes and system costs.

Goals and Relationship to Regional Goals:

Project Goals:

The primary goal of this program is to reduce unnecessary ED visits and PPRs by providing patients accessing the emergency care system for reduction of ED visits and PPR with coordinated, timely, and site-appropriate health care services.

Secondary goals include improving individual health status, improving community health and reducing health care costs.

This project meets the following Regional goals:

This project meets a number of Regional goals which are aligned with the goals of the Waiver and the Institute for Healthcare Improvement's (IHI) triple aim. Specifically, this program will improve care by navigating patients to PCPs and other medical homes for more coordinated, safer medical care which will improve the patient's overall health and quality of life. In addition, navigating patients away from high cost ED settings to more appropriate, less expensive settings will reduce the cost of caring for these patients.

Challenges:
Like most U.S. hospitals JPS Health Network has a high volume of patients entering the ED for primary care issues. While patients' immediate health care needs may be dealt with in the ED, the ED is not set up to provide the longitudinal care and care coordination important for overall patient health. Under this project, patients seeking primary care services in the ED would be navigated to their patient-centered medical home (PCMH), which can provide care that is safer, more effective and efficient, provided in the right setting and timely, based on the patients presentation. Limited funding has prevented JPS Health Network and MedStar from expanding the program to benefit the entire cohort of patients who require it.

5-Year Expected Outcome for Provider and Patients:
During the Waiver period, JPS Health Network and MedStar will participate in four admission/readmission avoidance programs. The 911 Nurse Triage program will reduce potentially preventable ED visits - by - 1,920 visits. The Observation Admission Avoidance program will reduce ACSC inpatient admissions by 15% from established baseline. We estimate 162 potentially preventable ED visits -will be avoided through the high-utilization group (HUG) program. The CHF target population program will prevent 113 ED visits and potentially preventable readmissions.

Starting Point/Baseline:
Over the past 12 months, 528 unduplicated patients have been enrolled in various components of the Patient Navigation program. MedStar utilizes 4.5 community health paramedic FTEs (4.9% of the full-time paramedic workforce) and one 911 Triage Nurse (2.7% of the call center workforce) for the program. There have been approximately 1,084 encounters with these patients over the past 12 months.

In the JPS Health Network system, 778 patient patients have been identified as having four or more JPS Health Network ED or inpatient admissions during FY11, equating to 1,423 potentially avoidable ED encounters and 161 potentially avoidable inpatient admissions.

Rationale:
In Fort Worth, nearly 12,000 people call 911 each year with very low-acuity medical complaints. Up to 38% of these patients can be navigated to a specially trained RN in the 911 call center to assist them with finding the right care in the right setting without an ambulance response and transport to an ED. Numerous studies and published data from CMS and other sources indicate that frequent ED and EMS system users suffer added health issues due to lack of care coordination and a PCMH. Further, a 70,000 patient population in a peer hospital system in Ft. Worth experienced 3,000 observational admissions until they could be seen by their PCMH or

PCP. This type of utilization leads to uncoordinated care, unnecessary procedures and an overall risk to patient safety.
Readmissions for CHF-related illnesses are another major cost driver for the health care system. Using mobile CHPs, the program aims to respond proactively to patients who may normally access the emergency care system to provide in-home education, assessments and interventions and build patients' ability to better manage their own care.

As a Region, there were 1.1 million visits to hospital EDs in 2010, with a rate of 447.5 visits per 1,000 persons. The 2007 national ED visit rate was 390.5 per 1,000 persons, increasing 23% since 1997, but lower than the ED visit rate of Region 10. Under this program, we will reduce 911 calls resulting in an ambulance response and transport to an ED by - 40%, reduce - PPA for Ambulatory Sensitive -Conditions by - by15% in enrolled patients, reduce CHF PPRs by 50% in enrolled patients and reduce - ED visits for PPA -HUG patients by -40%.

Project Components:
Project components include:

- Identifying target populations for program enrollment and using patient navigators in the 911 and the field to reduce ED visits and PPRs.
- Training health care navigators in cultural competency.
- Deploying community health paramedics (CHPs) as innovative health care personnel to provide the right care in the right setting to prevent unnecessary ambulance transport to ED.
- Navigating patients to established PCMHs or PCPs in the community.
- Focusing on care coordination by conducting monthly meetings of a Care Coordination Council. All case managers participating in the patient's care will come together to review the care provided and the patient's health care resource use to improve care coordination. Care is also coordinated with the patient's PCP as needed by the community health paramedics on scene with patients during home visits.
- Educating healthcare teams in chronic disease self-management.
- Conducting Plan-Do-Cycle-Act (PDSA) rapid cycle testing to evaluate results for processes used and make adjustments as necessary based on this analysis.

Unique community need identification numbers the project addresses:

- CN. – 10 Overuse of ED services
- CN. – 11 Need for more care coordination

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

This initiative significantly enhances a program that has already demonstrated significant improvement in health care, and reduced costs to the system. Funding has limited the program to only 528 eligible patients over the past three years. We expect additional funding will allow us to impact more than 6,525 patients during the Waiver period.

The MedStar Community Health Program was recently profiled by AHRQ as a best-practice innovation on their Innovation Exchange[xxviii]. The RAND Corporation just completed a review of the program and will be recommending to CMS that this is a best practice for community care coordination. (Their report will be published in December 2012). The Institute of Medicine (IOM) published a Consensus document in 2006 called "EMS at the Crossroads" which encouraged partners and governments to utilize EMS providers in new roles in an effort to improve individual health status and reduce costs[xxix].

There is no other HHS funding provided for these programs.

Related Category 3 Outcome Measures:

Outcome Measure 1: Observation Admission Avoidance Program

IT-2.11 Ambulatory Care Sensitive Admission Rate:

Reduce the number of acute care hospitalization for ambulatory care sensitive conditions under age 75 years by 15% from established baseline.

In our community, one hospital and payer group have identified that 3,000 patients are admitted to 23-hour observation at a cost of $5,000 per admission. In some cases, these observational admissions are simply because the ED physician is uncomfortable sending the patient home to an unknown and medically unsupervised setting. Under this program, MedStar will receive these patients into their community health program; conduct any necessary follow-up visits until the patient can be scheduled for follow-up with his or her primary care provider. It is anticipated that for each observation admission avoided, there will be a $3,000 to $5,000 cost-savings to the community.

Outcome Measure 3: CHF Readmission Avoidance Program

IT-3.2 Congestive Heart Failure 30-day readmission rate

113 PPR for CHF patients (50% of the 225 enrollees) will be avoided during the project term.

All counties identified it as a system cap and need. Barriers include complexity of coordination, lack of staff, and lack of financial integration, fragmented system service, and practicing in silos. Providers did not feel there was strong care coordination between primary care providers, hospitals, and specialists.

Relationship to Other Projects:

This project will operate in tandem with other related JPS Health Network projects: JPS Health Network's Patient-centered Medical Home Project (126675104.2.2), Care Connections for the Homeless (126675104.2.3) and Community Connect (126675104.2.10)

RD-1-1. Potentially Preventable Admissions
The 911 Nurse Triage, HUG and Observation Admit components of the Patient Navigation project will reduce PPA for ACSC, with specific focus on diabetes and COPD.
RD-2-1. CHF 30-Day Readmission
The CHF program will specifically target the patients at risk for PPA and PPR for CHF conditions.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as patients who dial 911 for medical assistance. The percentage of the population expected to be positively impacted by the project is 41%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, - their potential to spend time in the ED or Observation is reduced.
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To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, the system costs are greatly reduced and access to care to the ED for other members of the community is increased as well.

126675104.2.8	*2.9.1*	*2.9.1 A-E*	2.9 Establish/Expand a Patient Care Navigation Program- MedStar Patient Navigation	
JPS Health Network				**126675104**
Related Category 3 Outcome Measure(s):	**126675104.3.29** **126675104.3.52**	**IT-3.2** **IT 2.11**	Congestive Heart Failure 30-day readmission rate (Stand-alone measure) -Ambulatory Care Sensitive Condition Admission rate (Stand-alone 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)**
Process Milestone 1: (P-1): Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. (Including frequency and costs of episodic care for traditional care model.) Metric 1 (P-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, service maps or flowcharts). •Ideal number of patients targeted for enrollment in the patient navigation program •Number of Patient Navigators	**Process Milestone 2: (P-3):** Provide care management/navigation services to targeted patients. (Targeted patients include low acuity 911 callers, patients that are candidates for observation only admissions, frequent ED/EMS users and CHF patients at risk for 30-day readmissions.) Metric 1 [P-3]: Increase in the number or percent of targeted patients enrolled in the program Baseline/Goal: 911 Nurse Triage – Enroll 1500 in the program. Data Source: MedStar 911 Records Observational Admission Avoidance -		**Milestone - 4: (I-8):** -Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1: I-8.1: 911 Nurse Triage- Reduce ED visits (pre and post navigation services) by 35% for the 911 Nurse Triage Program. Goal: 630 patients (35% of the 1,800 DY-4 enrollees) will be navigated away from the ED. Enroll 1800 new patients into the program. Data Source: MedStar 911 Records - -Metric 1: I-8.1:	**Milestone - 5: (I-8):** -Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1: I-8.1: 911 Nurse Triage- Reduce ED visits (pre and post navigation services) by 40% for the 911 Nurse Triage Program. Goal: 840 patients (40% of the 2,100 DY-5 enrollees) will be navigated away from the ED. Enroll 2,100 new patients into the program. Data Source: MedStar 911 Records - -Metric 1: I-8.1:

126675104.2.8	*2.9.1*	*2.9.1 A-E*	2.9 Establish/Expand a Patient Care Navigation Program- MedStar Patient Navigation	
JPS Health Network				**126675104**
Related Category 3 Outcome Measure(s):	**126675104.3.29** **126675104.3.52**	**IT-3.2** **IT 2.11**	Congestive Heart Failure 30-day readmission rate (Stand-alone measure) -Ambulatory Care Sensitive Condition Admission rate (Stand-alone 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)**
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: *For 911 Nurse Triage* – Review 911 call volume records to identify protocol/call types most appropriate for transfer to MedStar Triage Nurse. Data Source: MedStar 911 call records, JPS Health Network and MedStar EMR records. Baseline/Goal: For Observation Admission Avoidance Review EMR to establish number and most frequent Dx of patients admitted	100 observational admission patients referred for navigation to a PCMH instead of observational admission Data Source: JPS EMRs. CHF In-Home Management – Enroll 50 patients at risk for PPR for CHF are referred to the MedStar program. Data Source: JPS and MedStar EMRs. High Utilization Group – Enroll 100 of the patients identified by JPS as having used the ED for ACSC services 4 or more times in the past 12 months. Patient Count. Data Source: JPS EMRs. Milestone 2 Estimated Incentive Payment (maximum amount): $612,306 **Milestone 3: (I-8):**		High Utilization Group Program– Improvement Target: High Utilization Group (HUG) program Metric: Reduce ED visits for potentially avoidable admissions. Goal: 52 patients (35% of the DY4-150 enrollees) will experience reduced PPA to the ED for 12 months. Enroll 150 of the patients identified by JPS as having used the ED for ACSC services 4 or more times in the past 12 months. Metric: Patient Count. Data Source: JPS EMRs. Milestone 4 Estimated Incentive Payment (maximum amount): $1,310,049	High Utilization Group Program– Improvement Target: High Utilization Group (HUG) program Metric: Reduce ED visits for potentially avoidable admissions. Goal: 80 patients (40% of the DY4-200 enrollees) will experience reduced PPA to the ED for 12 months. Enroll 200 of the patients identified by JPS as having used the ED for ASCS services 4 or more times in the past 12 months. Metric: Patient Count. Data Source: JPS EMRs. Milestone 5 Estimated Incentive Payment (maximum amount): $1,082,215

126675104.2.8	*2.9.1*	*2.9.1 A-E*	2.9 Establish/Expand a Patient Care Navigation Program- MedStar Patient Navigation	
JPS Health Network				**126675104**
Related Category 3 Outcome Measure(s):	**126675104.3.29** **126675104.3.52**	**IT-3.2** **IT 2.11**	Congestive Heart Failure 30-day readmission rate (Stand-alone measure) -Ambulatory Care Sensitive Condition Admission rate (Stand-alone 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)**
to JPS Health Network for 23 hour observation during the preceding 12 months. Baseline/Goal: High Utilization Group (HUG) Program – Review EMR to identify the most frequent ED and EMS users (High Utilization Group – HUG) as the initial target population for intervention. Data Source: MedStar and JPS EMR records. Baseline/Goal: CHF Readmission Reduction Program – Review case files from JPS Health Network cardiology group to identify patient profiles that lead to PPR. Establish referral procedures to enroll these patients into MedStar CHF program to reduce the incidence of PPR. Data Source: JPS Health Network Cardiology Records	Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1: I-8.1: 911 Nurse Triage- Reduce ED visits (pre and post navigation services) by 30% for the 911 Nurse Triage Program. Goal: 450 patients (30% of the 1,500 DY-4 enrollees) will be navigated away from the ED. Data Source: Information on 911 call dispositions. Metric 1: I-8.1: High Utilization Group Program– Improvement Target: High Utilization Group (HUG) program Metric: Reduce ED visits for potentially avoidable admissions. Goal: 30 patients (30% of the DY3-150 enrollees) will experience reduced PPA to the ED for 12 months. Improvement Target 3 Estimated Incentive Payment $612,305			

126675104.2.8	***2.9.1***	***2.9.1 A-E***	2.9 Establish/Expand a Patient Care Navigation Program-MedStar Patient Navigation	
JPS Health Network				**126675104**
Related Category 3 Outcome Measure(s):	**126675104.3.29** **126675104.3.52**	**IT-3.2** **IT 2.11**	Congestive Heart Failure 30-day readmission rate (Stand-alone measure) -Ambulatory Care Sensitive Condition Admission rate (Stand-alone 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 Estimated Incentive Payment (maximum amount): $1,197,357				
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,197,357	Year 3 Estimated Milestone Bundle Amount: $1,224,611		Year 4 Estimated Milestone Bundle Amount: $1,310,049	Year 5 Estimated Milestone Bundle Amount: $1,082,215
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $4,814,232				

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 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

Unique Project ID: 126675104.2.9
Performing Provider Name/TPI: JPS Health Network / 126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: The project will create a virtual psychiatric and clinical guidance service to 1,802 primary care providers in Region 10. The virtual psychiatric and clinical guidance service will allow medical professionals in primary care settings to access - behavioral health professionals (psychiatrists, psychiatric nurses, psychiatric social workers) -via - telephone, - facsimile, and e-mail- who will support PCPs delivering services regionally with the necessary resources and guidance to adequately treat patients who present with a wide variety of behavioral health conditions. This project is a new initiative.
Need for the project: This project addresses the following community needs: a) CN.1 - Lack of provider capacity, b) CN.4- Lack of access to mental health services, c) CN.5 - Insufficient integration of mental health care in the primary care medical care system, d) CN.7 - Need to address geographic barriers that impede access to care, e) CN.8 - Lack of access to healthcare due to financial barriers, f) CN.10 - Overuse of emergency department (ED) services, and g) CN.11 - Need for more care coordination.
Target population: Primary care physicians in Region 10 who will address behavioral health issues in primary care settings for 9,047 patients (DY2 = 452, DY3 = 1810, DY4 = 2940, DY5 = 3845) and with target population of 1,759 to reach experience identified improvements. Medicaid and the uninsured of our service area will benefit from increased access to behavioral health services within the patient's medical home setting, increase coordination between primary and behavioral health care providers and increase teamwork and consultations so the patient's physical and behavioral health issues are treated synergistically.
Category 1 or 2 expected patient benefits:
Milestones P-1.1, P-2.1, P-2.2, P-4.1, P-5.1, P-X1.1, P-X1.2, P-X2.1, PX2.2, P-X2.3, I-7.1, and I-9.1 were selected. Each milestone selected was due to their natural progression to project implementation or a natural result of implementing integrated care components.
Category 3 outcomes: Outcomes IT-1.8 and IT-1.9 were selected. There is an evidence base to suggest that a virtual consultation service will have positive impact on each of those outcome areas.

Project Option 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

Unique Project ID: 126675104.2.9
Performing Provider Name/TPI: JPS Health Network / 126675104
Project Description:
This intervention creates a virtual psychiatric and clinical guidance service available to 1,802 primary care providers in Region 10. The virtual psychiatric and clinical guidance service will provide support to primary care providers delivering services regionally with the necessary resources and guidance to adequately treat patients who present with a wide variety of behavioral health conditions. The support will include, but is not limited to, 1) information and referral assistance, 2) general information about various mental illnesses and tools to assist with determining an appropriate diagnosis, 3) an evidence based center with current research based literature and best practices from multiple sources on behavioral health disorders and topics to be available to medical professionals including guidelines for psychotropic medication indications, diagnosis and symptomology, psychotropic medication administration and monitoring, and appropriate screening, prevention, and interventions in community settings, 4) webinar types of education and training for primary care providers focused on improved identification, diagnosis, and treatment of common behavioral health conditions, and 5) virtual behavioral health guidance consisting of an interdisciplinary consultative team comprised by a psychiatrist, a master's level psychiatric social worker and a psychiatry nurse who will ensure virtual psychiatric guidance services are available within 30 minutes on a 24-hour basis to primary care providers. The medical professionals in primary care settings - will access professional behavioral health expertise -via telephone, - facsimile, and email).

This service will rely heavily upon evidence-based treatment protocols to promote better adherence to evidence-based guidelines for specific behavioral health conditions by primary care physicians. Access to services will allow the medical treatment team to utilize behavioral health expertise in areas including but not limited to: diagnostic impressions, psychiatric medication administration, trajectory and outcomes of mental health diagnoses, cultural considerations relevant to behavioral health treatment, and referral recommendations for ongoing treatment, and behavioral health self-management resources. Interventions for this project include primary care physician, nursing, and case worker support in treatment through education and virtual clinical guidance for behavioral health issues with recommendations from evidence and research based literature and best practices, complicated case reviews, referral recommendations for ongoing treatment, patient and family resource education and suggestions, psychotropic titration, administration, monitoring and ongoing management recommendations. Other interventions will be developed and identified based on primary care provider stated needs and requests.

Goals and Relationship to Regional Goals:
Project Goals:

This project will increase patient access to behavioral health services within the patient's medical home setting, increase coordination between primary and behavioral health care providers and increase teamwork and consultations between primary and behavioral health care providers so that the patient's physical and behavioral health issues are treated synergistically. JPS Health Network will Integrate Behavioral Health Capacity into the PCMH Model by assisting primary care providers in delivering high quality, evidence-based psychiatric medication management as appropriate in primary care settings throughout Region 10. Additionally, this project will directly impact multiple community health needs identified below.

This project meets the following Regional goals:
This project addresses the Regional need for more access to behavioral health services and increased coordination between primary care and behavioral health.

Challenges:
Fewer than one-third of patients with a diagnosable mental disorder receive treatment in the mental health system[242] and primary care physicians (i.e., family physicians, general internists, and obstetrician-gynecologists) serve as the initial health care provider for between 40% and 60% of individuals with depressive disorders. These statistics explain why 77% of all antidepressant medications are prescribed by primary care providers.[243] Additionally, Region 10's Stakeholder Needs Assessment found that 69% of respondents believed the effectiveness of primary care physician co-managing patients who have both mental health and medical conditions with mental health patients was either somewhat ineffective or very ineffective. In many circumstances, the clear solution is to implement broader care integration across primary care and behavioral health . However, eight of Region 10's nine counties are federally designated Mental Health Provider Shortage Areas.[244] Due to the shortage of mental health providers, traditional integrated care is not an option. This combination of a lack of mental health providers in Region 10 and the common practice for patients with mental health issues to seek treatment in primary care settings requires an innovative intervention.

5-Year Expected Outcome for Provider and Patients:
By the end of the Waiver period, there will be an - increase over baseline in adherence to evidence-based guidelines for specific behavioral health conditions and an increase (baseline and target to be established in DY3) in improved provider satisfaction.

Starting Point/Baseline:
JPS Health Network has extensive experience in providing emergency psychiatric services, inpatient psychiatry, and ambulatory behavioral health services. Our partner for this project is UNTHSC Department of Psychiatry, which maintains a core competency in education and

[242] National Institute of Mental Health, 1999. "Mental Health: A Report of the Surgeon General"
[243] Integrated Behavioral Health Project, 2009. "Partners in Health: Primary Care/County Mental Health Collaboration Tool Kit"
[244] Professional Shortage Areas (http://hpsafind.hrsa.gov/)

information sharing. Also, JPS Health Network operates a hospital-based consultation/liaison service and an Integrated Medical Unit that provide co-management by an internal medicine physician and psychiatrist for patients with serious medical and psychiatric issues requiring hospitalization. There is no current virtual psychiatric and clinical guidance program throughout Region 10.

Rationale:
Despite the high prevalence and substantial impact of depression, detection and treatment in the primary care setting are frequently suboptimal. Studies have shown that usual care by primary care physicians fails to recognize 30% to 50% of depressed patients. Because patients in whom depression goes unrecognized cannot be appropriately treated, systematic screening has been advocated as a means of improving detection, treatment, and outcomes of depression. Compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up. This project was selected to address these challenges because of the clear need for additional resources to primary care providers attempting to manage behavioral health issues in their offices. JPS Health Network proposes an innovative approach for more effectively integrating behavioral health capacity into primary care settings in spite of mental health provider shortages throughout our Region.

The category 3 outcomes selected for this project are focused on depression as these were the only options provided in the outcome menu. This project will not be limited to providing support to providers for depressive disorder only but will be available to offer expertise and guidance with multiple symptoms and diagnoses including, but not limited to, Major Depression, Anxiety, Schizophrenia, Schizoaffective Disorder, Bipolar Disorder and others.

Project Components:
The proposed intervention is a virtual psychiatric and clinical guidance service to 1,802 primary care providers in Region 10. The virtual psychiatric and clinical guidance service will allow medical professionals in primary care settings to access professional behavioral health expertise (via - telephone, - facsimile, and email). We have included in our project's design all core and optional project components because they will serve as basic guideposts and steps to completion for our project implementation plan. Each of these items builds on the previous step to ensure a well-developed project plan. -Required core project components:

Core Component A: We will establish the infrastructure and clinical expertise to provide remote psychiatric consultative services. This will include the expertise and consultative services from an interdisciplinary team with behavioral health experience. The team and infrastructure will be developed during the planning phase of this project and will incorporate the community needs assessment and collaboration from primary care providers to identify their needed and lacking areas of expertise.

Core Component B: We will 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.

The project will develop a survey to assess needs in primary care settings as well as utilize the community needs assessment to identify appropriate locations lacking behavioral health expertise and what are their greatest needs.

Core Component C: We will assess applicable models for deployment of virtual psychiatric consultative and clinical guidance models.

During the development and planning of this project models for deployment and clinical guidelines will be evaluated for appropriateness to meet community needs and seek out best practices to adopt.

Core Component D: We will build the infrastructure needed to connect providers to virtual behavioral health consultation. This will consist of an interdisciplinary consultative team by procuring a Psychiatrist, a master's level psychiatric social worker and a psychiatry nurse.

Core Component E: We will ensure staff administering virtual psychiatric consultative services is available to field communication from medical staff on a 24-hour basis to ensure primary care providers are able to communicate and contact the team and have a response within 30 minutes of a request anytime.

Core Component F: We will identify which medical disciplines within primary care settings (nursing, nursing assistants, pharmacists, primary care physicians, etc.) could benefit from remote psychiatric consultation. We are beginning with an assumption that psychiatric consultation can benefit the primary care physicians, case workers, nursing, and nursing assistants. Other disciplines may be identified throughout the implementation of the project.

Core Component G: We will 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. This will occur in the pre-operational phase where a specific protocol will with contact information and guidelines will be created with contact information to ensure efficient access to services is achieved.

Core Component H: We will identify clinical code modifiers and/or modify electronic health record data systems to allow for documenting the use of telephonic behavioral health consultation. In doing so, we will evaluate multiple opportunities and methods of documentation and electronic record keeping ensuring occurrences of consultation are captured and documented appropriately. We will also seek out best practices from similarly established and existing services in the nation to develop a documentation practice for this program.

Core Component I: We will develop and implement data collection and reporting standards for remotely delivered behavioral health consultative services. In doing so, we will evaluate

multiple methods of data collection and develop and implement a reporting system to accurately reflect unique and significant data from consultation services and occurrences.

Core Component J: We will 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. Review of interventions, lessons learned, and expansion will be ongoing through our CQI activity managed with milestone P-5.1. We will also assess progress, further community and provider needs, constraints and limitations, and challenges to expansion.

Core Component K: We will develop a database or information resource center for behavioral health professionals to ensure appropriate research based interventions are being communicated to providers. There will be a resource database or information resource center for behavioral health professionals to ensure appropriate and current research based interventions and best practices from multiple sources are available and communicated to providers.

Core Component L: We will develop or adapt best practice resources and research based literature to medical professions on a range of behavioral health topics that frequently occur in primary care settings (including guidelines for best practices for administration of psychotropic medications for all of the most common mental health conditions and monitoring of these medications).

Additionally, we will create a database or center with current research based literature and best practices from multiple sources on behavioral health disorders and topics to be available to medical professionals including guidelines for psychotropic medication indications, diagnosis and symptomology, psychotropic medication administration and monitoring, and appropriate screening, prevention, and interventions in community settings.

- **Unique community need identification numbers the project addresses:**
  CN.1 – Lack of provider capacity. Patients find difficulty in navigating the system and have noted the difficulty in finding a provider, particularly Medicaid providers. Five counties recognized as medically underserved areas.
- CN.4 – Lack of access to mental health services. All but one county in Region 10 are recognized as Health Professional Shortage Areas for mental health providers.
- CN.5 – Insufficient integration of mental health care in the primary care medical care system. Community stakeholders cite a need to achieve better integration of primary care and mental health care services in the primary care setting through heightened awareness of medical models for mental health integration.
- CN.7 – Need to address geographic barriers that impede access to care. There is a skewed distribution of providers in Region 10, with most located in the major urban centers,

particularly Fort Worth, Tarrant County. Individuals from rural counties have difficulty with access to care, especially specialty care.

- CN.8 – Lack of access to health care due to financial barriers (i.e., lack of affordable care). Providers overwhelmingly list lack of coverage/financial hardship as a major barrier for low-income patients.
- CN.10 – Overuse of emergency department (ED) services. Demand for ED visits is on the rise and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow. As a Region, there were 1.1 million visits to hospital EDs in 2010, with a rate of 447.5 visits per 1,000 persons. The 2007 national ED visit rate was 390.5 per 1,000 persons, increasing 23% since 1997, but lower than the ED visit rate of Region 10.
- CN.11 – Need for more care coordination. All Region 10 counties identified it as a need. Barriers include complexity of coordination, lack of staff, lack of financial integration, fragmented system service, and practicing in silos. Providers did not feel there was strong care coordination between primary care providers, hospitals, and specialists.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This is a new initiative for Regional 10 and we have received no other funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) was selected because CMS has stated the evidence is adequate to conclude that screening for depression in adults, which is recommended with a grade of B by the U.S. Preventive Services Task Force (USPSTF), is reasonable and necessary for the prevention or early detection of illness or disability, and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.[245] Despite the high prevalence and substantial impact of depression, detection and treatment in the primary care setting have been suboptimal. Studies have shown that during usual care by primary care, depression goes unrecognized and cannot be appropriately treated. Systematic screening has been advocated as a means of improving detection, treatment, and outcomes of depression. Compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up. The virtual psychiatric and clinical guidance

[245] Centers for Medicare and Medicaid Services (CMS) http://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?&NcaName=Screening%2520for%2520Depression%2520in%2520Adults&bc=ACAAAAAAIAAA&NCAId=251.

service should improve on the depression screening and the effectiveness of follow-up plans as well as treatment.
(NEW) IT-1.9 Depression management: *Depression Remission at 12 Months (NQF# 0710)* was selected because CMS has stated the evidence is adequate to conclude that screening for depression in adults, which is recommended with a grade of B by the U.S. Preventive Services Task Force (USPSTF), is reasonable and necessary for the prevention or early detection of illness or disability, and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.[246] Primary care providers (PCPs) tend to be the first (and often last) stop for services for individuals with mental illness and substance use disorders. Indeed, more than one-third of all patients rely solely on PCPs to treat psychiatric disorders. These individuals may have medical conditions that are created or exacerbated by untreated or undertreated mental illness and substance abuse. This trend means PCPs should have adequate resources and expertise to treat behavioral health conditions. Treating behavioral health conditions during a PCP visit reduces the chances of losing the patient during the referral process. The goal of this project is to provide PCPs delivering services Regionally with the necessary resources and guidance to adequately treat patients who present with behavioral health conditions. Clinical guidance will be provided remotely via the following communication methods: telephone, instant message, videoconference, facsimile, and email. Access to these services will allow the medical treatment team to utilize behavioral health expertise in areas including, but not limited to: diagnostic impressions, psychiatric medication administration, trajectory and outcomes of mental health diagnoses, cultural considerations relevant to behavioral health treatment, and referral recommendations for ongoing treatment, and behavioral health self-management resources. PCPs will increase their knowledge base about behavioral health conditions while also having quick access to cutting edge and research based behavioral health interventions over several communication methods. This effort will bridge the often disparate disciplines of behavioral and physical health, providing better outcomes for patients who increasingly rely on primary care settings for treatment of their behavioral health conditions. As such we will utilize the Patient Health Questionnaire (PHQ-9) tool because it is a widely accepted, standardized tool that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at 12.

The PHQ-9 will be used to assist with integrated behavioral health as well as in remote settings to assist primary care providers in early detection, prevention, symptomology, and rating severity of depression. It will used to assist primary care providers in delivering care and will be used in conjunction with consultative services to educate primary care providers and increase their base knowledge and expertise in the treatment of depression.

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[246] Centers for Medicare and Medicaid Services (CMS) http://www.cms.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?&NcaName=Screening%2520for%2520Depression%2520in%2520Adults&bc=ACAAAAAAIAAA&NCAId=251.

Relationship to Other Projects:
This project will work in tandem with, and be a resource for, the JPS Health Network project 126675104.2.6 – Design, implement, and evaluate projects that provide integrated primary and behavioral health care services

This project is related to RD-1.3 Potentially preventable admissions Behavioral Health and Substance Abuse Admission rate (based on other selected PPA primary diagnoses). This reporting measure was selected because it is anticipated this project will reduce potentially preventable admissions by behavioral health patients for medical conditions by improving the care and adherence to treatment recommendations through virtual psychiatric and clinical guidance.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as primary care physicians in Region 10 who will potentially address behavioral health issue in primary care settings. The percentage of the population expected to be positively impacted by the project is 26%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or her quality of care is significantly improved.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number

because when a person is positively impacted, the coordination of care in the community is greatly increased.

Specifically, 9,047 patients (DY2 = 452, DY3 = 1810, DY4 = 2940, DY5 = 3845) receiving care from primary care providers will be positively impacted in the following quantifiable ways:

- Increase use of evidence-based treatment protocols and adherence to evidence-based guidelines for specific behavioral health conditions (these conditions could include schizophrenia, autism, bipolar depression, etc.) by primary care physicians by 10% over life of project.
- Percentage of Primary Care Providers reporting improved satisfaction with virtual psychiatric consultative services by 10% over life of project.
- Increase in patient's screened for clinical depression using a standardized tool AND follow-up plan is documented by a percentage to be determined in DY3.
- Improved percentage of patients who have depression remission at 12 months by a percentage to be determined in DY3.

126675104.2.9	2.16.1	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
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.31	IT-1.8 IT-1.9	Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non- stand-alone 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]**:** Conduct needs assessment of complex behavioral health populations and primary care providers who could benefit from telephonic psychiatric consultation. Metric 1 [P-1.1]: Conduct needs assessment including items such as the following: - Numbers of patients who could benefit from project - Numbers of PCP locations that could benefit from project - Description of expertise that PCPs have identified they lack and that would be most helpful if offered by a telephonic consultative service - Demographics, location, and diagnoses Data Source: Inpatient, discharge and ED records; survey of primary care providers; literature review Baseline/Goal: Complete Needs assessment Milestone 1 Estimated Incentive Payment: - $1,722,521	**Milestone 5** [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 2 [P-2.2]: Documentation of use of the psychiatric consultative services by primary care providers Data Source: Follow-up surveys of primary care providers to indicate they are using the service and that it is meeting their needs Baseline/Goal: Number of providers using psychiatric consultative services Milestone 2 Estimated Incentive Payment: -$1,174,486 **Milestone 6** [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	**Milestone 7** [I-7]**:** Evidence-based Protocols and Guidelines Metric 1 [I-7.1]: Increase use of evidence-based treatment protocols and adherence to evidence-based guidelines for specific behavioral health conditions (these conditions could include schizophrenia, autism, bipolar depression, etc) by primary care physicians Data Source: - Provider Survey Data; Baseline/Goal: Increase by 5% from baseline Milestone 7 Estimated Incentive Payment: $3,769,282 **Milestone 8** [I-9]**:** Primary Care Provider Satisfaction with virtual Psychiatric Consultative Services Metric 1 [I-9.1]**:** Percentage of Primary Care Providers reporting improved satisfaction with virtual psychiatric consultative services. Baseline/Goal: Increase by 5% from baseline Data Source: Primary Care Provider Survey data	**Milestone 9** [I-7]**:** Evidence-based Protocols and Guidelines Metric 1 [I-7.1]**:** Increase use of evidence-based treatment protocols and adherence to evidence-based guidelines for specific behavioral health conditions (these conditions could include schizophrenia, autism, bipolar depression, etc) by primary care physicians Data Source: - Provider Survey Data; Baseline/Goal: Increase by 10% from baseline Milestone 9 Estimated Incentive Payment: $3,113,755 **Milestone 10** [I-9]**:** Primary Care Provider Satisfaction with virtual Psychiatric Consultative Services Metric 1 [I-9.1]**:** Percentage of Primary Care Providers reporting improved satisfaction with virtual psychiatric consultative services. Data Source: Primary Care Provider Survey data Baseline/Goal: Increase by 10% from baseline

126675104.2.9	2.16.1	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
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.31	IT-1.8 IT-1.9	Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non- stand-alone 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 2 [P-2]**:** Design psychiatric consultation services that would allow medical professionals in primary care settings to access professional behavioral health expertise -via - telephone, - facsimile, and email). Metric 1 [P-2.1]: Establish project plans which are based on evidence/experience and which address the project goals Data Source: Project documentation Baseline/Goal: Completed Project Plan Metric 2 [P-2.2]: Documentation of use of the psychiatric consultative services by primary care providers Data Source: Follow-up surveys of primary care providers to indicate they are using the service and that it is meeting their needs Baseline/Goal: Number of providers using psychiatric consultative services Milestone 2 Estimated Incentive Payment: - $1,722,521	Baseline/Goal: Quarterly PI report to existing departmental PI Committee Data Source: Project reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts, monthly dashboards, and feedback from primary care providers to drive improvement) Milestone 4 Estimated Incentive Payment: -$1,174,486 **Milestone 7** [P-X1]: Establish a baseline rate for use of evidence-based treatment protocols and adherence to evidence-based guidelines for specific behavioral health conditions by primary care physicians Metric 1 [P-X1.1]: Create Baseline Utilization Report Baseline/goal: Baseline Utilization Report Metric 2 [P-X1.2]: Create	Milestone 8 Estimated Incentive Payment: $3,769,281	Milestone 10 Estimated Incentive Payment: $3,113,754

126675104.2.9	2.16.1	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
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.31	IT-1.8 IT-1.9	Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non- stand-alone 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 3 [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: Enrollment Report showing number of PCP settings using psychiatric consultative services Data Source: Project documentation Milestone 2 Estimated Incentive Payment: - $1,722,521 **Milestone 4** [P-4]: Determine the impact of the project. Metric 1 [P-4.1]: Evaluation plan including metrics, operational and evaluation protocols Baseline/Goal: Evaluation Plan Data source: Project documentation, provider survey, EMR, Provider data, interview data Milestone 3 Estimated Incentive Payment: - $1,722,521	improvement target Baseline/goal: Improvement Target Data Source: EMR, Provider Data, Survey Results, Baseline Utilization Report Milestone 5 Estimated Incentive Payment: -$1,174,486 **Milestone 8** [P-X2]: Establish a baseline rate for the percentage of Primary Care Providers reporting improved satisfaction with virtual psychiatric consultative services Metric 1 [P-X2.1]: Create provider satisfaction survey Baseline/Goal: Survey Data Source: Existing survey tools Metric 2 [P-X2.2]: Create Baseline Provider Satisfaction Report Baseline/goal: Baseline Utilization Report Data Source: Survey results Metric 3 [P-X2.3]: Create improvement target Baseline/goal: Improvement		

126675104.2.9	2.16.1	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
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	126675104.3.31	IT-1.8 IT-1.9	Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non- stand-alone 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)
	Target Data Source: Provider Survey Results Milestone 6 Estimated Incentive Payment: -$1,174,486 **Milestone 9** [P-X3]: Increase education available to primary care providers on identification, diagnosis, and treatment of mental health issues commonly found in primary care practice. Metric 1 [P-X3.1]: Complete training course on depression in primary care Baseline/goal: Complete one training program Data Source: Attendance logs Metric 2 [P-X3.2]: Complete training course on anxiety in primary care Baseline/goal: Complete one training program Data Source: Attendance logs Milestone 7 Estimated Incentive Payment: $1,174,486 **Milestone 10** [P-X4]: Increase availability of evidence based information to primary care providers		

126675104.2.9	2.16.1	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	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.31	IT-1.8 IT-1.9	Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non- stand-alone 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)**
	regarding identification, diagnosis, and treatment of mental health issues commonly found in primary care practices. Metric 1 [P-X4.1]: Disseminate 12 monthly information packets containing evidence base information on mental illnesses. Baseline/goal: Complete and distribute monthly educational documents Data Source: Education packets Milestone 7 Estimated Incentive Payment: $1,174,486			
9]Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $6,890,085	Year 3 Estimated Milestone Bundle Amount: $7,046,918		Year 4 Estimated Milestone Bundle Amount: $7,538,563	Year 5 Estimated Milestone Bundle Amount: $6,227,509
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $27,703,074				

Project Option 2.12.1 – Implement/Expand Care Transitions Programs: Community Connect-Transitioning Care/Continuity of Care with non- JPS Health Network Clinics

Unique Project ID: 126675104.2.10

Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.

Intervention: This project will increase access to primary and specialty care services, and improve quality outcomes for the residually uninsured Tarrant County residents through care coordinators, expanded primary care and specialty services, and improved information sharing with JPS Health Network collaborative partners. The project will also improve care transitions to identify and navigate patients at risk for reducing potentially preventable emergency department (ED) visits and hospital re-admissions to more appropriate and effective settings. This project is a new initiative. Currently care for the residually uninsured in Tarrant County is provided in the ED, Federally Qualified Health Care (FQHC), charitable clinics, and urgent care centers are fragmented and not shared across the continuum, or this target population does not currently have access to primary care and specialty services.

Need for the project: Tarrant County has 36,000 residually uninsured residents. Further, the state's population is growing rapidly placing additional demands on a system that is already underserving the residually uninsured due to shortages of primary and specialty care providers.

Target population: This project will serve 5,000 unduplicated patients during the reporting period. The target population includes the residually uninsured patients that are currently utilizing the ED or urgent care for their primary care needs or do not currently have access to primary care providers.

Expected patient benefits: Coordinating care and increasing access to primary and specialty care services will improve health care outcomes; and in return reduce expenditures by Medicaid through reduced ED visits and hospital re-admissions.

Category 1 or 2 expected patient benefits: This project will serve 5,000 unduplicated patients during the reporting period (DY3-1,000, DY4-2,000, and DY5-2,000).

Category 3 outcomes: IT1-10: Diabetes Care (HbA1c Poor Control) and IT-9.2: ED appropriate Utilization: Our goal is to improve the overall health of the residually underinsured patients identified as having HbA1c in poor control by 10% in DY4 and 15% in DY5; and reducing ED visits by 10% in DY4 and 15% in DY5.

Project Option 2.12.1 – Implement/Expand Care Transitions Programs: Community Connect-Transitioning Care/Continuity of Care with non- JPS Health Network Clinics

Unique Project ID: 126675104.2.10

Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
The Transition Care/Continuity of Care Program will transform health care delivery for some of our area's most disadvantaged residents by better coordinating care and creating more health services resources for those who will remain residually uninsured even after possible future reform-related coverage expansions. To meet the needs of this population, JPS Health Network will strengthen its existing collaborative relationships with North Texas Area Community Health Center Inc. (NTACHC), MedStar, and Project Access of Tarrant County (PATC) (an all volunteer physician program founded by the Tarrant County Medical Society and with grant funding from The Amon G. Carter Foundation, The Sid W. Richardson Foundation and The Martha Sue Parr Trust. We propose to develop a multisystem approach to providing needed care for the residually uninsured that incorporates JPS Health Network resources (including a project manager, patient navigators, and care coordinators) works to strengthen our safety net provider partners (NTACHC), identified charitable clinic partners and/or PATC. -This project will focus to develop and maintain IT systems information processes across the - identified entities to facilitate better patient tracking and outcomes monitoring-This project will also provide for additional primary care services, maintain effective recruitment efforts for generating adequate staffing of volunteer specialists, and improved data sharing capabilities across the continuum. This program will enable us to educate the residually uninsured residents of our county about their non-emergency care options (such as MedStar Patient Navigators)) and to help them receive a referral to NTACHC Patient-centered Medical Home; and/or Project Access of Tarrant County for coordination of specialty care, transportation, or translation services.
The program will link patients and their families with the appropriate resources and ensure better access to primary and specialty care and other needed services for this population within the Tarrant County Community Collaborative partnership. This project will offer assistance in navigating the health care system, educate residually uninsured residents about their care options, and encourage continuity of care and better outcomes monitoring through a shared information system, and reduce inappropriate reliance on the ED as the primary care provider of last resort.

Goals and Relationship to Regional Goals:
Project Goals:
During the Waiver period, JPS Health Network will build on its existing collaborative partnership within the Tarrant County health care community to assist the low-income individuals who don't qualify for health insurance by facilitating access to appropriate services. The partnership will focus on placing these patients into a medical home at NTACHC and/or PACT and providing additional resources to NTACHC and PACT to improve access to

preventive care, self education, and chronic disease management for residually uninsured residents of Tarrant County. We propose to develop an information sharing system among all collaborative partners to ensure providers receive discharge information on our mutual patients and create continuity of care beyond JPS Health Network. Working with our collaborative partners to assist them in placing the patients into a Patient-Centered Medical Home to care for their chronic conditions such as hypertension (HTN) and hemoglobin A1c (HbA1c) (listed as top contributors for frequent emergency department visits and admissions which can be preventable when managed by a primary care physician on a regular basis) will lead to improved quality outcomes, and reduced emergency department visits and preventable admissions to the hospital, therefore, reducing the overall health care costs to the community for this very underserved population.

This project meets the following Regional goals:
This project meets a number of Regional goals, all of which are aligned with the goals of the Waiver and The Institute for Healthcare Improvement's triple aim. Specifically, through better care coordination along with increased access to primary and specialty care, we will improve quality outcomes for low-income and uninsured Tarrant County residents. In addition, the project will contribute to reducing frequent ED visits, and readmissions for preventable conditions.

Challenges:
Low-income individuals who don't qualify for public health insurance programs and without other affordable coverage options struggle to access outpatient services in our community and will continue to do so even with public program expansions. This problem is growing because of our Region's steady and rapid population growth and a chronic Regional shortage of primary and specialty care for low-income individuals.

JPS Health Network and its partners throughout Tarrant County recognize that they provide fragmented care for low-income residents who don't qualify for health insurance and that only expanded resource sharing, newly strengthened collaboration efforts, and an increased focus on data sharing and data measurement will improve this underserved population's access to appropriate care. JPS Health Network and its collaborative partners are dedicated to serving Tarrant County's uninsured population. This project will overcome the fragmented information problem by developing a JPS Health Network -based team to develop a shared information system and data monitoring approach. This collaborative approach under JPS Health Network project leadership will improve our Regional health care system for those individuals who receive hospitalization through JPS Health Network and other services through NTACHC and PATC.

5-Year Expected Outcome for Provider and Patients:

This project will serve 5,000 unduplicated patients by the end of the Waiver period. The project will reduce the number of ED admissions by 15% from established baseline and will reduce the number of patients with HbA1c in poor control by 15% from established baseline in year five. It will also promote improved outcomes for patients with chronic conditions (to be measured through Patient-Centered Medical Home and meaningful use guidelines).

Starting Point/Baseline:
Our two safety net provider partners– NTACHC and PATC – both report useful starting points for developing accurate baseline. Since beginning to provide primary care services in September 2005, NTACHC reports a total of 23,293 primary care encounters. Project Access (PATC), which started in September 2011, has provided 700 volunteer hours of specialty care services. We anticipate using information from these two providers as baseline and we expect to refine our project numbers after implementation.

Rationale:
Texas has among the nation's highest rates of low-income residents who don't qualify for public health care coverage. Further, the state's population is growing twice as fast as the national average, placing additional demands on a system that is already shortchanging the uninsured. JPS Health Network is committed to developing a Regional solution to better meeting the health care needs of residents who don't qualify for public programs by helping to reduce system information fragmentation and improving its existing partnerships with other county safety net providers. Only a carefully designed and shared approach will enable us to ensure the right care for every uninsured low-income person every time, including those with chronic conditions. Further, identifying and facilitating care for our low-income residents who will remain residually uninsured, combined with developing a system to share information among stakeholders, is the best way for us to work to reduce repeat visits to the ED and/or admissions to the hospital and improve longer term patient outcomes. *(See JPS Health Network, Transforming Health Care Together, http://www.transforminghealthcare.com; The Tarrant County BRFSS, 2009/2010, www.unitedwaytarrantcounty.org).*

Rationale Outcomes Selected and Why:

"Texas is the uninsured capital of the United States. More than 6.3 million Texans-including 1.2 million children-lack health insurance. Texas' uninsured rates, 1.5 to 2 times the national average, create significant problems in the financing and delivery of health care to all Texans. Those who lack insurance coverage typically enjoy far-worse health status than their uninsured counterparts. (See Texas Medical Society: The Uninsured in Texas, http://www.texmed.org).

With the current uninsured population in Tarrant County at 480,951, and the lack of care coordination for those seeking services outside of JPS, and/or increased utilization of the emergency room for avoidable conditions the following outcomes were selected:

IT 9.2 ED appropriate utilization:

As a Region, there were 1.1 million visits to hospital EDs in 2010, with a rate of 447.5 visits per 1,000 persons. Data from July 2011 through June 2012 reveals that 59.27% of current ED admissions to JPS were potentially unnecessary visits. Under this program we will reduce the number of unnecessary ED visits through care coordination and increased access to primary care and specialty care (utilizing a physician recruiter to increase volunteer service hours) with the projects collaborative partners.

IT-1.10 Diabetes care: HbA1c-poor control:

In 2007, an estimated 7.8 percent of the United States population suffered from diabetes with 1.6 million new cases of diabetes diagnosed that year. Additionally, diabetes-related complications rank as the seventh leading cause of death in the United States as well as Tarrant County."

"When untreated or under-treated, diabetes can contribute to increases in heart disease and stroke, high blood pressure, vision problems, kidney and nervous system diseases, amputation, and periodontal diseases. Experts approximate that diabetes cost the United States population more than $170 billion in 2007 due to medical expenditures, days of lost hospitalizations involving diabetes short-term and long-term complications cost residents over $240 million." *The Tarrant County BRFSS, 2009/2010, www.unitedwaytarrantcounty.org).*

Under this program we will work to reduce HbA1c in poor control using current HEDIS measures. The impact to these patients can result in a reduction of preventable disease, and ED visits. Currently with programs goal to increase diabetic services to 500 patients by DY5 with at starting base line at the 50th percentile of diabetic patients whose HbA1c is >9% a reduction 10% from established baseline by DY4 (Anticipated impact 22 patients); and a reduction in baseline by 15% in DY5 (Anticipated impact 32 patients).

Project Components:

- Project components were selected based on evidence linking poor or inadequate care transitions for low-income patients unable to qualify for health insurance with increased ED visits and preventable admission. Specifically, our approach includes:
- Utilization of HEDIS best practices for reducing recurrent ED visits.
- Analysis of key drivers of 30-day hospital readmissions using a chart review tool and patient interviews.
- Integrating information systems to facilitate continuity of care.
- Developing a system to identify patients being discharged who are at risk of needing acute care services within 30-60 days.
- Implementing discharge planning and support.
- Developing a cross-continuum team which may include but is not limited to clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.

- 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.

In DY2, the Transition Care/Continuity of Care program will engage community resources, determine/refine baseline rates, and develop and test data systems. In DY3, we will develop staffing and an implementation plan to provide primary care and support services for the residually uninsured who frequent the emergency department. A PDSA cycle will be performed to test changes. In DYs 4-5, milestones will identify reductions in ED usage, and will focus to identify patients with top chronic conditions and other patient characteristics of socioeconomic factors that are common causes of avoidable ED use from the baseline. Taken together, these milestones represent how care coordinators and patient navigators will help manage transitions to improve health and decrease costs.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.3 – Shortage of specialty care
- CN.8 – Lack of access to health care due to financial barriers
- CN.10 – Overuse of ED services
- CN.11 – Need more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new initiative and we are not receiving any other federal funding.

Related Category 3 Outcome Measures:
IT-1.10-Diabetes Care: HbA1c Poor Control
IT-9.2: ED appropriate Utilization

Relationship to Other Projects:
The MedStar Navigator program (126675104.2.-8) enters the patient into a system which monitors their calls to 911. The patient is triaged based on protocols to determine whether a visit from a paramedic or transportation to the ED is indicated. These new initiatives will focus on navigating care to appropriate facilities, while reducing ED visits, and preventable admission to JPS Health Network.

RD-1(2.ii) Uncontrolled Diabetes-Diabetes is the seventh leading cause of death in the U.S. and Tarrant County; and contributes to several diabetes-related conditions at the top of the list of

preventable hospitalizations in Tarrant County.[247] Placing these patients into an FQHC-based medical home to improve their quality outcomes will decrease frequent ED visits, and readmissions at JPS Health Network.

RD-2.7 All-Cause: 30-day Readmission– Almost 80,000 potentially preventable hospitalizations in Tarrant County over the five-year period in 2006-2010 cost an estimated $2.2 By increasing access to primary care providers for this residually uninsured low-income population, we anticipate a measurable reduction in preventable readmissions.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaborative along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as the underserved population in Tarrant County, specifically the diabetic unduplicated patients who are low-income, uninsured, and ineligible for public programs. The percentage of the population expected to be positively impacted by the project is 15%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, his or her quality of life is not significantly improved. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, - increased access to emergent care will be available for other members of the community through a reduced ED utilization of the specific target population for this project.

126675104.2.10	2.12.1	2.12.1 A-G	Implement/Expand Care Transitions Program – Community Connect	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.32 126675104.3.33	IT-1.10 IT-9.2	Diabetes Care: HbA1c Poor Control 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-4]: Conduct an assessment and establish linkages between community-based organizations to create a support network for targeted patients postdischarge: Conduct an assessment and establish linkages between community-bases organizations to create a support network for targeted patients postdischarge. Metric 1 [P-4.1]: Care transition Assessment: Submission of care transitions assessment and resource planning documents: Review each organizations role supporting low income population who don't qualify for health insurance patients postdischarge: Baseline/Goal: Conduct an assessment and establish linkages within Tarrant County to create a support net work for the low income uninsured population within Tarrant	**Milestone 3** [P-2]: Implement standardized care transition processes: Create and Implement a standardized transition processes for all organizations listed above-JPS, FQHC, PACT, MedStar, and Catholic Charities. Metric 1 [P-2.1]: Care Transitions policies and procedures: Develop policies and procedures Submission of protocols: Develop protocols for care coordinators and patient navigators for the low income population without insurance Baseline/Goal: Develop policies and procedures for care transitions program. Data Source: Policies and procedures of care transitions program materials: Develop policies and procedures for each organization listed above Milestone 3 Estimated Incentive		**Milestone 5** [I-10]: Identify the top chronic conditions and other patient characteristics or socioeconomic factors that are common cause of avoidable readmissions. Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in the highest readmission rates. Goal: Enroll 2,000 new unduplicated patients of low income population into the program (3,000 patients in total by end of DY4). Data Source: : EPIC (EMR), NextGen (EMR), and DyaWeb (Diabetic Management System) Milestone 5 Estimated Incentive Payment: $1,093,251	**Milestone 6** [I-10]: Identify the top chronic conditions and other patient characteristics or socioeconomic factors that are common cause of avoidable readmissions. Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in the highest readmission rates. Goal: Enroll 2,000 new unduplicated patients of low income population into the program (5,000 patients in total by end of DY5). Data Source: EPIC (EMR), NextGen (EMR), and DyaWeb (Diabetic Management System) Milestone 6 Estimated Incentive Payment: $903,121

126675104.2.10	2.12.1	2.12.1 A-G	Implement/Expand Care Transitions Program – Community Connect	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.32 126675104.3.33	IT-1.10 IT-9.2	Diabetes Care: HbA1c Poor Control 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)**
County postdischarge Data Source: Care transitions assessment and resource planning documents: Review documentation from each entity to ensure each organization is performing the correct role to achieve the objective Milestone 1 Estimated Incentive Payment: $499,604 **Milestone 2** [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program. Metric 1 [P-7.1]: Documentation for the staffing plan. Goal/Baseline: Define the number and types of staff needed and the specific roles of each participant. This will be defined in collaboration with identified partners (JPS. FQHC, PACT, MedStar, and Catholic Charities). Data Source: Staffing and implementation plan.	Payment: $510,976 **Milestone 4** [I-10]: Identify the top chronic conditions and other patient characteristics or socioeconomic factors that are common cause of avoidable readmissions. Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors, or other patient characteristics resulting in the highest readmission rates. Goal: Enroll 1,000 unduplicated patients of low income population into the program. Data Source: EPIC (EMR), NextGen (EMR), and DyaWeb(Diabetic Management System) Milestone 4 Estimated Incentive Payment: $510,976			

126675104.2.10	2.12.1	2.12.1 A-G	Implement/Expand Care Transitions Program – Community Connect	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.32 126675104.3.33	IT-1.10 IT-9.2	Diabetes Care: HbA1c Poor Control 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 2 Estimated Incentive Payment: $499,604				
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $999,208	Year 3 Estimated Milestone Bundle Amount: $1,021,952		Year 4 Estimated Milestone Bundle Amount: $1,093,251	Year 5 Estimated Milestone Bundle Amount: $903,121
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5)**:** $4,017,533				

Project Option 2.4.-1 – Redesign to Improve the Patient Experience 126675104 – Program Innovation and Redesign

Unique Project ID: 126675104.2.11
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.

Intervention: This project will develop a patient experience focus within JPS Health Network. This project represents a new initiative.

Need for the project: Patient perception scores are especially low for the Network and a focused effort will be needed to make more than incremental movement.

Target population: Patients and their families accessing care in the JPS Health Network. Estimated - 124,000 patients and their family members will be served over each year - of waiver period. There were 124,000 unique patients seen in the specialty and primary care clinics in FY2011. Currently between 25-50 patients per week are newly enrolled in the Connection program and have access to the JPS network adding an additional 2500 new patients per year to the program. Each of these patients and members of their family will potentially be impacted by this program. In addition, the network provided care for 100,000 additional unique patients via the Emergency Department, Urgent Care, our psychiatry programs or inpatient admissions.

Expected patient benefits: The project will improve quality of care received by those members of our community that have little choice in their healthcare provider. Improvement efforts will be determined by survey results but will likely focus largely on access to the right care at the right time. Current survey results are especially low in the domain of "moving through the visit". This domain measures delays and information about delays in the coordination of care. With focused improvement efforts, patients and families visiting the network will experience improvement in communication, efficiency and quality. The targeted domains are access to timely care, appointment, and information, provider communication, access to specialty care, patient's involvement in shared decision making and patient's overall health status. While the outcomes of this project are primarily targeted to patients visiting our outpatient clinics, there will be benefits for all patients as the project requires an overall strategy for patient experience improvement.

Category 1 or 2 expected patient benefits: Milestones include aligning the patient experience under the oversight of one executive with the establishment of a steering committee, enhanced employee training and integration of patient experience into performance measurement. A strategic plan will be developed.

Category 3 outcomes: Category 3 IT-6.1 measures are related to improving patient experience scores on a nationally recognized tool. In year DY4 the planned activities are expected to increase topbox scores by 5%. In DY5, the planned activities are expected to increase topbox scores by 10%.

Project Option 2.4.- 1– Redesign to Improve the Patient Experience 126675104 – Program Innovation and Redesign

Unique Project ID: 126675104.2.11
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
JPS Health Network will develop a patient experience focus within the organization, starting at the top by appointing an executive dedicated to improving the patient experience throughout the organization with a multipronged strategy:

Shared organizational vision – A dedicated leader, steering committee and development and adoption of a strategic patient experience plan will allow for a single shared vision. A patient experience team will be commissioned. Staffing in the Office of the Patient and Family Experience will be increased.

Increased staff training – The patient experience team will provide more focused patient experience training by building competency in patient and family centered principles and culturally competent care. [248] Using both external and internal resources, the Patient Experience Team will provide on-site, unit-based coaching directed toward improving the patient experience. Internal change agents will be identified, trained and allocated to target areas to lead patient experience training and focused projects at each site. Team members will be trained using LEAN tools, methods and approaches.[249] Expertise will be developed in reducing operational waste and improving efficiency by focusing on value-added activities that improve patient satisfaction and quality of care across the health care system.

Site Specific Leadership and Surveying –The CAHPS tools will be utilized to survey patient experience. Physician/staff/administration and community partnerships will be developed at each target area/site to focus on needed improvement domains. Patient experience leadership competency will be developed, recognized and rewarded.

248 http://www.ipfcc.org

249 http://www.lean.org

Shared Lessons Learned – The Patient Experience Team will catalog and share lessons learned from each project as well as coordinate action planning to corroborate and implement best practice across the network.

Listen to the Patient's Voice – The Patient and Family Advisory Council (currently in its infancy) will be expanded to ensure that the voice of the patient is represented in all process improvement initiatives across the network.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of this project is to improve patient experience of care by developing organizational competency in patient and family centered care as defined by the Patient and Family Centered Care Collaborative. [1] A successful project will improve coordination of care across the district thereby improving health and patient/family satisfaction. By better focusing on and understanding how patient experience could be improved, JPS Health Network will be better able to implement community-based delivery system improvement actions.

As noted above, the organization will appoint an executive responsible for the patient experience, assess and recruit both internal and external talent to build a Patient Experience Team. At least 4.0 FTEs with LEAN training and health care experience will be hired to provide immediate expertise while competency is developed across the organization. Additionally, patient and family centered education will be incorporated in the New Employee Orientation experience, expanded to existing employees as a component of annual required training and reinforced as part of daily huddles. The patient experience outcomes as measured by CAHPS survey tools will be added to management performance to ensure accountability with cultural change. Outcomes will be displayed and transparent across the organization to ensure a continued focus on improvement. All improvement teams will include patients and their family members. The end goal will be to develop a sustainable model of process improvement that will continue to increase patient satisfaction and improve coordination of care across the continuum

This project meets the following Regional goals:
A major goal of the Region is to pursue the triple aim of health care by improving patient experience of care, improve health of populations and reduce the cost of health care. Redesigning the patient experience at the largest safety net hospital in the Region will impact the health of our community by keeping patients engaged in the health care system.

Challenges:
JPS Health Network patient experience scores need significant improvement. Overall perception of care averaged across all ambulatory practice sites has remained below the 10th percentile for the current fiscal year as measured by Press Ganey patient satisfaction surveys. Areas with

lowest mean scores include: ease of getting clinic on the phone, ease of scheduling appointments, wait times and sensitivity to patient needs. Incremental progress has not been sustainable pointing to a need for improving operational efficiency and customer service competency across the network. There is great variability in processes which causes great difficulty for our patients trying to navigate a network of 47 clinic sites. In reviewing the year's focused activities related to patient satisfaction, JPS Health Network believes that part of the reason for its inability to improve patient experience scores is the lack of a dedicated, organization-wide patient experience focus.

In looking around the organization, there is very little experience or expertise in LEAN principles. The organization has been teaching the Model for Improvement (Plan-Do-Study-Act, or PDSA) to willing volunteers for about the past two years.[250] This training has resulted in some small improvements within units or departments but there has been little organization-wide momentum. Under the direction of the Patient Experience Steering Committee resources will be prioritized and efforts directed toward improving the patient experience. The Steering Committee will provide a governance structure for directing and implementing change such that efforts are not duplicated or wasted and are aligned with other strategic priorities for the organization.

The selection of the project was precipitated by the need for transformative change in the delivery system that will impact the health of our patients. Programs intended to improve patient health outcomes and not perceived as meaningful by those directly impacted will fail to produce the intended results. Patient, provider and employee engagement is key to the success of all of the improvement projects.[251]

5-Year Expected Outcome for Provider and Patients:
Our five year goal is to increase patient satisfaction scores in the selected domains. Using the top box score as the baseline, JPS Health Network expects to increase our patient satisfaction scores by 10% over the Waiver period specifically for the ambulatory survey.

Starting Point/Baseline:
In hospital fiscal year 2011, there were 224,000 unique patients that visited our hospital system. A sample of these patients received a survey of patient experience in that same year. A subset of the population with an inpatient visit received the HCAHPS tool. The CGCAHPS tool has only been used in a pilot form in the outpatient primary care and specialty clinics. The organization plans to implement a recognized CGCAHPS tool in FY 2013.

Rationale:

[250] Langley GL, Nolan KM, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organization Performance (San Francisco: Jossey-Bass; 2009.
[251] Fernandez, S, Rainey H. Managing Successful Organizational Change in the Public Sector. March/April 2006.

Patient experience scores are pulled from Press Ganey and shared transparently throughout the organization at various committees with little coordination. Without a specific leadership focus, all efforts to improve are diluted by the many other operational priorities of a large health care organization. A patient/family experience strategic plan will eliminate duplication of time and effort and provide a roadmap for improvement and best practice. Engaging patients and families in the process will strengthen the organization's resolve to get better and stay better. Improvement targets like those selected for our project have been very successful at other institutions such as Virginia Mason and Denver Health.[252,253]

Our milestones measure the development and integration of a patient experience plan into all areas of the organization including employee training, performance measurement and policy changes. The milestones also measure the ongoing communication of all patient experience improvement projects ensuring that patient experience data is transparent to the organization and the community. The combination of these improvement milestones will impact the overall patient perception of care in the organization and increase patient satisfaction using the CAHPS tool.

Project Components:

Our project contains all of the core components with one noted exception:

- We will not develop a process to certify independent survey vendors to administer the patient experience survey. We will be using a nationally recognized vendor, Press Ganey (we may change our survey vendor).

The project does include the following core elements:

- Organizational integration and prioritization of patient experience
- Data and performance measurement will be collected by utilizing patient experience of care measures from the HCAHPS in addition to CAHPS
- Process improvement to improve patient's experience in getting through to the clinical practice

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.10 – Overuse of the emergency department services
- CN.11 – Need for more care coordination
- CN.12 – Need for more culturally competent care to address unmet needs

252 Kenney C. Transforming Health Care: Virginia Mason Medical Center's Pursuit of the Perfect Patient Relationship, Productivity Press, 2011

253 NuzumoR, McCarthy D, Gauthier A, and Beck C. A Denver Health, A High Performance Public Health Care System, The Commonwealth Fund, July 2007

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:
Outcome Measure 1: IT-6.1: Increase patient satisfaction scores
By the end of the Waiver, our goal is to increase patient satisfaction for CGCAHPS identified domain targets by10% of the top box percentage points over baseline.

Relationship to Other Projects:
This project is aligned with other projects that improve the patient experience by providing high-quality health care at every touch. The projects that are most closely aligned are: 126675104.2.2 (Enhance/expand medical homes), 126675104.1.3 (Expand/enhance specialty care) 126675104.1.2 (Enhancing urgent medical advice) and 126675104.2.5 (Enhancing care transitions). There is a small overlap in population outcomes for Category 3 with the following projects: 126675104.2.4 (CHF) -. - Each of the two projects measure patient satisfaction IT 6.1. There are 263 patients targeted in the CHF project and a subset of patients with asthma and obesity/diabetes in the school-based project.
This project is aligned with RD 4 which is designed to improve patient satisfaction in the inpatient setting. While the call center is directed toward the outpatient population, those patients transitioning from inpatient care to outpatient primary or specialty care will be directed to the call center for 24/7 nurse advice.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as all patients and family members who utilize JPS Health Network hospital system. The percentage of the population expected to be positively impacted by the project is 10%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

126675104.2.11	2.4.-1		Redesign to Improve Patient Experience (JPSCares)	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.34	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]: Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance Metric 1 [P-1.1]**:** Documentation of an executive assigned responsibility experience performance Data Source: Org Chart or job description (if percentage of time) Baseline/Goal: Appoint executive/clarify job description Data Source: Job Description and org chart Milestone 1 Estimated Incentive Payment *(maximum amount):* $524,590 **Milestone 2** [P-3]: Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee should meet at least twice a month. Metric 1 [P-3.1]:Documentation of committee proceedings and list of	**Milestone 5** [P-4]: Integrate patient experience into employee training Metric 1 [P-4.1]:Percent of new employees who received patient experience training as part of their new employee orientation Baseline/Goal: **95%**of new employees receive patient experience training through an education module integrated with new employee orientation Data Source: HR Orientation documentation and agenda that includes patient experience education module Milestone 5 Estimated Incentive Payment: $715,374 **Milestone 6** [P-5]: Integrate patient and/or employee experience into management performance measures Metric1 [P-5.1]: Documentation of specific patient and/or employee experience objectives into management work plans and measures of performance, such as internal quality controls or	**Milestone 8** [I-18]:Develop regular organizational display(s) of patient and/or employee experience data (e.g.,, via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families Metric 1 [I-18.1]: Number of organization-wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 36 displays Data Source: Verification of organization wide displays as collected by project historian Milestone 8 Estimated Incentive Payment: $1,147,926	-**Milestone 10** [I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g. via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patient and their families Metric 1[I-18-1] Number of organization –wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: 36 displays Data Source: Verification of organization wide displays collected by project historian Milestone 10 Estimated Incentive Payment: $1,896,574

126675104.2.11	2.4.-1		Redesign to Improve Patient Experience (JPSCares)	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.34	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)**
committee members Baseline/Goal: Appoint committee members and establish meeting schedule Data Source: Committee minutes and agendas Milestone 2 Estimated Incentive Payment *(maximum amount):* $524,590 **Milestone 3** [P-2]: Write and disseminate a patient/family experience strategic plan Metric 1 [P-2.1]: Submission of a strategic plan and documentation of the dissemination of that plan throughout the organization Baseline/Goal: Documented patient experience plan and communication strategies well defined Data Source: Completed patient experience plan, verification of communication throughout the organization Milestone 3 Estimated Incentive Payment *(maximum amount):* $524,590		performance dashboard. Baseline/Goal: Develop management dashboard that includes patient experience across all areas surveyed Data Source: Documentation of quality improvement plans and dashboard related to patient experience Milestone 6 Estimated Incentive Payment: $715,374 **Milestone 7** [P-11]: Orchestrate improvement work on identified experience targets. Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each group. Metric 1 [P-11.1} Submission of implementation plans. Baseline/Goal: Development of at least 2 plans for implementation. Data Source: Implementation plans Milestone 7 Estimated Incentive Payment: $715,375		**Milestone 9** [P-19] Make patient and /or employee experience data available externally and provide updates to the general public on the efforts the organizations undertaking to improve the experience of its patients and their families. Metric 1 [P-19.1] Number of external communications aimed at the general public's understanding of the organization's results and improvement efforts in the area of patient or employee experience. Goal: 12 external communication updates Data Source: External Communications Milestone 9 Estimated Incentive Payment: $1,147,926	

126675104.2.11	2.4.-1		Redesign to Improve Patient Experience (JPSCares)	
JPS Health Network				126675104
Related Category 3 Outcome Measure(s):	126675104.3.34	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 4 [P-15]: Develop a training program on the patient experience. Metric 1 [P-15-1] Submission of training materials Baseline/Goal: Development of one training program. Data Source: Completed training documents and implementation plan Milestone 4 Estimated incentive payment $524,590				
	Year 3 Estimated Milestone Bundle Amount: $2,146,123		Year 4 Estimated Milestone Bundle Amount: $2,295,852	Year 5 Estimated Milestone Bundle Amount: $1,896,574
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$8,436,908				

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 2.8.11 – Sepsis
Unique Project ID: 126675104.2.12
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: The purpose of the project is to implement an evidence-based early detection and treatment plan for patients presenting in the ED with sepsis; the intended outcome of the project is to reduce the mortality rate associated with sepsis. JPS' goal is to improve the reliability with the identification and application of the Sepsis Management and Resuscitation Bundles for patients who meet the specified criteria in the ED. A 24 hour – 7 days/week "Sepsis Response" team comprised of an intensivist, critical care nurse and other clinicians will increase consistency in initiating and complying with the bundle, decrease - variation in diagnosis and management, the complications and mortality rates -and result in better overall outcomes for our patients. . Continuous quality improvement e.g. Rapid Cycle PDSA, Six Sigma, Lean will be utilized to drive improvement and sustain the gains. This is a new initiative.
Need for the project: During the baseline period 2011, 192 ED patients were diagnosed with Sepsis- The compliance with Sepsis Identification and Management Bundle was less than 35% (67 patients received perfect sepsis care) and the mortality rate was 20% (37 patients expired). The average ICU LOS for patients with a primary diagnosis of sepsis was 5.33 days and all other patients was 4.27 days.
Target population: The target population for this projects includes patients with a diagnosis of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl). In 2011, 192 patients met criteria for goal directed therapy, estimated to be one third of the target population (patients presenting to the ED with infection related conditions). The target population estimated at 576 annually (1728 target population spanning waiver period) will be screened on entry to the ED, of those 60%/345 is estimated will meet criteria for goal directed therapy..
Expected patient benefits: Early recognition and activation of the Sepsis Bundle is effective in arresting the development of complications, such as end organ failure and death. JPS anticipates reducing mortality from 20% to 12%, this represents 15(192/2011 goal directed therapy candidates) or 28 (345 goal directed therapy candidates projected with improved sepsis identification and response)saved lives over the waiver period.
Category 1 or 2 expected patient benefits: The Sepsis Resuscitation and Management milestones includes the formation of an improvement plan with key stakeholders (ED, ICU,

EMS, METs, etc.) The plan addresses engagement of stakeholders, gaining an understanding the current state, areas of the variation, resources, baselines, roles and responsibilities, expectations, process and outcome measure definitions ,etc. Continuous quality improvement e.g. Rapid Cycle PDSA, Six Sigma, Lean will be utilized to drive improvement and sustain the gains.
Category 3 outcome: IT-4.9 ICU Length of stay

Project Option 2.8.11 – Sepsis

Unique Project ID: 126675104.2.12
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
When sepsis remains undetected for any period of time, the likelihood of complications and increased mortality rises rapidly. This project will implement an evidence-based early detection and treatment plan for patients presenting in the ED with sepsis. In order for JPS Health Network to effectively improve the health outcomes of this population, this project will:

- Fully develop the multidisciplinary Code Sepsis Team and provide the team with a common knowledge base to identify early on and treat patients who present with sepsis in order to achieve a greater than 95% compliance with the sepsis resuscitation and management bundles to improve patient outcomes. By Y5, based on the estimated 345 patients, we will correctly diagnose and manage 293/85% using the six hour sepsis bundle. Goal directed therapy will enable us to move from a 20% (69 deaths) to 12%(41 deaths). This represents 28 saved lives.
- Standardize the process and outcome definitions;
- Effectively and fully implement the measurement and reporting system supporting compliance with sepsis resuscitation and management bundles, including establishing baseline data, initiating process improvement, and developing and implementing evidence-based order sets;
- Hire a Sepsis Coordinator and clinical analyst to hardwire the coordination of continuous improvement (and we are considering adding biomarkers within the ED; and
- Partner with and expand Emergency Medical Services' Medical Emergency Team (MET) that provides coverage for sepsis alerts to improve the delivery of care to patients with suspected infection; 24hour -7 day per week coverage sepsis response will require 2.5 critical care nurses.

The target population for this projects includes patients with a diagnosis of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl).

Goals and Relationship to Regional Goals:

Project Goals:
JPS Health Network' goal is to improve reliability of the identification and application of the sepsis management and resuscitation bundles for patients who meet the specified criteria in the ED. By decreasing variation in diagnosis and management, the complications and mortality rates will be reduced and result in better overall outcomes for our patients. Thus, the goals of implementing early detection and treatment of patients with sepsis are to reduce the risk of mortality, minimize complications and decrease the patient's intensive care unit (ICU) length of stay (LOS).

This project meets the following Regional goals: This project focuses on reducing potentially preventable morbidity and mortality.

Challenges:
The National Critical Care Medicine has identified Sepsis as a major improvement opportunity as evidenced by the following:

- 750,000 severe cases of sepsis in the U.S.;
- Severe sepsis mortality is greater than breast cancer and AIDS mortality; and
- Severe sepsis causes an undue burden on the health care system with annual cost exceeding $16 billion.

Sepsis is difficult to detect, both from a clinical judgment perspective and through diagnostic coding, because the symptoms of sepsis and the International Classification of Diseases (ICD) codes could indicate a number of other conditions. In fact, JPS Health Network has used varying definitions for sepsis (e.g., baseline mortality rate currently includes non-septic patients for whom the bundle was implemented), so it is currently difficult to measure and analyze data on sepsis. JPS Health Network does not have standardized processes for early detection of and treating patients with sepsis who present to the ED. As a result, patients going undetected may not receive the needed treatment, resulting in complications and even mortality from sepsis.

5-Year Expected outcome for Provider and Patients:
At the end of the Waiver, this project will:

1. Achieve 85% compliance with identification of early goal directed therapy candidates on arrival to the ED(estimated targeted population of 345 patients) 293 patients will be appropriately diagnosed.

2. Achieve 95% compliance with the sepsis six hour bundles in patients admitted to the Medical ICU (MICU) from the ED; 327 patients will receive perfect sepsis bundle care.

3. Reduce the mortality rate for septic patients admitted through ED to MICU from the current 20% to 12%(28 lives saved based on 345 goal directed candidates).

Starting Point/Baseline:
During the baseline period 2011, 192 ED patients were diagnosed with sepsis, and 37 of those patients expired. The compliance with sepsis identification and management bundle was 32% and the mortality rate was 20%. The average ICU LOS for patients with a primary diagnosis of sepsis was 5.33 days and all other patients was 4.27 days.

Rationale:
By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early treatment, decrease complications, mortality, length of stay and health care costs.[254] The reason for choosing the Category 3 outcomes, mortality and cost is because identifying the presence of sepsis along with early intervention will prevent complications and decrease length of stay, reduce health care cost and mortality.

The Sepsis resuscitation and management milestones include the formation of an improvement plan with key stakeholders (ED, ICU, EMS, METs). The plan addresses engagement of stakeholders, gaining an understanding the current state, areas of the variation, resources, baselines, roles and responsibilities, expectations, process and outcome measure definitions. In order to have an impact on reducing mortality and average LOS, compliance with sepsis diagnosis and protocols for sepsis bundles are critical. The implementation plan is necessary to examine the plan as it is implemented and understand what is working, what needs continued improvement, barriers and make corrective actions.

Project Components:
In 2008, the Surviving Sepsis Campaign was initiated by the Institute for Healthcare Improvement (IHI): the focus of the campaign was and still is early recognition and improving reliability in managing sepsis. Consistent with best practices identified by IHI, the JPS Health Network project consists of four components: 1) sepsis recognition; 2) sepsis response, 3) sepsis management in the ED and ICU; and 4) immediate feedback to the providers regarding response times and compliance with evidence-based protocols. 5) Continuous quality improvement e.g., rapid cycle PDSA, Six Sigma, and Lean will be utilized to drive improvement and sustain the gains. By DY3 the team infrastructure will include EPIC redesign, and a functioning sepsis response team will have been put into place so that PDSA cycles aim to eliminate variation and the team's metrics will be focused on progress to goals.

Unique community need identification numbers the project addresses: CN 11: Need for more care coordination.

[254] The Institute for Health care Improvement ' Surviving Sepsis Campaign, The Society of Critical Care Medicine,; IDSA Guidelines for appropriate antibiotic selection

- CN 11 – Need for more care coordination. All counties identified CN11 as a need. Barriers include complexity of coordination, lack of staff, lack of financial integration, fragmented system service, and practicing in silos. Providers did not feel there was strong care coordination between primary care providers, hospitals, and specialists. Care coordination is a challenge for the sepsis patients presenting in the ED. The absence of a system to identify these patients and implement the bundle increases the incidence of complications, costs and mortality. Due to the lack of access to health care resources, a large number of patients treated in our hospital will benefit from earlier detection of sepsis. The benefit of this program will ultimately extend housewide to include all patient care units.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This is a new project and JPS Health Network is not receiving any other federal funds for this work.

Related Category 3 Outcome Measures:

Outcome Measure 1: Mortality IT-4.8 Sepsis Mortality: The reason for choosing the Category 3 outcomes, mortality and cost is because identifying the presence of sepsis along with early intervention will prevent complications and decrease length of stay, reduce health care cost and mortality.

National Critical Care Medicine has identified Sepsis as a major improvement opportunity as evidenced by the following:

- 750,000 severe cases of sepsis in the U.S.
- Severe sepsis mortality is greater than breast cancer and AIDS mortality
- Severe sepsis causes an undue burden on the health care system with annual costs exceeding $16 billion

By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early treatment and decrease length of stay, reduce health care cost and mortality. Institute for Healthcare Improvement; Surviving Sepsis Campaign; Society of Critical Care Medicine; IDSA Guidelines for appropriate antibiotic selection.

Outcome Measure 2: Average ICU LOS IT-4.9: By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early treatment and decrease complications with resulting ICU length of stay reduction.

Relationship to Other Projects:

JPS Health Network is submitting the Transformation of Care at the Bedside project which is aimed at harm reduction by reducing health care acquired conditions. The five conditions included under the TCAB initiative are reduction of CAUTIs, CLABSIs, SSIs, VTE, Falls. The sepsis rate will be impacted by interventions planned for the HAIs.

Sepsis recognition and management is aimed at reducing the complications associated with Category 4, #35, Septicemia and Severe Infections.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as JPS Health Network Emergency Department population. The percentage of the population expected to be positively impacted by the project is 30%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her chance to survive sepsis-related life-threatening conditions is significantly improved in addition ICU - length of stay is reduced
To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because reducing ICU length of stay opens up more ICU beds for other acute patients-.

126675104.2.12	***2.8.11***		***Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications***
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.35*** ***126675104.3.53***	*IT-4.9* *IT 4.8*	*ICU LOS Reduction from current 5.2 days to 3.7 days* *Mortality Rate Reduction from 20% (37 deaths/2011baseline to 12%(30 deaths/2011 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)**
Milestone 1 [P-2]: Establish baseline, in order to measure improvement over self (for correct diagnosis of sepsis) Metric 1 [P-2.1]: Establish baseline for correct diagnosis of sepsis (Target population of 576) Baseline(32%)/Goal(50%/288): Percent compliance with correct diagnosis of sepsis. Data source: EPIC Metric 2 [P-2.2]: Establish baseline for bundle compliance Baseline/Goal: 32% / Goal 50% (288) early goal directed therapy candidates) Data source: Surviving Sepsis Campaign (SSC) Database Milestone 1 Estimated Incentive Payment (maximum amount): $2,650,815 **Milestone 2** [P-6]: Implement a program to improve efficiencies and/or reduce program variation (Implement the sepsis resuscitation and management bundles Metric 1 [P-6.1]: Performance improvement events (assess improvements in delivery	**Milestone 4** [P-2]: Establish baseline to measure improvement over self (for ICU LOS for Septic patients admitted from ED) Metric 1 [P-2.3]: Reduce the current LOS for patients admitted to the ICU from the ED Baseline/Goal: 5.12/ 4.7 Source Data: EPIC Milestone 4 Estimated Incentive Payment (maximum amount): $4,066,730 **Milestone 5** [I-13]: Progress toward target/goal (number of sepsis-related measures as specified in each metric below) Metric 1 [I-13.1.1]: Percent of all clinical cases that meet target/goal (correct diagnosis of sepsis) Goal: Achieve 65%(224 patients) compliance with correct diagnosis for 345 patients with - sepsis Data source: EPIC Metric 2 [I-13.1.2]: Percent of all	**Milestone 6** [I-13]: Progress toward target/goal Metric 1 [I-13.1.1]: Percent of all clinical cases that meet target/goal (correct diagnosis of sepsis) Goal: Achieve 75% compliance (259 of 345 patients)with correct diagnosis of sepsis Data source: EPIC Metric 2 [I-13.1.2]: Percent of all clinical cases that meet target/goal Numerator(2011): Number of diagnoses of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl where at least 1 Sepsis Resuscitation bundle was used in its entirety. Denominator: Total number of diagnoses of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl) Goal: compliance with sepsis resuscitation and management bundles and assess improvements in delivery reliability through the assessment of process measures	**Milestone 7** [I-13]: Progress toward target/goal Metric 1 [I-13.1.1]: Percent of all clinical cases that meet target/goal (correct diagnosis of sepsis) Goal: Achieve 85%(293 patients) compliance with correct diagnosis of sepsis Data source: EPIC Metric 2 [I-13.1.2]: Percent of all clinical cases that meet target/goal Numerator(2011): Number of diagnoses of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl where at least 1 Sepsis Resuscitation bundle was used in its entirety. Denominator: Total number of diagnoses of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl) Goal: compliance with sepsis resuscitation and management bundles and assess improvements in delivery reliability through the assessment of process measures

126675104.2.12	***2.8.11***		***Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications***	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.35*** ***126675104.3.53***	*IT-4.9* *IT 4.8*	*ICU LOS Reduction from current 5.2 days to 3.7 days* *Mortality Rate Reduction from 20% (37 deaths/2011baseline to 12%(30 deaths/2011 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)**
reliability through the assessment of process measures in patients admitted to the MICU from the Emergency Department) Baseline/Goal: Implement a program. Data Source: Code Sepsis Team minutes and data specific to selected changes. Milestone 2 Estimated Incentive Payment (maximum amount): $2,650,815 **Milestone 3** [P-13]: Participate in learning collaborative. <u>Metric 1</u> [P13.1]: Participate in no less than monthly Sepsis PI Team meetings and collaborative meetings, conference calls or webinars organized by the RHP that the providers participated in. Baseline/Goal: Attend two meetings per year. Data Source: Learning Collaborative Meeting agendas and/or minutes. Milestone 3 Estimated Incentive Payment (maximum amount): $2,650,815	clinical cases that meet target/goal Numerator(2011): Number of diagnoses of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl where at least 1 Sepsis Resuscitation bundle was used in its entirety. Denominator: Total number of diagnoses of severe sepsis, septic shock, and/or lactate >4mmol/L (36mg/dl) Goal: compliance with sepsis resuscitation and management bundles and assess improvements in delivery reliability through the assessment of process measures in patients admitted to the MICU from the Emergency Department achieving >65% compliance (224 of 345patients) . Data Source: EPIC Milestone 5 Estimated Incentive Payment (maximum amount): $4,066,730		in patients admitted to the MICU from the Emergency Department achieving >85% compliance(293 of 345 patients). Data Source: EPIC <u>Metric 4</u> [I-13.1.4]: Percent of all clinical cases that meet target/goal (reduce ICU LOS or Septic patients admitted from ED) Goal: 5% reduction over baseline(4.94days) Data source: EPIC Milestone 6 Estimated Incentive Payment (maximum amount): $8,700,911	in patients admitted to the MICU from the Emergency Department achieving >95%(327 of 345 patients) compliance. Data Source: <u>Metric 4</u> [I-13.1.4]: Percent of all clinical cases that meet target/goal (reduce ICU LOS or Septic patients admitted from ED) Goal: 10% reduction over baseline(3.7days) Milestone 7 Estimated Incentive Payment (maximum amount): $7,187,709

126675104.2.12	***2.8.11***		***Implement an innovative and evidence-based intervention that will lead to reductions in sepsis complications***
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	***126675104.3.35*** ***126675104.3.53***	*IT-4.9* *IT 4.8*	*ICU LOS Reduction from current 5.2 days to 3.7 days* *Mortality Rate Reduction from 20% (37 deaths/2011baseline to 12%(30 deaths/2011 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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $7,952,445	Year 3 Estimated Milestone Bundle Amount: $8,133,460	Year 4 Estimated Milestone Bundle Amount: $8,700,911	Year 5 Estimated Milestone Bundle Amount: $7,187,709
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $31,974,525			

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 2.10.1 – Implement a Palliative Care Program to address patients with end-of-life decisions and care needs

Unique Project ID: 126675104.2.13 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: The project will create a comprehensive palliative care consultation program for patients with serious or life-threatening illnesses. This project is a new initiative.
Need for this project: This project addresses the following community needs: a) CN. 9. - Need for increased geriatric, long-term, and home care resources (e.g. beds, Medicare providers) and b) CN.11 - Need for more care coordination.
Target population: Patients who are terminally or chronically ill as approximated by the CAPC research of over 500 hospitals based on number of staffed beds - DY3 = 269, DY4 = 403, DY5 = 537 (1208 total for DY3, DY4, and DY5). Medicaid and the uninsured of our service area with serious illnesses will benefit from (1) better symptom management; (2) relief from pain and suffering; (3) more psychosocial and spiritual support; (4) an alternative to aggressive treatment and time in intensive care units. As a result, patients will experience improved quality of life, medical care based on the patient's goals for care and increased patient and family satisfaction with the care received.
Category 1 or 2 expected patient benefit: Milestones P-3.1, P-4.1, P-5.1, P-7.1, P-X1.1, P-X1.2, I-9.1, and I-10.1 were selected. Each milestone selected was due to their natural progression to project implementation or a natural result of implementing integrated care components.
Category 3 outcomes:
Outcomes IT-5.1, IT-13.1, and IT-13.2 were selected. There is an evidence base to suggest that a palliative care service will have positive impact on each of those outcome areas.

Project Option 2.10.1 – Implement a Palliative Care Program to address patients with end-of-life decisions and care needs

Unique Project ID: 126675104.2.13 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
We will implement a comprehensive palliative care consultation program for patients with serious or life-threatening illnesses.[255] The program will focus on optimizing patients' quality of life through symptom management and the alleviation of pain and suffering. This project is targeting 1,208 patients (DY3 = 269, DY4 = 403, DY5 = 537) who are terminally or chronically ill who will receive inpatient palliative care consultation services. Beginning as an inpatient consultation service, the palliative care program will initially be comprised of an RN palliative care program coordinator, a social worker, a chaplain and a physician from the JPS Physician Group who is experienced in providing palliative care services. The inpatient consultation program model will be based on the Clinical Practice Guidelines for Quality Palliative Care (see evidence-based citation). The model contains 21 guidelines with associated criteria that are organized around eight core domains of all quality palliative care programs. These domains were established by the National Consensus Project and the National Quality Forum.[256] Where possible, the palliative care program will implement the 38 preferred practices also identified in the evidence-based model.

Goals and Relationship to Regional Goals:
Project Goals:
The goals of this project are to provide chronically and seriously ill patients (and their families where appropriate): (1) better symptom management; (2) relief from pain and suffering; (3) more psychosocial and spiritual support; (4) an alternative to aggressive treatment and time in intensive care units. As a result, patients will experience improved quality of life, medical care

[255] The central focus of the palliative care model is comprehensive, interdisciplinary care that provides medical, emotional, spiritual and practical support. It is provided simultaneously with all other appropriate medical treatments, and is coordinated among all caregivers and specialists. Studies show that palliative care improves quality of life for seriously ill patients and consistently reduces symptom distress and improves patient and family satisfaction. Palliative care programs can also alleviate inpatient overcrowding, bed shortages and inappropriate use of intensive care unit beds. Palliative care, when done right, improves the communication of all parties involved in the patient's care. Much of this evidence has been synthesized and made available by the Center to Advance Palliative Care (CAPC). A list of specific studies would include:
a. Do Palliative Care Consultations Improve Patient Outcomes? – *Journal of American Geriatric Society*, 2008, 56:593-599.
b. Hospital-Based Palliative Care Consultation: Effects on Hospital Cost – *Journal of Palliative Medicine*, 2010. Volume 13, Number 8
c. Cost Savings Associated with U.S. Hospital Palliative Care Consultation Programs – *Archives of Internal Medicine*, 2008. 168 (16): 1783-1790
d. Clinical Practice Guidelines for Quality Palliative Care – National Consensus Project, 2009.
[256] www.nationalconsensusproject.org/guideline.pdf.

based on the patient's goals for care and increased patient and family satisfaction with the care received.

This project meets the following Regional goals:

Challenges:
Nationally, over 80% of hospitals with more than 300 beds have palliative care services within their system. JPS currently has no organized inpatient palliative care program. With the aging of the American population, and the steady growth in the number of people living with chronic illness, palliative care approaches have emerged in recent years to ease the prolonged pain and suffering associated with being severely ill. It is estimated that 70% of people who experience chronic pain do so without adequate treatment: Symptoms such as anxiety, depression, shortness of breath, and fatigue are sometimes overlooked or ignored by health care professionals. In addition, caregivers of people with chronic or life-threatening illnesses often feel alone in their struggle to provide good care. Palliative care strives to deal with the many issues surrounding people who deal with life-threatening illnesses, and provide them with the tools to make critical decisions about end-of-life care.

5-Year Expected Outcome for Provider and Patients:
JPS will develop palliative care competencies and capacity across the continuum to meet population health needs. By the end of the waiver period, a significant portion of total in-hospital deaths will have had a palliative care consult. Additionally, a large percentage of hospice or palliative care patients will have been screened for pain to ensure proper pain management.

Starting Point/Baseline:
JPS does not currently have a palliative care program. In 2011 there were at least 600 patients who died in the hospital who would have benefitted from palliative care. By DY5, it is expected JPS will have a fully operational consultative palliative care program to meet the palliative care needs of patients with specific chronic conditions that is utilized by the hospitalists as appropriate.

Rationale:
JPS has selected this project because of the documentation that palliative care programs routinely improve patient outcomes, expedite communication and decision making for patients and family members, increase coordination among health care providers, ease patient transitions between care settings, boost patient and family satisfaction, reduce the burden of time-intensive and complex cases to improve staff satisfaction, apply a more systematic approach to outlier patients, and promote beneficial care resulting in more appropriate hospital resources/cost avoidance/improved bed capacity. In addition, palliative care centers treatment around the goals of the patient and family to include increased family presence and interaction, very intentional

management of pain and suffering and allows the patient to maintain dignity during the dying process.

This region has a need for increased geriatric, long-term, and home care resources (CN.9) (e.g., beds, Medicare providers). Region 10's population is projected to grow 9% by 2016, with a 26% increase in the senior population (ages 65+). Palliative care services will be increasingly needed as the population ages and develops chronic or terminal conditions. These services have often not been available or integrated with community, emergency or intensive care services. This project will make available this much-needed approach to care especially to the geriatric population and enhance integration of palliative care with other approaches to care.
P-3 was selected because all primary care specialties are involved with chronic diseases and the associated chronic symptoms and management of these symptoms, but may not have specific expertise in palliative care programs and planning. As the goal of this palliative program is to provide resources to patients and families to improve patient experiences, the education programs will also consider the use of palliative care medicine for health care personnel (including ancillary staff).
P-4 was selected because measures all the metrics (e.g. percentage clinic visits documented in the EHR, the amount of lab values accurately placed in the patient chart, or even the number of e-prescriptions sent over an established timeframe) document the palliative care program effectiveness. A study of 2021 hospitals showed that the quality of care provided improved among all types of hospitals that implemented a form of EHR[257]
P-5 was selected because there is widespread evidence that palliative care can improve the quality of care while reducing cost.[258]
P-7 was selected to assess the effectiveness of this consult service in large numbers of patients and families, and how it improve their health care experience. Not all patients with a chronic condition are candidates for palliative care.
I-10 was selected to ensure the ideal of palliative consults for most patients who died in the hospital so that the patient and the family have the choice of how the patient spends his/her end of life.

Project Components:
This project has not adopted the project component related to developing a business case for palliative care because this step has already been completed. While there is not a milestone associated with it, our program will strive to transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility. The idea of a survey was explored. However, currently all patient satisfaction surveys are managed through a third party vendor and extensive efforts would be required to ensure surveys did not conflict with existing efforts or HCAPS surveys. Existing survey results can be monitored at the patient level, and results will be

[257] http://www.healthcareitnews.com/news/study-highlights-lurking-question-measuring-ehr-effectiveness.
[258] See http://www.capc.org.

tabulated for those who receive palliative care consults with a comparison to normal care. We will conduct quality improvement for project using methods such as rapid-cycle improvement. These efforts will be included in annual report to the hospital Quality Committee and the Board of Managers Quality Committee.

Unique community need identification numbers the project addresses:
CN. 9. Need for increased geriatric, long-term, and home care resources (e.g., beds, Medicare providers). Region 10's population is projected to grow 9% by 2016, with a 26% increase in the senior population (ages 65+).
CN. 11. Need for more care coordination. All counties identified it as a system cap and need. Providers did not feel there was strong care coordination between primary care providers, hospitals, and specialists.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new initiative and is not receiving any other federal funding.

Related Category 3 Outcome Measures:

2. **Outcome Measure 1: IT-13.1 Pain Assessment (non-stand-alone)** was selected because the NQF Report states, "The Hospice and Palliative Care – Pain Assessment measure addresses pain for patients with high severity of illness and risk of death, including seriously and incurably ill patients enrolled in hospice or hospital-based palliative care. Research on care of patients with serious incurable illness and those nearing the end of life shows they experience high rates of pain (40%-70% prevalence) and other physical, emotional, and spiritual causes of distress.[259],[260] The National Priorities Partnership has identified palliative care and end-of-life care as one of its national priorities. A goal of this priority is to ensure that all patients with life-limiting illness have access to effective treatment for symptoms such as pain and shortness of breath.[261] The affected populations are large; in 2009, 1.56 million people with life-limiting illness received hospice care.[262] In 2008, 58.5% of U.S. hospitals with 50 or more beds had some form of palliative care service, and national trends

[259] The Writing Group for the SUPPORT Investigators. A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognosis and preferences for outcomes and risks of treatments (SUPPORT). *JAMA*. 1995; 274:1591-159.
[260] Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. J Palliat Med. 2008; 11(2):180-190.
[261] http://www.nationalprioritiesparternship.org/prioritydetails.aspx?id=608
[262] NHPCO Facts and Figures: Hospice care in America 2010 edition http://www.nhpco.org/files/public/statistics_research/hospice_facts_figures_oct-2010.pdf

show steady expansion of these services.[263] Patients and family caregivers rate pain management as a high priority when living with serious and life-threatening illnesses.[264]

3. **Outcome Measure 2: IT-13.2 Treatment Preferences (non-stand-alone)** was selected because the NQF Report states "Hospice and Palliative Care – Treatment Preferences measure addresses patient autonomy for patients with high severity of illness and risk of death, including seriously and incurably ill patients enrolled in hospice or hospital-based palliative care. The National Priorities Partnership has identified palliative and end-of-life care as one of its national priorities. A goal of this priority is to ensure that all patients with life-limiting illness have the right to express preferences that guide use of invasive or life-sustaining forms of treatment.[265] The affected populations are large; in 2009, 1.56 million people with life-limiting illness received hospice care.[266] In 2008, 58.5% of U.S. hospitals with 50 or more beds had some form of palliative care service, and national trends show steady expansion of these services.[267] From a recent systematic review of clinical trials, moderate evidence supports multicomponent interventions to increase advance directives, and 'care planning through engaging values, involving skilled facilitators, and focusing on key decision makers.' These studies found improved outcomes of patient-physician communication, improved satisfaction with care, and increased hospice enrollment.[268] The more recently published Coping with Cancer Study, a prospective observational study of over 300 patients with advanced cancer, found that communication of patient treatment preferences was associated with use of treatments honoring those preferences and wishes for lesser use of aggressive, high-cost treatments."[269,270]

Outcome Measure 3: 5.1 Improve cost savings: This outcome measure was selected due to the wide body of evidence that suggests implementation of palliative care services reduces hospital costs.[271] The process milestone selected for DY2 is a required building block to accurately identify the baseline costs of specific diagnoses that commonly warrant palliative care but have not had access to the service. The DY3 process measure related to identifying the baseline costs

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[263] Center to Advance Palliative Care http://www.capc.org/news-and-events/releases/04-05-10

[264] Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspective. JAMA 1999; 281: 163-168

[265] http://www.nationalprioritiespartnership.org/prioritydetails.aspx?id=608

[266] NHPCO Facts and Figures: Hospice care in America 2010 edition http://www.nhpco.org/files/public/statistics_research/hospice_facts_figures_oct-2010.pdf

[267] Center to Advance Palliative Care http://www.capc.org/news-and-events/releases/04-05-10

[268] Lorenz KA, Lynn J, Dy SM, et al. Evidence for improving palliative care at the end of life: a systematic review. *Ann Intern Med* 2008: 148:147-159

[269] Wright AA, Mack JW, Kritek PA, Balboni TA, Massaro AF, Matulonis UA, Block SD, Prigerson HG. Influence of patients' preferences and treatment site on cancer patients' end of life care. *Cancer*. 2010 Oct 1; 116(19):4656-63

[270] Wright AA, Zhang B, Ray A et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA* 2008; 300:1665-1673.

[271] Morrison RS, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE. Cost savings associated with US hospital palliative care consultation programs. Palliative Care Leadership Centers' Outcomes Group. *Arch Intern Med*. 2008 Sep 8; 168(16):1783-90.

is a critical step that must be accomplished to compare improvement targets for palliative care patients. Outcome improvement targets for DY4 and DY5 will be established in DY3.

Relationship to Other Projects:
This project is related to RD-4.1 patient satisfaction. It is widely asserted that palliative care programs have positive impacts on patients' perception of care because of the coordinated nature of the services.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the Region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*
We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted by this intervention, his or her comfort, peace of mind and coordination of care, and reduction in unnecessary procedures increases. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, there is a resulting reduction of utilization, increased comfort of family members and more appropriate allocation of health care resources.

Specifically, 941 (DY3=180, DY4=314, DY5=448) patients who are terminally or chronically ill will be positively impacted in the following quantifiable ways:

- Increase percent of total in-hospital deaths that had a palliative care consult to ensure 30% of those dying in the hospital have a palliative care consult over the life of the project.

- Increase Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services to ensure 25% of those with a palliative care consult are transitioned over the life of the project.
- Increase percent of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by a percentage to be determined in DY3
- Increase percent of palliative care patients with chart documentation of preferences for life-sustaining treatments
- Reduce costs of patients who receive palliative care services by a percentage to be determined in DY3

126675104.2.13	***2.10.1***	***2.10.1.A, 2.10.1.B, 2.10.1.C, 2.10.1.D***	Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.41 126675104.3.42 126675104.3.43	*IT-13.1* *IT-13.2* *IT-5.1*	*Pain Assessment* *Treatment preferences* *Improved cost savings*

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]: Implement palliative care education and training programs for providers (physicians, RNs, PAs, NPs, etc.) that incorporates management of non-cancer patients. Metric 1 [P-3.1]: Palliative care training and education for other providers Baseline/Goal: Baseline is 1 provider with a goal of training 5 providers Data Source: Physician Credentialing, Training Logs, Program Documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,260,432 **Milestone 2 [P-4]**: Develop an EHR/system (e.g. a rounding tool or a registry or software) that analyzes the palliative care system data to determine if the program is effective Metric 2 [P-4.1]: EHR system implementation with capacity for palliative care registry and metric analysis. Baseline/Goal: Currently there	**Milestone 5 [P-7]:** Determine how many consults are submitted per number of patients admitted with chronic conditions or MCC (e.g. COPD exacerbation, heart failure exacerbation, fluid overload in an ESRD patient, etc.) that are candidates for palliative care services. Metric 1 [P-7.1]: Palliative care consults for patients with chronic conditions. Baseline/Goal: Chronic Condition Palliative Care Consult Report Data Source: EMR Milestone 5 Estimated Incentive Payment *(maximum amount):* $2,578,557 **Milestone 6 [P-X]:** Establish benchmark and improvement target for measure I-10 for DY4 and DY5 Metric 1 [P-X.1]: Benchmark for total in-hospital deaths who had a palliative care consult Metric 2 [P-X.2]: Improvement target for I-10 regarding total in-hospital deaths who had a palliative care consult	**Milestone 7 [I-10]:** Among patients who died in the hospital, increase the proportion of those who received a palliative care consult Metric 1 [I-10.1]: Percent of total in-hospital deaths who had a palliative care consult Goal: 20% Data Source: EMR Milestone 7 Estimated Incentive Payment: $2,762,996 **Milestone 8** [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 1 [I-9.1]: Transitions accomplished Baseline/Goal: 15% Data Source: EMR Milestone 8 Estimated Incentive Payment: $2,762,996	**Milestone 9 [I-10]:** Among patients who died in the hospital, increase the proportion of those who received a palliative care consult Metric 1 [I-10.1]: Percent of total in-hospital deaths who had a palliative care consult Goal: 30% Data Source: EMR Milestone 9 Estimated Incentive Payment: $2,282,475 **Milestone 10** [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 1 [I-9.1]: Transitions accomplished Baseline/Goal: 25% Data Source: EMR Milestone 10 Estimated Incentive Payment: $2,282,475

126675104.2.13	***2.10.1***	***2.10.1.A, 2.10.1.B, 2.10.1.C, 2.10.1.D***	Implement a Palliative Care Program to address patients with end-of-life decisions and care needs
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.41 126675104.3.42 126675104.3.43	*IT-13.1* *IT-13.2* *IT-5.1*	*Pain Assessment* *Treatment preferences* *Improved cost savings*

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)
are no reports available regarding palliative care Data Source: EMR Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,260,432 **Milestone 3 [P-5]:** Implement/expand a palliative care program Metric 1 [P-5.1]: Implement comprehensive palliative care program Baseline/Goal: Scope of service for consult palliative care program Data Source: Palliative care project documentation, HR files Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,260,432 **Milestone 4 [P-X]:** Establish benchmark and improvement target for measure I-9 for DY4 and DY5 Metric 1 [P-X.1]: Benchmark for Palliative care patients	Goal: Benchmark and improvement target Data Source: EMR, Encounter Data, Consult Reports Milestone 6 Estimated Incentive Payment: $2,578,557		

126675104.2.13	***2.10.1***	***2.10.1.A, 2.10.1.B, 2.10.1.C, 2.10.1.D***	Implement a Palliative Care Program to address patients with end-of-life decisions and care needs	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	126675104.3.41 126675104.3.42 126675104.3.43	*IT-13.1* *IT-13.2* *IT-5.1*	*Pain Assessment* *Treatment preferences* *Improved cost savings*	
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)**
transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 2 [I-X.2]: Improvement target for I-9 regarding Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Goal: Benchmark and improvement target Data Source: EMR Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,260,433				
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $5,041,729	**Year 3 Estimated Milestone Bundle Amount: $5,157,114**		**Year 4 Estimated Milestone Bundle Amount: $5,525,992**	**Year 5 Estimated Milestone Bundle Amount: $4,564,950**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $20,289,785				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.5.1: Integrated care model with outcome-based payments

Unique Project ID: 126675104.2.14 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility. JPS Health Network has a program called the Connections Program that is a managed care like program for the population of Tarrant County below 200% of the FPL. This program offers insurance for medical services at JPS Health Network locations. The benefit to the indigent population will be reduced wait times by increased access to primary care and specialty care, reduction in duplication of services, reduction in emergency room utilization because they cannot see a provider.
Intervention: To develop a payment model that is based on outcomes instead of Fee for Service for approximately 46,000 Connection enrolled patients. The project is a new intervention that will reduce medical costs. The providers that participate in the Connections program are reimbursed on a Fee for Service basis. This program allows itself a perfect opportunity to transition to an outcome based program. JPS Health Network can work with the providers to transform the care and payment options for both the patients and providers. This will allow for an improvement in access, quality, cost, and improve outcomes.
Need for the project: The project addresses the following community needs CN.10, 11, and 22. This project will fund payments based on outcomes and not fee for service in an underserved population, the JPS Health Network Connections population, of Region 10 that is similar to Medicaid.
Target population: The target population is 37,500 Connections members. JPS Health Network needs to realign the payment structure from a fee for service model to an access, outcome and performance based system. This will align providers, patients (Connection enrollees) and JPS Health Network and begin the journey on the development of an integrated care model
Category 1 or 2 expected patient benefits: Milestones P-1, P-2, P-3, P-4, P-9, I-7,I-8, and I-9.1 were selected. Each milestone selected was due to their natural progression to project implementation or a natural result of implementing integrated care components.
Category 3 outcomes: Outcomes IT-5.1 was selected. There is an evidence base to suggest that Integrated Care with Outcome based payments will have positive impact.

Project Option 2.5.1: Integrated care model with outcome-based payments

Unique Project ID: 126675104.2.14 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
JPS Health Network has a program that is similar to an insurance program for the indigent population of Tarrant County. A person below 200% of the FPL can apply for a program funded by the taxpayers of Tarrant County. There are certain asset and income tests similar to the Texas Medicaid program that is applied during the application process. If the person qualifies they will be enrolled for a 12 month period and receive medical care at the JPS Health Network locations and prescription drug benefits at JPS Health Network pharmacies with small individual responsibility such as copays for medical and pharmacy care. The current program reimburses physicians on a fee for service basis and does not tie access or outcomes to a payment method. The program currently has approximately 45,000 individuals enrolled in the program but during a year 75,000 individuals are covered under the program. The current wait time for an appointment for a new patient with a primary care physician is 189 days in some areas, the average wait time for a surgical consult is over 45 days, and the average wait time for a medical specialty consult is over 55 days. Due to the wait in the specialty clinics many tests need to be performed a second time causing additional costs and waste of resources, along with unnecessary strain on the patients, and increased utilization of the emergency room.

JPS Health Network will develop an integrated care model with outcome-based payments. This new payment model will integrate the providers into the development of the model so that the access issues, duplication of tests, and scheduling issues can be addressed. The individuals in the Connections program will receive care in a more timely and concise manner. The Connections members will have a medical home (primary care physician) that can coordinate their care reducing unnecessary emergency utilization and duplication of tests. The patient will be become a partner in the care treatment plan. The benefit to the indigent population is an increase in access at primary care locations and specialty offices with more concise structured care and less wait time for tests, appointments, and results.

An executive will be appointed to implement the integrated care model with outcome-based payments. The new model will be developed and implemented using a multistage process.

Organizational integrated outcome-based payments – a dedicated leader, steering committee, and development of an integrated outcome-based payment strategy will allow for a single shared payment plan. An integrated outcome-based payment team will be created.

Physicians, executives, and financial staff will be trained to track and report outcomes using clinical and financial measures. Payments will be made based on outcomes instead of the

traditional fee-for-service methodology. Expertise will be developed to track and report the outcomes and the impact on the delivery of health care.

Outcomes will be determined and payment structures identified for the providers. These outcomes will be shared with the Region.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of this project is to provide better care with a focus on access, quality and outcomes with the lowest cost. A successful project for JPS Health Network will transition from a fee-for-service payment to a quality-based payment system that is driven by outcomes and funded by the savings from better health in the community.

This project meets the following Regional goals:
A major goal of the Region is to pursue the triple aim of health care by improving patient experience of care, improve health of populations and reduce the cost of health care. Developing an integrated care model with outcome-based payments will impact the cost of health care in the Region and improve the health of the population due to the focus on outcomes.

Challenges:
JPS Health Network needs to realign the payment structure from a fee-for-service model to an access, outcome and performance-based system. This will align providers and JPS Health Network and begin the journey toward the development of an integrated care model.

5-Year Expected Outcome for Provider and Patients:
At the end of the Waiver this project will:
These Core Components are reflected in the Milestones.

1. Implement a cost accounting system – JPS Health Network will evaluate the overall costs that are associated with providing services to the Connections patients. JPS Health Network will research and decide upon a cost accounting system that measures how wisely medical services are being utilized, cost accounting helps to provide the data relevant to the current situation. By identifying medical costs and further defining the cost of by three or more successive business cycles, it is possible to note any trends that indicate a rise in costs without any appreciable changes or increase in utilization of services.. This system will be implemented so that cost information regarding services for the Connection patients can be reported. This new system will be implemented.
2. Provide data-based cost and quality measures – By using the cost accounting system that is implemented JPS Health Network will obtain cost information for all types and levels of care provided to Connection patients, The cost of Primary Care, Specialty Care, Emergency Care, Inpatient and Outpatient Care, and Ancillary care will be reviewed and

analyzed. The cost will be reviewed with quality measures around access measures for Primary Care and Specialty Care, number of tests (utilization per 1000 patients) performed, Emergency Utilization, Readmission, and Prescription drugs prescribed.

3. Identify cost efficiencies – A Team of Physicians, Executives, and Financial staff will review the data provided by the cost accounting system to identify the costs and compare them with benchmarks for similar populations. These comparisons will help determine costs that need to be improved and the team will drive the efficiencies among the Network.
4. Increase access – An increase access to Primary Care and Specialty Care will be the result. JPS Health Network expects to decrease wait times for Specialty Surgery below the 45 days, for Medicine Specialty below the 55 days and to have new members able to see a primary care physician within 21 days.

Starting Point/Baseline:
As of October 2012, approximately 46,000 individuals were enrolled in the Connections program at JPS Health Network. Each of these had a medical encounter of some kind with JPS Health Network. The cost of these encounters are not captured and tracked accurately.

Rationale:
Cost, quality data, and access data are pulled from disparate systems and a team of individuals calculate measures. In order to reduce costs JPS Health Network must have reliable data that is easily accessible by clinicians, financial analysts, operational experts, and others. The cost for the Connections program is a combination of price, program needs, acuity of the population, ability to access the services, and volume of services provided. In order to provide better care at the correct setting, data needs to be analyzed to determine the correct proportion of the variables.

Project Components:
Project contains all of the core components,

Unique community need identification number the project addresses:
CN .10 Overuse of emergency department services
CN.11 need for more care coordination
CN.22 inadequate health IT infrastructure

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This is a new project and JPS Health Network is not receiving any other federal funds for this work.

Related Category 3 Outcome Measures:

Outcome Measure #1: IT 5.1 Improved cost savings: Demonstrate cost savings in care delivery

Relationship to Other Projects:

JPS Health Network projects are designed to provide better care, improve health, and lower costs.

Relationship to Other Projects:
This project is aligned with other projects that improve health and provide better care. The goal of all projects is to lower costs.

Relationship to Other Performing Providers Projects and Plan for Learning Collaborative:
(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the Region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as all JPS Connections patients. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

126675104.2.14	***2.5.1***	***2.5.1(A-D)***	Integrated care model with outcome-based payments	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.44*	*IT 5.1*	*Improved cost savings: Demonstrate cost savings in care delivery*	
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]: Develop/identify a cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions. To identify areas for cost improvements and movement from Fee for service to outcome based payments. Metric 1 [P-1.1]: Metric: Cost-accounting methodology/metric Baseline: Average Annual Cost of selected measures for chosen diagnoses and provider panels for a 9 month period 1/12-9/12 Goal: Documentation of the methodology and metric. Data Source: Cost-accounting system or another administrative, financial or clinical data set Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,769,073 **Milestone 2 [P-2]:** Establish a baseline for cost Metric 1 [P-2.1]: Establish a baseline for cost. Submission of baseline data**.** Baseline: Establish a baseline for cost. Goal: Submission of baseline data.	**Milestone 3** [P-3]:Implement the cost-accounting methodology and related systems to measure intervention impacts and movement from a fee for service to an outcome based payment, Metric 1 [P-3.1:] Cost-accounting system. Baseline/Goal: Methodology and or system not installed Goal: Adoption, installation, upgrade, and/or interface of technology, and/or implementation of system using existing technology Data Source: System installed Milestone 3 Estimated Incentive Payment: $1,888,297 **Milestone 4** [P-4]:Conduct cost analysis Metric 1 [P-4.1]:Cost analysis plan or results Baseline/Goal: Comparative report from DY3 to baseline DY2. Goal: Submission of cost analysis plan for targeted improvement in cost and quality. Data Source: Reports from data systems. Milestone 4 Estimated Incentive		**Milestone 6** [I-7]: Measure cost containment by re-measuring health care costs of **first set of interventions** and compare to baseline to gauge improvements in cost and transition from fee for service to outcome based payment Metric 1 [I-7.1]: Measure health care costs of intervention and gauge improvement and transition from fee for service to outcome based payment . Goal: Improve cost against baseline Data Source: Cost accounting system Milestone 4 Estimated Incentive Payment: $6,070,091	**Milestone 8** [I-7]: Measure cost containment by re-measuring health care costs of **second set of interventions** and compare to baseline to gauge improvements in cost and transition from fee for service to outcome based payment Metric 1 [I-7.1]: Measure health care costs of intervention and gauge improvement and transition from fee for service to outcome based payment . Goal: Improve cost against baseline Data Source: Cost accounting system Milestone 4 Estimated Incentive Payment: $5,014,423

126675104.2.14	***2.5.1***	***2.5.1(A-D)***	Integrated care model with outcome-based payments	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.44*	*IT 5.1*	*Improved cost savings: Demonstrate cost savings in care delivery*	
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)**
Data Source: Cost-accounting system or another administrative, financial, or clinical data set. Milestone 2 Estimated Incentive Payment $2,769,073	Payment: $1,888,297 **Milestone 5** [P-9]: 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 Metric 1 [P-9.1]:Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: participate in both meetings Present and mentor best practices Data Source: Documentation of semiannual meetings including, meeting agenda, slides from presentations, and/or meeting notes Milestone 5 Estimated Incentive Payment: $1,888,299			
Year 2 Estimated Milestone Bundle Amount: ***(add incentive payments amounts from each milestone):***	**Year 3 Estimated Milestone Bundle Amount: $5,664,893**		**Year 4 Estimated Milestone Bundle Amount: $6,070,091**	**Year 5 Estimated Milestone Bundle Amount: $5,014,423**

126675104.2.14	***2.5.1***	***2.5.1(A-D)***	Integrated care model with outcome-based payments	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.44*	*IT 5.1*	*Improved cost savings: Demonstrate cost savings in care delivery*	
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)**
$5,538,146				
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $22,287,553				

Project Option 2.7.3 – Implement Evidence-based Disease Prevention Programs: Implement Innovative evidence-based strategies to increase early enrollment in prenatal care – Journey to Life: Prenatal Care and Healthy Babies Initiative.
Unique Project ID: 126675104.2.15 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: CenteringPregnancy and the Maternity Medical Home, will provide patients with comprehensive care in innovative settings with the goals of increasing the number of women seen early in care; increasing compliance and frequency of prenatal care; increasing compliance of postnatal care; and reducing inappropriate emergency department utilization. JPS Health Network adopted CenteringPregnancy in 2011 with limited trained staff at Health Center for Women–Main. JPS Health Network proposes to expand services to increase the number of trained staff at HCW–Main, and expand to 3 additional clinics. The Maternity Medical Home is a new initiative that will be at 4 additional JPS Health Network Clinics that will utilize the principles of the Patient Centered Medical Home.
Need for the project: The Tarrant County Fetal Infant Mortality Review reported that 42% of the cases reviewed in 2008 reported having access to care issues. 48% of women giving birth in Tarrant County received late or no prenatal care. In Texas, only 48.0% of women received a postpartum visit on or before 21 days and 56 days after delivery. The postpartum care rate at JPS is estimated to be 40%, and the national average is 64.1%.
Target population: JPS Health Network will deliver services to the medically underserved, Medicaid, indigent, and underinsured prenatal patients in Tarrant County. The number of patients to be served over the waiver period is 6,959 women. The population was calculated based on the number of women receiving JPS prenatal care and delivered at JPS in FY11.
Expected patient benefit: Journey to Life will enhance access by providing pre-appointed dates and times for visits to help patients plan for child care, transportation, and other needed services. This will increase early enrollment into care and improve compliance with prenatal and postnatal care. It also increases patient satisfaction and engagement by providing the opportunity to enhance learning, build relationships and be linked to community resources through established agencies. Outreach through these programs will allow the team to more closely monitor the patient's needs, provide continuity of care, and decrease the inappropriate utilization of the emergency department.
Category 1 or 2 expected patient benefit/Category 3 outcomes: The Category 2 milestone selected will enroll 3,084 patients in Journey to Life in DY4 and 3,875 patients in DY5. Each patient will be seen 11 times during their pregnancy which makes the volume of visits 33,924 for DY4 and 42,625 for DY5. For category 3, IT 8.1 will increase in the timeliness of prenatal and postnatal care in DY4 and DY5; – and IT 9.2 will decrease emergency department use by 162 visits in DY4 and 323 visits in DY5.

Project Option 2.7.3 – Implement Evidence-based Disease Prevention Programs: Implement Innovative evidence-based strategies to increase early enrollment in prenatal care – Journey to Life: Prenatal Care and Healthy Babies Initiative.

Unique Project ID: 126675104.2.15 (Pass 2)

Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
Develop and implement an innovative, comprehensive Perinatal Services Program that includes preconception, prenatal and interconception care for low-income women of childbearing age in Tarrant County. The program will include implementing and expanding two evidence-based proven models of prenatal care that contribute to healthier mothers and babies: **CenteringPregnancy**[272] (to provide Comprehensive Perinatal Services Program and Group visits in clinics with high numbers of pregnant women) **Maternity Medical Home**[273] (to provide pregnant women enhanced services through health care coordination and navigation in those clinics with small numbers of pregnant women). These models will be utilized to effectively address birth outcomes and disparities by implementing preconception and interconception interventions.

By providing women the opportunity to participate in the CenteringPregnancy and Maternity Medical Home models of care, women are empowered to choose health-promoting behaviors such as attending all their scheduled appointments. Through recruiting and retaining women in the program throughout their prenatal and postpartum care, birth outcomes will be better. Staff will communicate with patients via phone, mail, and/or other available method to encourage attendance and participation in the group sessions. Incentives such as baby supplies will be offered at each visit to further encourage participants to complete the program.

Goals and Relationship to Regional Goals:
Project Goals:
JPS will deliver prenatal services through the evidence-based CenteringPregnancy and Maternity Medical Home models to at least 75% of patients served by JPS outpatient clinics for prenatal care. JPS will have four clinics participating in CenteringPregnancy and four clinics with the Maternity Medical Home.
JPS proposes to serve low-income women of childbearing years in Tarrant County that are in need of preconception, prenatal and interconception care. The JPS Outpatient service provides prenatal care to over 5,140 women annually throughout Tarrant County. JPS proposes to have four clinics participating in CenteringPregnancy and four clinics with the Maternity Medical Home. JPS' 537-bed hospital setting and outpatient clinics are well-positioned to provide these services.

[272] CenteringPregnancy is a multifaceted model of group care that integrates the three major components of care: health assessment, education and support, into a unified program within a group setting. The CenteringPregnancy model is based on the Centering Healthcare Institute model. This results-driven model repeatedly demonstrates better fetal outcomes in evidence-based clinical studies. The Centering Healthcare Institute assists clinical sites with education, consultation, guidance, and materials to start CenteringPregnancy groups. https://www.centeringhealthcare.org/pages/centerin-model/pregnancy-overview.php.
[273] The Maternity Medical Home will provide linkages to services in the community and will offer follow-up to patients. This will help increase prenatal and postnatal care that will affect birth outcomes.

This project meets the following Regional goals:
This project meets a number of Regional goals, which are aligned with the goals of the Waiver and IHI's triple aim. Specifically, low-income pregnant Medicaid/CHIP recipients residing in Tarrant County are the targeted designated population for this proposal. Tarrant County, located in North Texas, is the third most populous county in the state and includes the cities of Fort Worth and Arlington.

Challenges:
Low-income women in Tarrant County face significant risks to their health and the health of their babies during pregnancy. Preterm birth is one of the three leading causes of infant death in Tarrant County, and the number one cause for African-American women. Tarrant County has the second highest infant mortality rate among Texas counties with 10,000 or more live births per year.The clinical staff will work directly with the women to form ongoing relationships that will keep them coming back to the same clinic for care. The population is fairly transient which, without the relationships, may cause them to transfer from clinic to clinic, or utilize the emergency department inappropriately for care.

5-Year Expected Outcome for Provider and Patients:
CenteringPregnancy and Maternity Medical Home outcomes at the end of the Waiver will be that the number of infants born to the program will have - more timely prenatal and postnatal care, decreased emergency department utilization, and additional collateral benefits. The desired outcome for this patient population is to - increase the timeliness of prenatal and postnatal visits, and decrease the utilization of the emergency department for prenatal care.

Starting Point/Baseline:
The JPS outpatient service provides prenatal care to over 5,140 women annually throughout Tarrant County. Currently 92% of the women who deliver their babies at JPS receive their prenatal care at one of our JPS outpatient health centers. JPS Health Network adopted CenteringPregnancy in December 2011. Currently, JPS has four mid-level providers who were trained by the CenteringHealthcare Institute (CHI) and see patients for CenteringPregnancy. This represents only 16% of the providers who provide prenatal care and less than 5% of JPS' patient visits.To date, 52 women have enrolled and 21 have delivered. The UNT Women's Health Nurse Practitioners facilitate the group with support from JPS Health Network staff. With this proposed model, JPS will expand services from four providers at one clinic to 24 providers at four clinics and will have groups in both English and Spanish.

Maternity Medical Home: Currently we are providing prenatal care through the traditional OB visit model at several of our Community Health Centers. In several of these clinics, JPS has one nurse practitioner who provides obstetric care. In these sites there are fewer prenatal patients and

the CenteringPregnancy model is not recommended. In order to bring innovative services in these clinics, JPS plans to expand services to include a Maternity Medical Home service to provide patient navigation and health care coaching. Through this support staff, patients will be more readily linked to available community resources and health care.

Rationale:
Currently, there is an identified need to improve services in Tarrant County with Tarrant County having the second highest infant mortality rate among Texas counties with 10,000 or more live births each year and preterm birth ranking as one of the three leading causes of infant death. By providing enhanced services through innovative care, JPS will be able to work with partnering organization and groups to provide more timely care. Outreach will be incorporated into each model, so that JPS can reach out to patients and get them into care earlier in their pregnancy.

DY2: JPS timeliness to prenatal care is below the national average and is the primary, if not only source of preconception and interconception care for low-income women in Tarrant County. By providing innovative opportunities for care, JPS will increase timeliness to prenatal and postnatal care, and decrease the inappropriate utilization of the emergency department. JPS will develop a staffing plan to expand the Journey to Life team roles, including outreach into the community. This will include redefining the roles and responsibilities of the team and training the team for their new roles. While engaging the staff and preparing them for Journey to Life, a team will establish the criteria for Journey to Life assignment. An assessment tool will need to be utilized to establish eligibility. This tool can be used during OB intake where all their OB appointments will be made for better patient compliance. Journey to Life will be an opt-out program; however, there are some patients who would be better served with traditional care. JPS will also utilize this time to establish a baseline using current and past data on utilization rates of Journey to Life. JPS will implement and document a process to increase utilization through outreach and partnering with community organizations.
DY3: JPS will implement Journey to Life in a total of eight JPS Health Centers for Women and Community Clinics in DY3. By rolling the project out over this time frame, JPS can ensure a quality sustainable program. JPS will also develop a plan of disseminating the findings and best practices to the stakeholders through a Community Stakeholder Committee. Disseminating this information will demonstrate improvement opportunities for the program across the clinics and in the community.
DY4 and DY5: The number of patients enrolled in Journey to Life prenatal and postnatal outcomes, and emergency department utilization will be measured. By establishing and validating the data baselines in DY2 and implementation, and best practices implemented from feedback given by the Community Stakeholder Committee in DY3, outcomes will be measured to show the increase in timeliness of prenatal and postnatal care, utilization of the emergency department and participation in Journey to Life.

Project Components: CQI Core Components
Ongoing engagement and support of community stakeholders is essential to the successful recruitment of women into the program and providing a continuum of care through integrated referrals. JPS will bring together an oversight board consisting of the members of JPS and other pertinent agencies or individuals quarterly. The project will include a focus on continuous quality improvement by:

- Completing a rapid cycle improvement on early enrollment/access to care
- Identifying project impacts through the measurement of prenatal patients seen inappropriately in the emergency department
- "Lessons learned" will be utilized to identify barriers to care with special considerations for safety-net populations
- Key challenges associated with expansion of the project from one site to eight sites throughout the network, and these challenges will be communicated to the internal and external stakeholders.

Unique community need identification numbers the project addresses:
CN.11 Need for more care coordination
CN.19 Need for more and earlier onset of prenatal care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
In choosing option 2.7.3, implement innovative evidence-based strategies to increase early enrollment in prenatal care, CenteringPregnancy will enhance access by providing group care with preappointed dates and times to help patients plan for child care, transportation, and other needed services. It also increases patient satisfaction and engagement by providing the opportunity to learn from other patients and build relationships. Clinicians who have delivered care through CenteringPregnancy report higher satisfaction with their practice. The Maternity Medical Home will expand services to provide care navigation, health care coordination as well as expanding education/prenatal care and enhancing the delivery of maternity services by utilizing community resources through established agencies. Although this is not a new initiative, JPS is not receiving federal funding for this project.

Related Category 3 Outcome Measures:

a. **Outcome Measure 2: IT-8.1: Timeliness of Prenatal/Postpartum Care** The Fetal Infant Mortality Review reported that 42% of the cases reviewed in 2008 reporting having access to care issues. Forty-eight percent of women giving birth in Tarrant County received late or no prenatal care. In Texas, even among women with commercial HMO insurance, only 48% of women received a postpartum visit on or before 21 days and 56 days after delivery. The postpartum care rate at JPS is

estimated to be 40%, and the national average is 64.1%. For low-income women, the postpartum visit may be the source of medical care until they become pregnant again.

b. -**Outcome Measure 1: IT-9.2 ED Appropriate Utilization:** During prenatal care, patients will utilize the emergency department as a secondary source of care to treat acute non-pregnancy-related issues. In fiscal year 2011, the emergency department provided 3,230 ED visits to pregnant women. During DY2, baseline data will be established to identify the percentage of ED visits that are potentially preventable. Through patient education and enhancing services in the outpatient setting, the number of prenatal patient seeking services in the ED can be decreased, and the patients can be seen in the most appropriate setting.

Relationship to Other Projects:

The Patient-Centered Medical Home (PCMH - 126675104.2.2) at JPS is related to the Maternity Medical Home. The Maternity Medical Home will utilize the principles of the PCMH model to develop and implement the program. The goals of the PCMH project are to decrease potentially avoidable ED admissions, reduce inpatient admissions, increase compliance with prevention cancer screening, and increase patient satisfaction. This project will not duplicate services provided under the PCMH project.

- RD3(59) – Medical and Anesthesia Obstetric Complications – Obstetric anesthesia is generally considered to be one of the higher-risk areas of anesthetic pregnancy. Both regional and general anesthesia carries with them the potential for complications. Improving these outcomes will improve the lives of both the mother and the baby.
- RD3(60) – Major Puerperal Infection and Other Major Obstetric Complications Puerperal infection is a bacterial infection following childbirth. A small number of women who deliver vaginally suffer from a puerperal infection; however, for caesarean sections it is five to 10 times higher. Decreasing the number of elective caesarean sections will help reduce the number of infections.

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

JPS will work collaboratively with the University of North Texas Health Science Center (UNTHSC) project team to improve the timeliness of prenatal and postnatal care, and reduce infant mortality. The UNTHSC Category 2 project is titled Implement innovative evidence-based strategies to reduce low birth weight and preterm births – Tarrant County Preconception and Perinatal Health Promotion Initiative. Both organizations will be a referral source for the other, and will work together to influence positive birth outcomes for the whole county.

Through the Centering Healthcare Institute (CHI), JPS will work with Texas Health Arlington Memorial to share ideas and experiences with CenteringPregnancy. CHI provides support by holding local and national meetings for providers and their teams. This will give both programs

the opportunity to work together to provide innovative methods of care. CHI will focus on a distinct target prenatal population not receiving prenatal services at JPS. The outcomes for Texas Health Arlington Memorial's project are different from those of JPS; however, they are not in conflict with each other. Journey to Life will not duplicate services provided by either of these projects.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as women receiving care through JPS Health Network. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, the health of the mother and baby is improved through proper prenatal care and education. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively their chances of having a high-risk pregnancy and delivery, resulting in a complicated hospital admission is decreased.

126675104.2.15	***2.7.3***	***2.7.3 CQI***	*Implement Evidence-based Disease Prevention Programs: Implement Innovative evidence-based strategies to increase early enrollment in prenatal care – "Journey to Life: Prenatal Care and Healthy Babies Initiative"*
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	*126675104.3.45* *126675104.3.46*	*3.IT 8.1* *3.IT 9.2*	*Timeliness of Prenatal/Postnatal Care* *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]: Development of innovative evidence-based project for prenatal population. Metric 1 [P-1.1]: Document development innovational strategy and plan to - increase prenatal and postnatal care and decrease the inappropriate utilization of the emergency department. This project plan will define necessary staffing and educational/training needs for implementation. Baseline/Goal: Documentation of a strategic plan to implement an innovative evidence-based project Data Source: Centering Healthcare Institute/HRSA/EPIC Milestone 1 Estimated Incentive Payment: $4,339,466	**Milestone 2 [P-2]**: Implement evidence-based project for prenatal population Metric [P-2.1]: Document implementation strategy and testing outcomes. Baseline/Goal: Documentation of implementation of CenteringPregnancy and Maternity Medical Home. Data Source: Centering Healthcare Institute/HRSA/EPIC Milestone 2 Estimated Incentive Payment: $4,438,780	**Milestone 3 [1-5]:** Identify the number of patients being in the defined population receiving innovative intervention consistent with the evidence-based model. Metric [I-5.1]: Numerator: Number of individuals of target populations reached by innovative projects of CenteringPregnancy and the Maternity Medical Home at JPS Health Centers for Women and Community Clinics. Denominator: Number of individuals in the being served in JPS Health Clinics for prenatal care. Baseline/Goal: 3,084 unduplicated patients (60% of patients receiving prenatal care at JPS sites based on FY11 data) in defined population Data Source: EPIC EHR Milestone 3 Estimated Incentive Payment: $4,756,277	**Milestone 4 [I-5]:** Identify the number of patients being in the defined population receiving innovative intervention consistent with the evidence-based model. Metric [I-5.1]: Numerator: Number of individuals of target populations reached by innovative projects of CenteringPregnancy and the Maternity Medical Home at JPS Health Centers for Women and Community Clinics. Denominator: Number of individuals in the being served in JPS Health Clinics for prenatal care. Baseline/Goal: 3,875 unduplicated patients (75% of patients receiving prenatal care at JPS sites based on FY11 data) in defined population Data Source: EPIC EHR Milestone 4 Estimated Incentive Payment: $3,929,098
Year 2 Estimated Milestone Bundle Amount: ***(add incentive payments amounts from each milestone):*** **$4,339,466**	**Year 3 Estimated Milestone Bundle Amount: $4,438,780**	**Year 4 Estimated Milestone Bundle Amount: $4,756,277**	**Year 5 Estimated Milestone Bundle Amount: $3,929,098**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $17,463,621			

Project Option 2.2.1 – Expand Chronic Care Management Models-School Based Collaborative Chronic Disease Care Model
Unique Project ID: 126675104.2.16 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: The multidisciplinary Wagner Chronic Care Model will be utilized to effectively approach the care and management of childhood and adolescent asthma and obesity/diabetes in our community with the goal of improving outcomes, preventing complications and reducing potentially preventable ED visits and inpatient readmissions. This project is a new initiative based on the Wagner Chronic Care Model.
Need for the project: 18.6% of children in Tarrant County have asthma and 32% are overweight or obese. Asthma is the most common chronic disease in childhood and children in low-income families are more than twice as likely to have been diagnosed with asthma as those that are not low-income. Among Medicaid-enrolled children with persistent asthma, the underuse of controller medications is widespread, reaching as high as 73 percent. Currently, patients seen in the 19 JPS Health Network School Based Health Centers with diagnoses of asthma and obesity/diabetes receive individual medical management and are provided with written education. There is no care coordination or multidisciplinary component to care, such as a focus on exercise, nutrition, social and psychological well-being, and no formalized self-management.
Target population: The project aims to serve 1,584 patients in DY4 and 1,980 patients in DY5 (a 10% increase from DY4). The target population is children and young adults with a diagnosis of asthma and/or obesity/diabetes who are currently accessing primary care services within our school based health centers as well as our community health centers.
Expected patient population: Improved health status through multidisciplinary care coordination and improved self- management tools as well as reduced expenditures by Medicaid through reduced ED visits and hospital readmissions.
Category 2 expected patient population: I-17: by DY5, 50% of identified target population will receive care under the chronic care model; I-18: Improve percentage of patients with self-management goals 60% from baseline by DY5.
Category 3 outcomes: IT-3.11-Reduce the percentage of pediatric and young adult patients with asthma who are readmitted to the hospital for any cause within 30 days of discharge from initial admission by 15% from established baseline by DY5; IT-9.3-Reduce the percentage of pediatric and young adult patients with asthma who have greater than or equal to one visit to the emergency room by 15% by DY5; IT-10.1: Improve quality of life score over established baseline by 10% for identified target population by DY5.

Achieving these outcomes will improve effective management of pediatric and adolescent asthma and obesity/diabetes, improve outcomes and reduce potentially preventable ED visits and inpatient readmissions.

Project Option 2.2.1 – Expand Chronic Care Management Models-School Based Collaborative Chronic Disease Care Model

Unique Project ID: 126675104.2.16 (Pass 2)

Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:

JPS Health Network has expanded access to primary care for underserved children and adolescents through its 19 regionally dispersed School-Based Health Centers. However, this population has very limited access to coordinated, proactive chronic care management for obesity, asthma, diabetes and other chronic conditions. This project will utilize the multidisciplinary Wagner Chronic Care Model[1] and its six essential elements to improve care and management of these childhood and adolescent conditions in our community.

1. Community: JPS Health Network will expand current partnerships with local school districts as well as local children's hospitals (Cook Children's Fort Worth and Children's Medical Center Dallas). During planning and development, JPS will create new alliances with local non-profits that support efforts to prevent chronic childhood diseases such as the North Texas Asthma Consortium and the FitWorth Healthy City Initiative. Forming such partnerships will create a community network to provide coordinated care with available resources at the local level.
2. Health System Organization of Health Care: JPS Health Network currently operates 19 School-Based Health Centers through partnerships with 12 of Tarrant County's 20 independent school districts. Located in low-income areas with poor health care access, these SBHCs are already expanding access to primary care in our community and treating children with chronic conditions. This well-developed system, along with its strong partnerships with local independent school districts, is poised to create a formalized regional model for children and teens with limited to no access to chronic care management services/programs.
3. Delivery System Design: The multidisciplinary care delivery system design will include clearly defined roles and stress efficient resource use. Multidisciplinary care teams will be hired to cover four distinct regions inclusive of the 19 SBHCs. In DY2, the project will develop a multidisciplinary team model likely to include the following disciplines: mid-level provider, RN educator/certified asthma educator, social work/case management, nutritionist/dietitian and bilingual outreach worker. Other program design elements are medical management clinics, group sessions, summer programs and self/family medical management classes/tools to encourage a proactive approach that improves health outcomes and reduces urgent care and emergency department visits. Patients will see the same clinicians at each visit to improve communication and continuity of care. Patients will receive an average of four clinical visits over the course of the program resulting in a volume of services of 6336 visits in DY4 and 7920 visits in DY5. Home visits will be made to the

most vulnerable patients to address behavioral and environmental problems. Patients will come to the program through multiple avenues, including referrals from SBHCs, school nurses and Family Resource Centers. The program will also include pediatric and adolescent referrals originating from other JPS Community Health Centers.

4. Decision Support: JPS Health Network and its partners will develop and implement recommendations for chronic childhood disease prevention/self-management and use evidence-based practice to create educational curriculums for patients, parents, school staff and community stakeholders.
5. Clinical Information Systems: JPS Health Network will optimize its electronic medical record to capture accurate and complete data to populate a registry for targeted childhood chronic diseases: asthma and obesity/diabetes. Program leaders will develop and implement processes to measure baseline/ongoing data pertaining to prevalence of chronic childhood diseases within the SBHC service delivery area.
6. Self-Management Support: Efforts will focus on raising student and parental awareness and parent-driven medical monitoring through educational offerings and home visits. Innovative, Internet-based, interactive self-management tools will be created to engage students and parents in care management.

Goals and Relationship to Regional Goals:

Project Goals:
The School-Based Collaborative Chronic Disease Care Model will expand chronic disease management services to underserved children and adolescents. Objectives achieved by DY5 will include: 50% of identified target population receive care under the chronic care model; A 15% reduction from baseline in the percentage of pediatric and young adult patients with asthma and one or more ED visits; 15% reduction in the percentage of pediatric and young adult patients with asthma readmitted to the hospital for any reason within 30 days of discharge; 10% improvement in the target population's quality of life score from baseline.

This project meets the following Regional goals:
Project goals are aligned with the goals of the Waiver and -Institute of Healthcare Improvement's triple aim, and will improve the health of underserved asthmatic and/or obese/diabetic children in our community. Through better management of chronic conditions, we will improve health outcomes and quality of life, while lowering health care costs.

Challenges:
At this time chronic disease care is fragmented, and chronic disease prevention, management and education is not widely available for underserved children in our community.

5-Year Expected Outcome for Provider and Patients:

At the conclusion of the Waiver, we expect an innovative chronic care model focusing on care coordination, education and self-management to address the needs of children and adolescents with asthma and obesity/diabetes. Currently, children and adolescents with diagnoses of asthma and obesity/diabetes receive individual medical management treatment and are provided with written education at JPS SBHCs. They do not receive care coordination or other multidisciplinary care components such as a focus on exercise, nutrition, social and psychological well-being, and no formalized self-management tool or plan.

Starting Point/Baseline:
Our target population will be 3,960 children/young adults with a diagnosis of asthma and/or obesity/diabetes. In FY 2011, JPS SBHCs treated 3,960 children with the targeted diagnoses:

Asthma	2,035
Obesity	1,911
Diabetes	45
Any of the three diagnoses combined	31
TOTAL UNDUPLICATED	3,960

Rationale:
Tarrant County is home to 401,322 children ages 0-14. About 19% (18.6%) of those children have asthma and 32% are overweight or obese based on body mass index.[2] Asthma is the most common childhood chronic disease; children in low-income families are more than twice as likely to be diagnosed with asthma as children in higher-income families.[3] Asthma is the leading cause of ED visits and hospitalizations for children in the United States[4] as well as a major cause of school absenteeism. Asthma-related illnesses lead to almost 13 million school days missed per year.[5] Three time more children are obese now than two decades ago, leading to increases in type 2 diabetes and other comorbidities.[6] FitFuture of Tarrant County reported three ZIP codes where 44% to 57% of the children are obese: 76104 (south of downtown Fort Worth); 76013 (west Arlington); and 76014 (southeast Arlington).[7] - Our program implementation efforts will focus on incorporating the Wagner Chronic Care Model in all 19 School Based Health Centers, thereby benefiting children and adolescents throughout Tarrant County.

Both asthma and obesity have a high cost. The estimated annual cost of treating childhood asthma is $8 billion[8] with inpatient hospital services the largest single direct medical expense. Among Medicaid-enrolled children with persistent asthma, fully 73% may not be using recommended and prescribed controller medications. As a result, they account for many more emergency department visits, hospitalizations, and high preventable treatment costs.[9] According to the Centers for Disease Control and Prevention, hospital costs associated with childhood obesity rose from $35 million in 1979 to $127 million in 1999. Additionally, overweight and obese children are more likely to become obese adults, leading to an increased risk for many devastating and costly diseases over their lifetime including type 2 diabetes, heart disease, some

forms of arthritis, and several cancers.[10] Research suggests that among children 5 or older, asthma and overweight/obesity are significantly associated.[11] Obese children with asthma have 29% higher hospitalization costs than non-obese children hospitalized for asthma.[12]

Project Components:
This project creates a collaborative and innovative chronic disease management model within School-Based Health Centers (SBHCs) to target the most common chronic childhood diseases: asthma and obesity/diabetes. The project's design includes all core components including tailoring care teams to target population's needs; ensuring that patients have easy access to their care teams; increasing patient and parent engagement; offering components to empower children to make lifestyle changes and better manage their conditions; and conducting quality improvement efforts during the project to build on lessons learned and identify key challenges to address.

Unique community need identification numbers the project addresses:
CN.8 – Lack of access to healthcare due to financial barriers
CN.10 – Overuse of emergency department (ED) services-CN.11 – Need for more care coordination
CN.15 – Need for more education, resources and promotion of healthy lifestyles

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new initiative. We are receiving no other federal funding for this project. In 2011, JPS Health Network was awarded a HRSA grant in the amount of $500,000 for equipment and renovation to benefit existing School Based Health Centers.

Related Category 3 Outcome Measures:

- **Outcome Measure 1:** IT-9.3 Pediatric/Young Adult Emergency Department Visits
- **Outcome Measure 2:** IT-3.11 Pediatric Asthma 30-Day Readmission Rate

-**Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:**
We will measure pediatric/young adult ED visits and pediatric asthma 30-day readmission rates because asthma is the leading cause of emergency department visits in the U.S., and reducing those visits through a proactive and coordinated approach to care is a key outcome.

Relationship to Other Projects:
RD-1(6) – Potentially Preventable Admissions-Pediatric Asthma, RD-2 (6) – 30-Day Readmissions-Pediatric Asthma, RD-4 (1) – Patient-Centered Healthcare. With this DSRIP project, JPS intends to make a positive impact by decreasing the number of pediatric admissions and readmissions related to the diagnosis of asthma. The focus on chronic disease management

and care coordination is a key component of JPS' strive for patient-centered health care and goal to increase patient satisfaction.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the Region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
Efforts have been made to collaborate and link the School-Based Collaborative Chronic Care model with UNT's ASTHMA 411 – A Sustainable School-Based Asthma Program project. Examples include increased access to primary care and a written provider-driven asthma action plan through the JPS School-Based Health Clinics for students identified in the ASTHMA 411 program without a primary care provider. There is also a strong potential for collaboration on educational curriculums and data sharing through the mutual partnership with Fort Worth Independent School District. Although these projects share a similar focus, there will be no overlap in target populations.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

JPS Health Network defined the population that will be directly impacted by the project as children with asthma seen at our school-based clinics. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a child's asthma is addressed, the child is able to participate in a classroom and social setting more effectively.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number

because when a child is positively impacted, access to emergent care is available for other members in the community.

References:

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9. Stanton MW & Dougherty D. Chronic care for low-income children with asthma: strategies for improvement. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action Issue 18. AHRQ Pub. No. 05-0073.
10. Ogden CO, Carroll MD, Kit, BK & Flegal KM. Prevalence of obesity in the United States, 2009-2010. U.S. Department of Health and Human Services; Centers for Disease Control and Prevention. NCHS Data Brief No.82, January 2012.
11. Newcomb P & Cyr A. Conditions associated with childhood asthma in North Texas. ISRN *Allergy*, vol. 2012, Article ID 823608, 2012. doi:10.5402/2012/823608.
12. Arons A. (January 2011). Childhood obesity in Texas: the costs, the policies, and a framework for the future. Prepared for the Children's Hospital Association of Texas (CHAT).

126675104 .2.16	2.2.1	2.2.1 A-E	EXPAND CHRONIC CARE MANAGEMENT MODELS-SCHOOL BASED COLLABORATIVE CHRONIC DISEASE CARE MODEL
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	**126675104 .3.47** **126675104 .2.48**	3 IT-9.3 3 IT-3.11	• IT-9.3- Pediatric/Young Adult ED appropriate utilization • IT-3.11-30-Day Readmission

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 a comprehensive care management program Metric 1 [P-3.1]: Documentation of a care management program following evidence-based practices from the Wagner Chronic Care Model Baseline/Goal: Documentation of the care management model Data Source: Program Materials Milestone 1 Estimated Incentive Payment *(maximum amount):* $201,616	**Milestone 2** P-4: Formalize multi-disciplinary teams, pursuant to the Chronic Care Model defined by the Wagner Chronic Care Model Metric 1 [P-4.1]: Increase the number of multi-disciplinary teams or number of clinic sites with formalized teams and/or needed resources. Baseline/Goal: Documentation of staffing plan and implementation of plan Data Source: EPIC EMR, written staffing plan Milestone 2 Estimated Incentive Payment: $103,115 **Milestone 3** [P-11]: Develop and implement program to assist patients to better self-manage their chronic conditions of Asthma and/or Obesity/Diabetes. Metric 1 [P-11]: Increase the number of patients enrolled in a self-management program. Baseline/Goal: Establish self-management program tools and	**Milestone 4** [I-17]: Apply the Chronic Care Model to target chronic to targeted chronic diseases, which are prevalent locally. Metric 1 [I-17.1]: Additional patients receiving care under the Chronic Care Model for Asthma and/or Obesity/Diabetes. Goal: 1584 children/adolescents (40% of identified target population) will receive care under the chronic care model. Data Source: EPIC EMR, Patient registry Milestone 4 Estimated Incentive Payment: $110,490 **Milestone 5** [I-18]: Improve the percentage of patients with self-management goals. Metric 1 [I-18.1]: Patients with self-management goals. Goal: Increase by 50% from established baseline. (Estimated population impact: 792) Data Source: EPIC EMR	**Milestone 6** [I-17]: Apply the Chronic Care Model to target chronic to targeted chronic diseases, which are prevalent locally. Metric 1 [I-17.1]: Additional patients receiving care under the Chronic Care Model for Asthma and/or Obesity/Diabetes. Goal: 1980 children/adolescents (50% of identified target population) will receive care under the chronic care model. Data Source: EPIC EMR, Patient registry Milestone 6 Estimated Incentive Payment: $91,274 **Milestone 7** [I-18]: Improve the percentage of patients with self-management goals. Metric 1 [I-18.1]: Patients with self-management goals. Goal: Increase by 60% from established baseline. (Estimated population impact: 1188) Data Source: EPIC EMR

126675104 .2.16	*2.2.1*	*2.2.1 A-E*	*EXPAND CHRONIC CARE MANAGEMENT MODELS-SCHOOL BASED COLLABORATIVE CHRONIC DISEASE CARE MODEL*
JPS Health Network			126675104
Related Category 3 Outcome Measure(s):	**126675104 .3.47** **126675104 .2.48**	3 IT-9.3 3 IT-3.11	• IT-9.3- Pediatric/Young Adult ED appropriate utilization • IT-3.11-30-Day Readmission

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)
	resources available for Asthma and Obesity/Diabetes. Data Source: Program records and materials Milestone 3 Estimated Incentive Payment: $103,115	Milestone 5 Estimated Incentive Payment: $110,490	Milestone 7 Estimated Incentive Payment: $91,274
Year 2 Estimated Milestone Bundle Amount: ***(add incentive payments amounts from each milestone):*** **$201,616**	**Year 3 Estimated Milestone Bundle Amount: $206,229**	**Year 4 Estimated Milestone Bundle Amount: $220,980**	**Year 5 Estimated Milestone Bundle Amount: $182,548**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $811,373			

Project Summary

Project Option 2.12.1 – Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions – Develop rehab transition process for JPS Connections patients

Unique Project ID: 126675104.2.17 (Pass 3)
Performing Provider Name/TPI: JPS Health Network/126675104

Provider: JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth serving all of Tarrant County (897 sq. miles), with a population of approximately 1.8 million residents. As one of Texas' major urban public hospitals, JPS Health Network serves as the primary safety net provider of acute care for Tarrant County's Medicaid and uninsured populations. Medicaid, self-pay and uninsured individuals make up 75% of JPS' patient population. One of only two providers in Tarrant County delivering a full range of behavioral health care services, JPS Health Network is also Fort Worth's only acute psychiatric care facility.
Intervention: This project will create new and badly needed specialized inpatient rehabilitation purposes for uninsured individuals of Tarrant County. An estimated 420 vulnerable uninsured low-income Tarrant County residents requiring inpatient rehabilitation after stroke, hip replacement or hip fracture will receive specialty inpatient rehabilitation services through this intervention. For those who receive the intervention, we anticipate significantly shortened recovery times, higher functional status, and fewer re-admissions and ED visits compared with pre-intervention. This project is a new initiative.
Need for the project: The project will greatly increase access to specialty rehabilitation services for uninsured Tarrant County residents. The project specifically addresses three identified community health needs for Medicaid and Uninsured Region 10 residents: shortage of specialty care; overuse of ED services; and, need for more care coordination.
Target population: The target population is JPS Health Network patients who do not qualify for Medicaid in Texas and lack private coverage enrolled in JPS' patient coverage program called JPS Connections.
Expected patient benefits. This intervention will result in new specialty care access to inpatient rehabilitation services for approximately 420 uninsured JPS Connections patients recovering from stroke, hip replacement or hip fracture in need of inpatient specialty rehabilitation over the course of the waiver period. This project was designed to improve specialty care access for low and moderate income uninsured Tarrant County residents with specific diagnoses requiring specialty inpatient rehabilitation. This project will result in reduced overall lengths of stay for patients, improved patient satisfaction with care, improved long term functioning and reduced re-admission rates. The project's impact will be assessed through a CG-CAHPS pre- and post-intervention survey, achievement of milestones related to development and implementation timeline, as well as measurement of patient's overall length of stay and quality of life.

Project Option 2.12.1 – Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions – Develop rehab transition process for JPS Connections patients

Unique Project ID: 126675104.2.17 (Pass 3)
Performing Provider Name/TPI: JPS Health Network/126675104

Project Description:
JPS Health Network will establish a preferred partnership with a leading private provider of rehabilitation services ("Rehab Provider") that creates new and badly needed specialized inpatient rehabilitation access for JPS Connections patients.[274] By establishing a formal relationship with Rehab Provider, one of the Region's most highly regarded inpatient rehabilitation providers, this project will achieve both regional and JPS-specific objectives to improve regional system care transitions and increase access to appropriate, high quality, specialty care for some of Region 10's most vulnerable underserved and uninsured residents.

JPS Connections patients admitted to Rehab Provider will benefit significantly from an intensive, evidence-based rehabilitation therapy program with the potential for increased rates of clinical improvement resulting in earlier and safer home or community discharge. For individuals with qualifying conditions and presentations, inpatient rehabilitation hospitals promote the fastest and most comprehensive recovery opportunities. This partnership offers significant clinical benefits to patients as well as system-level cost reductions. JPS and Rehab Provider anticipate this partnership will reduce costs and improve functional independence and related outcomes for inpatient rehabilitation-eligible individuals. We expect our collaboration with Rehab Provider to reduce the target population's average inpatient length of stay at JPS Health Network to seven to 14 days from the current average of more than 20 days.

Goals and Relationship to Regional Goals:
Project Goals:
JPS Connections patients admitted to Rehab Provider will: 1) receive an active and ongoing therapeutic intervention under the supervision of a rehabilitation physician that incorporates multiple therapy disciplines; 2) require an intensive and targeted rehabilitation therapy program; 3) actively participate in a customized intensive rehabilitation therapy program; and, 4) make measurable timely improvements.

[274] JPS Connections patients do not qualify for Medicaid in Texas at this time and lack private coverage. There are three tiers of Connections patient coverage, depending on their income level: Tier 1 coverage levels and benefits are available to uninsured adults who do not qualify for Medicaid with incomes under 200% of the FPL; Tier 2 coverage levels and benefits are available to uninsured adults with incomes between 200% and 250% of the FPL. Additionally, JPS Connections is offered as a discounted fees program for uninsured adults with incomes above 250% of the FPL unable to secure affordable private coverage.

This project meets the following regional goals:
This project addresses Region 10's goals of 1) improving access for the uninsured and underserved to needed primary care and specialty care and 2) better coordination of care across the region's health care providers with an emphasis on more efficient care provided in clinically appropriate settings.

Challenges:
At this time Region 10 offers minimal and poorly coordinated access for the uninsured and underserved to specialty providers and specialized inpatient settings, including specialized rehabilitation inpatient services and other rehabilitation programs.

5-Year Expected outcome for Provider and Patients:
JPS Health Network will partner with Rehab Provider to transfer patients with three specific inpatient admission diagnoses (stroke, hip fracture and hip replacement) requiring ongoing therapy and targeted inpatient rehabilitation services to Rehab Provider. By the end of the Waiver period, JPS expects to have referred approximately 400 unique patients to Rehab Provider and a JPS PCP and reduced these patients' readmissions through the JPS Health Network Emergency Department by at least 25%. Additionally, this project will result in faster recovery periods for JPS patients admitted to the Rehab Provider. We anticipate the JPS inpatient length of stay to decrease by seven to 10 days for the transferred patients and total recovery periods for these patients to be shorter.

Starting Point/Baseline:
Until now there has been no formal relationship between JPS Health Network and Rehab Provider and no inpatient referral agreement between the two systems. Therefore the baseline for this project is zero.

Rationale:
This project option was selected because of the benefit it will provide to a particularly vulnerable set of JPS Connections patients at great risk of care transition errors and potentially preventable readmissions and the efficiency and improved rehabilitative outcome opportunity it presents.

Project Components:
This project encompasses all seven required core components. JPS Health Network will: work with Rehab Provider to identify/verify the most appropriate therapy and related protocols for each of three clinical diagnoses; conduct a chart review analysis of the 30-day hospital readmissions for similar JPS Connections patients who have not benefited from access to Rehab Provider and share that with Rehab Provider; integrate information system exchange between JPS Health Network and Rehab Provider; work with Rehab Provider after the project is

implemented to identify which patients are most likely to need acute care services in the 30-60 days after discharge; collaborate with Rehab Provider on a discharge planning and post-discharge support program; develop a cross-system, cross-continuum multidisciplinary team to support patient recovery; and engage throughout the project in ongoing activities with Rehab Provider to continuously learn from the collaborative implementation experience and transfer that knowledge both to other inpatient JPS populations as well as care transitions with other partner providers. Rehab Provider will focus on developing greater understanding of best practice approaches and specific challenges associated with providing therapeutic services to this underserved population.

JPS and Rehab Provider will work in good faith to establish a formal contractual relationship that will include such provisions as term and termination; payment provisions including claims submission and payment guidelines; performance categories; measurement period(s); incentive payment potential and general responsibilities of both parties. Additionally, the two parties will develop an agreement to share data and information about their shared patients and to work together on continuous care transitions quality improvement.

Unique community need identification numbers the project addresses:
CN.3: Shortage of specialty care
CN.10: Overuse of ED services
CN.11: Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents a new initiative as there is no such formal relationship established between the two parties. This project does not duplicate any federal funds.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/rationale for selecting the outcome measures:
Outcome Measure #1: IT-6.1 (5) Percent improvement over baseline of patient satisfaction score – (5) Patient's overall health status/functional status (Standalone measure)

Outcome Measure #2: IT-4.9 Average Length of Stay

Relationship to Other Projects:
There are no related Category 1 and 2 projects.

Related Category 4 Population-focused improvements
This project will impact RD-2: Potentially Preventable Readmissions. Specifically, this project will reduce RD-2.5 (Stroke readmissions) for the JPS Health Network ED

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. JPS Health Network has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

This intervention will result in new specialty care access to inpatient rehabilitation services for approximately 420 uninsured JPS Connections patients over the course of the waiver period, or 15% of the .- JPS Connections Patients with 3 specific diagnoses requiring inpatient rehabilitative therapy: stroke, hip replacement and hip fracture. -This population number - was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. JPS Health Network is anticipating both a reduction in length of stay, causing fewer costs to the hospital district and the Medicaid program, and thus an increase in patient satisfaction. The average length of stay for these types of patients at JPS costs $5,576 per day; decreasing the average length of stay, currently nearly 20 days, for patients by 15% over baseline by DY5 will result in a significant savings and an increase in patient satisfaction.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 4**.** We believe this to be the correct number because, when a person is positively impacted, clinical outcomes will be improved by the ability to access care in the proper setting and have a positively impacted patient experience through a reduced length of stay in an acute care setting.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3**.** We believe this to be the correct number because, when a person is positively impacted, there will be increased capacity for acute care patients in need of inpatient and rehabilitation beds.

126675104.2.17	***2.12.1***	***2.12.1 (A-G)***	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions – Develop rehab transition process for JPS Connections patients
JPS Health Network			*126675104*
Related Category 3 Outcome Measure(s):	*TPI.3.49* *TPI.3.50*	*3.IT-4.9 (5)* *3.IT-6.1*	*Average Length of Stay* *Patient's overall health status/functional status*

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]: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge (Establish a formal contract with Rehab Provider Corporation) Metric 1 [P-4.1]: Care transitions assessment Baseline/Goal: Establish formal relationship with Rehab Provider Data Source: Contract/agreement Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,140,322 **Milestone 2** [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program Metric 1 [P-7.1]: Documentation of the staffing plan. Baseline/Goal: Develop implementation plan Data Source: Documentation of	**Milestone 3** [I-11]: Improve - 5% relative to baseline of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [P-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Baseline/Goal: 140 - annual patients referred to Rehab Provider receiving rehab interventions Data Source: Electronic records Milestone 3 Estimated Incentive Payment: $2,332,838	**Milestone 4** [I-11]: Improve - 10% relative to baseline of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [P-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Baseline/Goal: 140 -annual -unique patients referred to Rehab Provider receiving rehab interventions Data Source: Electronic records Milestone 4 Estimated Incentive Payment: $1,249,850 **Milestone 5** [P-19]: 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:	**Milestone 6** [I-11]: Improve - 15% relative to baseline of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [P-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Baseline/Goal: 140 -annual unique patients referred to Rehab Provider receiving rehab interventions Data Source: Electronic records Milestone 6 Estimated Incentive Payment: $1,032,486 **Milestone 7** [P-19]: 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:

126675104.2.17	***2.12.1***	***2.12.1 (A-G)***	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions – Develop rehab transition process for JPS Connections patients	
JPS Health Network				*126675104*
Related Category 3 Outcome Measure(s):	*TPI.3.49* *TPI.3.50*	*3.IT-4.9 (5)* *3.IT-6.1*	*Average Length of Stay* *Patient's overall health status/functional status*	
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)**
plan Milestone 2 Estimated Incentive Payment: $1,140,321			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-19.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Goal: 20 bi-weekly meetings Data Source: Meeting agendas Milestone 5 Estimated Incentive Payment: $1,249,851	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-19.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Goal: 20 bi-weekly meetings Data Source: Meeting agendas Milestone 7 Estimated Incentive Payment: $1,032,485
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,280,643	Year 3 Estimated Milestone Bundle Amount: $2,332,838		Year 4 Estimated Milestone Bundle Amount: $2,499,701	Year 5 Estimated Milestone Bundle Amount: $2,064,971
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $9,178,153				

Project Option 2.2.1 – Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – Healthy Education and Lifestyles Program (HELP) Chronic Disease Management Program

Unique Project ID: 127304703.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Azle / 127304703
Provider: Texas Health Harris Methodist Hospital Azle's mission is to improve the health of the people in the communities we serve. The mission is the foundation for all of the facilities activities. Texas Health Harris Methodist Hospital Azle, a 36-bed hospital, is located on the border of Tarrant and Parker County, resulting in Texas Health Azle being the major source of primary health care to the area's 30,000 citizens since 1954.
Provider's Role in Region: The Tarrant County side has many resources, such as public health services; however, there is no public transportation from Azle to access these services. Parker County does not have a county hospital and only one clinic in Weatherford, which is approximately 20 miles from Azle. Again, there are no transportation options to Weatherford. Access for Medicaid patients is an equal concern. Although there are physicians in the large cities who accept Medicaid, there is not adequate transportation to these facilities.
Regional Need: The rural parts of Parker County provide an economic challenge. In fact, 18.7 percent of households in North Parker make less than $25,000 a year. In Parker County, the uninsured rate has jumped from 14.1 percent in 2007 to 24.8 percent in 2010[xxx]. The percent of children without insurance is 11.8[i] percent. Lack of insurance increases their dependence on Medicaid As a result, 56% of the patients seen in the emergency room at Texas Health Azle were either unfunded or Medicaid. This translates into approximately 13,154 patients.
Project Intervention: Unfunded or Medicaid patients, who have an uncontrolled chronic disease, do not have access to primary care. They wait until their chronic disease is at an emergent level, then they seek treatment at the Emergency department (ED). After receiving treatment, the cycle begins again. This is not a good way to manage a chronic disease; and it is extremely costly to both the patient and the provider. The HELP clinic provides a primary care home for these patients, where they will receive, not only a clinic visit, but education and a support group as well. The HELP clinic is in the design phase and is only seeing ten patients as a pilot project. The DSRIP funds will expand this munch needed program to include a multi-disciplinary team to provide a coordinated effort, and to ultimately redesigns the delivery of care.
Target Population and Benefit: Approximately 2,000 patients are seen in Texas Health Azle's ED at an average cost of $1,322.00 per patient per visit. In a recent focus group held at Texas Health Azle for patients with a chronic disease, ninety percent said they would utilize a medical home instead of the emergency department.
Category 2 Expected Patient Benefits: The project seeks to provide a medical home for approximately 900 patients, who have a chronic disease by DY5, resulting in higher quality of care in a more cost effective setting.
Category 3 Outcomes: One outcome of the HELP program is to reduce by 50% the number of unfunded/Medicaid visits treated in the emergency department for uncontrolled chronic disease

by DY 5, an estimated 951 visits. This would save in healthcare cost alone approximately $6,286,110.

Project Option 2.2.1 – Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – Healthy Education and Lifestyles Program (HELP) Chronic Disease Management Program

Unique Project ID: 127304703.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Azle / 127304703
Project Description:
Our HELP team of clinical and support staff will provide program participants monthly clinical office visits with a practitioner along with ongoing health coaching and education resources to support patients learning to effectively manage their chronic disease and to encourage them to take an active role in reducing the negative toll that their chronic conditions will otherwise take on their lives. The monthly office visits will ensure those who are uninsured gain access to lab testing, results and medications necessary to help them effectively self-manage their disease.

Goals and Relationship to Regional Goals:
Project Goals:
The goal of this project is to develop and implement a community-based innovative chronic disease management program to help low-income and unfunded residents of Tarrant and North Parker County better self-manage their chronic conditions with a particular clinical support focus on reducing the rates of uncontrolled diabetes and hypertension among project participants. Relying on an empirically validated, evidence-based self-management educational and clinical support approach, our goal is to improve the health outcomes and self-management competency of community residents in Tarrant and North Parker Counties living with chronic disease who in the absence of this program will continue to experience (1) unnecessarily reduced quality of life and (2) inappropriately high reliance on acute and emergent care community resources.

At this time, there are no programs like the one being proposed for this population, many of which are living with chronic disease in northwest Tarrant and Parker Counties. A community-based primary care model designed to reach out to disadvantaged adults living with a chronic illness is a much needed program for RHP 10 to improve the primary care access and chronic condition management needs of this population.

Our proposed intervention will help low-income and uninsured residents of northwest Tarrant and Parker Counties with chronic conditions to better self-manage their disease through disease education and peer support and provide them with appropriate access to chronic care management support resources, including lab and medications in an outpatient community-based setting. HELP care teams will be assigned based on individuals' health care needs and will include non-physician health professionals, such as pharmacists doing medication management;

case managers providing care outside of the clinic setting via phone, email and other electronic support, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system. Program participants will receive an individual assessment by a nurse practitioner under the direction of a Medical Director. They will participate in tailored self-care activities, including a health care and lifestyle self-assessment form, and have staff-facilitated peer to peer conversations with other participants about their disease management concerns. Participants will also be included in facilitated discussion by a registered nurse or nutritionist about a relevant health topic. In addition, high risk program participants will be given a tablet and other necessary medical equipment to monitor their chronic disease. These tablets will be electronically linked to the HELP care team to provide them with the ability to monitor participants' conditions beyond the clinic setting. Program participants will be encouraged to access their care teams in person, by phone or email.

This project meets the following Regional goals:
A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to achieving that goal by implementing a community-based, innovative chronic disease management program to help low-income senior and near senior residents of Tarrant and North Parker Counties better self-manage their chronic conditions, with a particular clinical support focus on reducing the rates of uncontrolled diabetes among project participants.

Challenges:
Higher than the national average of around 8%, 9.7% adults 18 years and older in Texas are diagnosed with diabetes. (i.e. about 1.8 million adults) Among the elderly population (older than 65 years), the rate is 23%, and among adults between 45-64 years of age, the rate is 14%.[275] While chronic conditions are a growing concern for all U.S. populations, the uninsured and Medicaid beneficiaries with chronic conditions are at the greatest risk of unnecessary disease-related complications and avoidable hospitalizations. Those who are uninsured or without access to appropriate care have been widely reported in clinical research literature as having the greatest difficulty in managing chronic conditions due to lack of a medical home, minimal or no primary care access, limited or no access to medications necessary for disease management, and limited or no access to regular lab work.[276]

We serve the Northwest Tarrant and the North Parker County areas. According to the Dallas Fort Worth Hospital Councils 2008 Community Needs Assessment, although the rate for uncontrolled

[275] Texas Behavioral Risk Factor Surveillance System, 2010. Center for Health Statistics, Texas Department of State Health Services.
[276] See Cardiovascular Disease Risk Among the Poor and Homeless – What We Know So Far by Charlotte A. Jones et. al. Curr. Cardio. Rev. 2009, January; 5(1):69-77; The Centers for Disease Control 2011 National Fact Sheet on Diabetes

diabetes for Northwest Tarrant County is lower than state and national levels, diabetes-related death rates have exceeded county rates for five of the past six years. Similarly, North Parker County death rates exceed county rates for the past six years with diabetes identified as a major health concern. In 2011, Texas Health Azle's ED treated 1,902 unfunded/Medicaid patients for an uncontrolled chronic disease.

This project was specifically selected because of its relevancy to providing improved cost-effective, competent care to help manage hypertension, high cholesterol and diabetes in the low income and uninsured population. We know this program is needed because, in August 2011, we conducted focus groups for uninsured patients living in our community with chronic disease. Findings from those focus groups indicated while chronic disease patients recognized their need for primary care and assistance with disease management, most felt they didn't have sufficient support and primary care access to do so.[277] Most focus group participants said they knew what they needed to do in order to be compliant: exercise, take proper medication, and improve their nutrition. Unfortunately, the same participants pinpointed their inability to pay as a critical barrier to following through with these needed management techniques and supports. Most respondents admitted to taking their medicine every other day to stretch out the medicine. Respondents also said they didn't want to use hospital ERs as their source of care when their disease flared, but lacked any alternative.

5-Year Expected outcome for Provider and Patients:
In the focus group held at Texas Health Azle, 90% of the participants said they did not want to use the emergency department as a primary care facility, but there was no alternative. HELP provides the alternative. By the end of the Waiver, the goal is a 50% improvement in the number of patients seen in the HELP clinic over the baseline.

Starting Point/Baseline:
In 2011 the emergency department at Texas Health Azle, 56% of the patients were either unfunded or Medicaid. This translates into approximately 13,154 patients. A review of patient records indicates 1,902 of these patients were treated for an uncontrolled chronic disease. Ninety percent of the focus group said they would utilize a medical home instead of the emergency department. One outcome of the HELP program is to reduce by 50% the number of unfunded/Medicaid patients treated in the emergency department for uncontrolled chronic disease.

Rationale:
In the past, our system has focused on providing high-quality inpatient and emergency services. However, technological advances and recognition of the inadequacies of a reactive inpatient-

[277] Our focus group findings were compiled in a June 2011 report, "What the Disadvantaged of Tarrant and Parker County Need to Improve Their Chronic Disease Self-Management Efforts."

centered system of care, particularly for those living with chronic illness, requires a system "make-over" in which primary care access is the basis for ensuring ongoing, coordinated care for patients. So patients can stay healthy and out of the hospital, we have selected this project to expand our primary care capacity. Additionally, we have focused this project on a population disproportionately affected by the lack of primary care: economically disadvantaged and underserved adults living with a chronic disease. The Community Needs Assessment clearly identifies; (1) geographical barriers to care; (2) the lack of health care due to financial inability to pay; and (3) inappropriate emergency department utilization as concerns for this area. This clinic will provide low-cost access to primary care close to home for low-income or unfunded patients to prevent costly emergency department visits.

Project Components:

The HELP project meets all (A-E) of the required core components in Category 2.2.1, including:

- Design and implement a care team tailored to the patient's health care needs through disease-specific patient education and self-management support;
- Increase patient engagement, through group visits and peer support opportunities as well as opportunities for participants to become auxiliary support resources for other participants as well as more broadly within their communities and families;;
- Implement chronic disease self-management to empower patients to make lifestyle changes;
- Clinically-led and mission-driven team that communicates and stays in touch with program participants;
- All participants will have access to the Care Team via phone or email;
- Electronic tablet distribution to highest-risk participants to facilitate daily monitoring by team;
- Monthly clinical visits for participants with lab work and medications provided, and;
- Conduct quality improvement using the Plan, Do, Study and Act (PDSA) cycle for improvement, including studying the opportunity to scale part of the project to a broader patient population.

Our milestones measure an increased population receiving chronic care management through a proven, effective model of care: (1) by establishing a multidisciplinary team and (2) increasing the number of patients served under this model, as measured by patient touches recorded in the registry. These milestones and metrics will measure how many patients are receiving ongoing chronic care management through this effective, coordinated model (rather than not receiving care, or receiving fragmented care).

Unique community need identification numbers the project addresses:

- CN.7 – Need to address geographic barriers that impede access to care
- CN.8 – Lack of access to health care due to financial barriers
- CN.10 – Overuse of emergency department services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
HELP is a new approach to offering outpatient care by implementing a team approach. Instead of just a clinic visit, each patient will receive education and support and lifestyle-changing techniques.

Related Category 3 Outcome Measures:
Outcome Measures:
IT-9.2 ED Appropriate Utilization (stand-alone)

Reasons/rationale for selecting the outcome measures:
This project was specifically selected because of its relevancy to providing improved cost-effective, competent care to help manage hypertension, high cholesterol and diabetes in the uninsured population. We know this program is needed because, in August 2011, we conducted focus groups for uninsured patients living in our community with chronic disease. Findings from those focus groups indicated that while chronic disease patients recognized their need for primary care and assistance with disease management, most felt they didn't have sufficient support and primary care access to do so. Most focus group participants said they knew what they needed to do in order to be compliant – exercise, take proper medication, and improve their nutrition. Unfortunately, the same participants pinpointed their inability to pay as a critical barrier to following through with these needed management techniques and supports. Most respondents admitted to taking their medicine every other day to stretch out the medicine. Respondents also said they didn't want to use hospital ERs as their only source of care when their disease flared, but lacked any alternative.

Relationship to Other Projects:
Related Category 1 and 2 projects:

Related Project(s)	Description of Relationship
1.1.1.42 Walk-in Care Clinic – THAZ	The expanded primary care capacity established in the Category 1 project will refer patients with chronic diseases to the HELP clinic for disease management.

Related Category 4 Population-focused improvements:
RD-1.2 Diabetes Admission Rates: Implementing our HELP CDSMP-based intervention for uninsured and disadvantaged adults with a serious chronic condition will have a positive impact on this reporting measure for HELP program participants.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology:** For every ED visit avoided, $1,322 in cost is saved by the health care system. The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** ED visit outcome improvement targets are dependent on the target population served (e.g., with either hypertension or diabetes), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.
- **Community benefits** were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

127304703.2.1	*2.2.1*	*2.2.1(A-E)*	*Expand Chronic Care Management Models – HELP Chronic Disease Management Program*	
Texas Health Harris Methodist Azle Hospital				*1273047-03*
Related Category 3 Outcome Measure(s):	*127304703.3.2*	*3.IT-9.2*	*ED Appropriate Utilization (Stand-alone 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]:Formalize multidisciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric 1 [P-4.1]: Increase the number of multidisciplinary teams (e.g.,, teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams Goal: Establish 1 team Data Source: HR records Milestone 1 Estimated Incentive Payment: $138,989 **Milestone 2** [P-X]: Establish baseline as the number of patients enrolled in HELP clinic. Metric 1: [P-X] Establish baseline as number of patients seen in the HELP clinic in DY2. Goal: Establish baseline Data Source: Patient records Milestone 2 Estimated Incentive Payment : $138,989	**Milestone 3** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. The following metrics are suggested for use with an innovative project option but are not required. Metric 1 [I-21.1]: Increase percentage of target population reached Goal: 10% increase in the number of patients seen in the HELP CDSMP Program over baseline (number of patients seen in DY2) Data Source: Patient Records Milestone 2 Estimated Incentive Payment:$269,144		**Milestone 4** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. The following metrics are suggested for use with an innovative project option but are not required. Metric 1 [I-21.1]: Increase percentage of target population reached Goal: 25% increase in the number of patients seen in the HELP CDSMP Program over baseline Data Source: Patient Records Milestone 4 Estimated Incentive Payment:$283,866	**Milestone 5** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. The following metrics are suggested for use with an innovative project option but are not required. Metric 1 [I-21.1]: Increase percentage of target population reached Goal: 50% increase in the number of patients seen in the HELP CDSMP Program over baseline Data Source: Patient Records Milestone 5: Estimated Incentive Payment:$229,209

127304703.2.1	*2.2.1*	*2.2.1(A-E)*	*Expand Chronic Care Management Models – HELP Chronic Disease Management Program*	
Texas Health Harris Methodist Azle Hospital				*1273047-03*
Related Category 3 Outcome Measure(s):	*127304703.3.2*	*3.IT-9.2*	*ED Appropriate Utilization (Stand-alone 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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $277,979	Year 3 Estimated Milestone Bundle Amount: $269,144		Year 4 Estimated Milestone Bundle Amount: $283,866	Year 5 Estimated Milestone Bundle Amount: $229,209*
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,060,197				

Project Summary Template to be completed for each Category 1 and 2 project
Project Option 2.18.1– Implement whole health peer support (Peer Support).

Unique Project ID: 127373205.2.1
Performing Provider Name/TPI: Helen Farabee Centers / 127373205

Provider: The Helen Farabee Center consists of 9 clinics in north-central Texas serving 19 counties across 16,705 square miles and a population of 318,665. The Helen Farabee Center is a Community Mental Health/Intellectual & Developmental Disability authority/provider. The Center serves primarily indigent clients and roughly 30% of them have Medicaid.
Intervention: The goal is to expand the Peer Provider staffing to better meet the needs of the patient population in Wise County. The project is an expansion of services occurring within the service area and it is new to Wise County.
Need for the project: The project meets the following needs identified through a regional needs assessment: CN.4 Lack of access to mental health services; CN.7 Need to address geographic barriers that impede access to care.
Target population: The target population for this project is Adults/Children who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Adults with Major Depression, Bipolar Disorder, Schizophrenia and Children with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental health disorders. The estimated target impact is 60 clients a year receiving a health assessment and 30 a year qualifying for full Whole Health treatment. Milestones in years 4 and 5 target improved health measures in 50% and 60% of recipients, respectively. The project represents a needed service that is currently absent in the identified service area and one that can be provided at low or no cost to Medicaid/indigent recipients.
Category 1 or 2 expected patient benefits: The benefit is the assessment of clients for health risks and treating them with a Whole Health approach by trained Peer Providers. This benefit meets the purpose of implementing Whole Health Peer Support in the identified service area.
Category 3 outcomes: How does this tie back to the project's purpose? The benefit of the project is a 5% and 10% improvement in quality of life as measured by assessments in DY's 4 and 5, respectively. This meets the project purpose of improving quality of life through Whole Health Peer Support for people in the identified service area.

Project Option 2.18.1– Implement whole health peer support (Peer Support).

Unique Project ID: 127373205.2.1
Performing Provider Name/TPI: Helen Farabee Centers / 127373205

Project Description:
Currently, Peer Provider services are provided by one Peer Provider staff member located in Wichita County who also attempts to provide the services in eighteen additional counties. The goal is to expand the Peer Provider staffing to better meet the needs of the patient population in Wise County (ZIP codes 76431, 76225, 76234, and 76073). The target population for this project is Adults who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (Major Depression, Bipolar Disorder, and Schizophrenia).The project fits within the Project Area in that it involves recruiting and training potential peer providers. The project fits within the Intervention in that the new staff will be implementing peer support services.

Goals and Relationship to Regional Goals:

Project Goals:
The goal is to expand the Peer Provider staffing by hiring two Peer Providers in Wise County to better meet the needs of the patient population in that county. These Peer Providers will use Whole Health Planning and health risk assessment tools in order to improve standardized health measures. The purpose of performing the project within this project area is that recruiting and training are integral to completing the goal.

This project meets the following Regional goals:
The project is related to Area of Focus Two: Care Coordination. The majority of respondents did not believe that low-income patients could access behavioral/mental health providers.
The project is related to Area of Focus Three: Community Health. Respondents felt that behavioral health, substance abuse and insufficient access to care were the top issues affecting population health. In addition, they listed friends and family, the Internet and their doctor as the main places where patients were getting health education.

The Helen Farabee Center primarily serves low-income individuals seeking mental/behavioral health care. The Peer Support model adds an additional layer of care coordination by providing peers as access points for clients in care. The Peer Model also serves as an important education source for patients.

Challenges:

According to the National Alliance on Mental Illness (NAMI),[278] one in four people will experience some sort of diagnosable mental illness. One in 17 people in the United States suffers from a *severe persistent* mental illness. Mental health interventions for these individuals have evolved over the years to include more evidence-based practices such as Peer Service Provision. Peer provision is a new shift in the way mental health centers can provide skills training and rehabilitative services to individuals with mental health needs. For the past few years this service has been provided in a limited capacity by a single peer provider employed by the Helen Farabee Center. More peer providers are needed to serve more of the Helen Farabee Service area. This project addresses these challenges by hiring and training the staff required to provide Peer Services in an area with limited Peer service.

5-Year Expected outcome for Provider and Patients:
The five-year outcome is to have hired two peer providers for Wise County and implement whole health planning for identified consumers resulting in improved standardized health measures for those consumers.

Starting Point/Baseline:
There is currently one peer provider centerwide. There are no consumers receiving Whole Health Planning interventions at any location. The goal is to provide services initially to 20 people.

Rationale:
On August 15, 2007 the Center for Medicare & Medicaid Services (CMS) issued a statement as part of a letter to state Medicaid offices encouraging the use of State certified peer specialists.[279] Currently, the Texas Department of State Health Services includes Peer Support among other best practices as part of the Texas Resilience and Recovery treatment model.[280] The corresponding milestones and metrics track the changes necessary to place, train, and equip peer providers in a location that currently lacks the service.

Project Components:
Core Component a) "Train administrators and key clinical staff in the use of peer specialists as an essential component of a comprehensive health system" was not included since the administrators and key clinical staff at the mental health center include certified Peer Specialists and already acknowledged peer specialists as a key component of the Texas Recover and Resiliency mental health system. Core component b) "Conduct readiness assessments of organization that will integrate peer specialists into their network." was not included because the organization has already integrated peer specialist services into its network. This project is an expansion of those services.

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[278]The High Costs of Cutting Mental Health (www.nami.org)
[279]http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf
[280]http://www.dshs.state.tx.us/mhprograms/RDM.shtm

Projects c) "Identify peer specialists interested in this type of work", 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) "Implement health risk assessments to identify existing and potential health risks for behavioral health consumers.", f) "Identify patients with serious mental illness who have health risk factors that can be modified.", g) "Implement whole health peer support.", h) "Connect patients to primary care and preventive services.", and i) "Track patient outcomes." were selected since they are integral to the whole health system of care and are areas that have not yet been fulfilled. They will require recruiting of additional peer specialists, training, implementing health risk assessments, identifying patients who have health risk factors, implementing the whole health peer support model, connecting patients to primary car or preventive services, and tracking outcomes.

The milestones and metrics were chosen based on the elements required to be in place in order to provide peer-provided whole health services at a new location where none had been provided before. The process requires the recruitment and training of peer specialists, implementing health risk assessments, identifying consumers with modifiable health risks, developing person-centered wellness plans, and tracking improvements in standardized health measures.

Unique community need identification numbers the project addresses:

- CN.4 Lack of access to mental health services
- CN.7 Need to address geographic barriers that impede access to care

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Using Peer Service Provision in our service area an initiative started through the Texas Department of State Health Services and continues within its Texas Resiliency and Recovery model of care. Since specific funding for peer initiatives is absent in the DSHS model, this project enhances the Peer Services model by specifically funding additional peer positions to more effectively meet consumer needs across the service area.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:
IT-10.1 Quality of Life.

This outcome is important to the RHP since improvements in this measure correlate to increased time in a regular community setting versus seeking help through the emergency department or

state hospital. When patients with behavioral health issues cannot get timely evaluations and care through a Local Mental Health Authority, they will likely visit a local emergency department. AHRQ reports that one in eight of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a substance abuse problem. Nearly 41% of these mental disorder and/or substance abuse-related visits resulted in hospitalization.[281] Many patients reporting improved QOL ratings may also be diverted from emergency departments if an immediate peer support intervention were available. The outcome also reflects any impact peer support services will have in ensuring patients remain in the community. Expansion of the peer provider program can foster recovery having a subsequent improvement on an individual's health overall well-being. Peer Service Provision is identified as a clinical best practice by the Texas Department of State Health services. Certified Peer Specialists are trained using a curriculum developed by the Appalachian Consulting Group, the leading provider of Peer Specialist training in the United States. Non-degreed, certified Peer Specialists can provide engagement and rehabilitative services which were previously limited only to degreed professionals. The resulting impact is that a peer provider network represents valuable clinical interventions at a lower cost to mental health authorities. In a 2004 research review, the Psychiatric Rehabilitation Journal noted studies showing little difference in outcomes resulting from professional versus nonprofessional (peer) providers. Other studies reviewed in this journal showed a decrease in hospitalizations and shorter hospital stays for clients connected to peer interventions.[282] Given the consistent findings of decreased hospitalization and shortened length of stay combined with the low cost of utilizing paraprofessionals and self-help groups, peer provided services are likely to result in cost savings. A 2008 policy briefing at the National Conference of State Legislatures described an expansion of the health care system through using Community Health Workers (including peer service provision). This briefing described current research which found the Community Health Worker model to be cost-effective, resulting in improved health, more preventive and primary care visits as opposed to urgent care, and fewer hospitalizations.[283] The expected improvement milestone for DY4 is to see improvement in quality of life, comparing assessments at three months with assessments at six months, as measured by the ANSA for 5% of adults receiving peer support services in Wise County. The milestone increases to 10% for DY5.

Relationship to Other Projects:

[281]Statistical Brief #92. Health care Cost and Utilization Project (HCUP). July 2010. Agency for Health care Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.
[282]Solomon P. (2004). Peer Support/Peer Provided Services: Underlying Processes, Benefits, and Critical Ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392-401.
[283]Goodwin K (2008). Community Health Workers: Expanding the Scope of the Health Care Delivery System. *Presentation to National Conference of State Legislators, 2008 Policy Brief.*

This Peer Support implementation project is related to project 127373205.1.2 Improve access to specialty care (psychiatric open access), in that it provides access to a service that would otherwise require a long wait or not be available in Wise County.

The Project relates to 127373205.1.1 Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (substance abuse expansion), in that it also provides a behavioral health service in an area that currently has very limited access to the service.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
Texas Health Harris Methodist Hospital Azle (127304703.2.1)

The target population for this project is Adults who meet diagnostic service eligibility requirements per our contract with the Department of State Health Services (adults with major depression, bipolar disorder, schizophrenia). Part of this eligibility includes geographic location limited to Wise County. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. We do not believe the project duplicates another provider's intervention for the same target population.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:
We applied a benefit-cost ratio of $3.71 per dollar invested. The closest studies relating to valuation of peer support programs came from Sari et al. (2008)[284] who found the benefit-cost ratio for a peer support program related to preventing adolescent suicide was $3.71 for each dollar invested. Kuyken et al., (2008)[285] in another peer-support program for prevention of adolescent suicide, found a benefit cost ratio of $43 for each dollar invested for Native American Youth. The average benefit cost ratio between these two studies is $23.36; however, since our target population contains little or no Native American representation, we chose the conservative amount of $3.71.

[284]Sari, N., de Castro, S., Newman, F.L., & Mills, G. (2008). Should we invest in suicide prevention programs? *The Journal of Socio-Economics 37 (2008),* 262–275.
[285]Kuyken, W., Byford, S., Taylor, R. S., Watkins, E., Holden, E., White, K., . . . Teasdale, J. D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression.*J Consult ClinPsychol, 76(6)*, 966-978.

127373205.2.1	*2.18.1*	*2.18.(A-I)*	***Implement whole health peer support (Peer Support).***
The Helen Farabee Center/ Wise County			*127373205*
Related Category 3 Outcome Measure(s):	*127373205.3.3*	*3.IT-10.1*	*Quality of Life (Peer Support)*

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: baseline of 0 peers trained in Whole Health peer support with a goal of 100% Data Source: Training records Milestone 1 Estimated Incentive Payment:$76,326 **Milestone 2** [P-4]: Select and implement a health risk assessment (HRA) tool Metric1 [P-4.1]: Number of HRAs completed by consumers Baseline/Goal: baseline of 0 consumers who have completed the HRA tool with a goal of 60 Data Source: Internal data base Milestone 2 Estimated Incentive Payment:$76,326	**Milestone 3** [P-5]: Identify health risks of consumers with serious mental illness Metric 1 [P-5.1]: Number of consumers identified with modifiable health risks Baseline/Goal: To determine the number of consumers with modifiable health risks so that Whole Health services can be offered and provided Data Source: Internal data base Milestone 3 Estimated Incentive Payment: $81,924 **Milestone 4** [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-6.1]: Number of participants receiving peer services Baseline/Goal: Baseline of 0 participants receiving services and goal of 30. Data source: Internal records and clinical records Metric 2 [P-6.2]: Number and quality of person centered wellness plans Baseline/Goal: Baseline of 0 participants receiving services and goal of 30, each with a wellness	**Milestone 5** [I-18]: Health Outcomes Metric 1 [I-18.1]: Improvements in standardized health measures for consumers who participate in whole health peer support Numerator: The number of people who participate in whole health peer support and experience improvement in standardized health measures Denominator: The number of people who participate in whole health peer support in the RHP Sites. Goal: Improved standardized health measures for at least 50% of identified participants. Data Source: Project Data; Medical Record Data; Participant Surveys Milestone 5 Estimated Incentive Payment:$175,248	**Milestone 6** [I-18]: Health Outcomes Metric 1 [I-18.1]: Improvements in standardized health measures for consumers who participate in whole health peer support. Numerator: The number of people who participate in whole health peer support and experience improvement in standardized health measures Denominator: The number of people who participate in whole health peer support in the RHP Sites. Goal: Improved standardized health measures for at least 60% of identified participants. Data Source: Project Data; Medical Record Data; Participant Surveys Milestone 6 Estimated Incentive Payment: $169,293

127373205.2.1	***2.18.1***	***2.18.(A-I)***	***Implement whole health peer support (Peer Support).***
The Helen Farabee Center/ Wise County			*127373205*
Related Category 3 Outcome Measure(s):	*127373205.3.3*	*3.IT-10.1*	*Quality of Life (Peer Support)*

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)**
	plan meeting Whole Health program criteria. Data Source: Internal records and clinical records Milestone 4 Estimated Incentive Payment: $81,923		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $152,651	Year 3 Estimated Milestone Bundle Amount: $163,847	Year 4 Estimated Milestone Bundle Amount: $175,248	Year 5 Estimated Milestone Bundle Amount: $169,293
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$661,039			

Project Option 2.16.1 – Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients Regionally (Virtual Psychiatric Consultation)

Unique Project ID: 127373205.2.2 (Pass 2)
Performing Provider Name/TPI: Helen Farabee Centers/127373205

Provider: The Helen Farabee Center consists of 9 clinics in north-central Texas serving 19 counties across 16,705 square miles and a population of 318,665. The Helen Farabee Center is a Community Mental Health/Intellectual & Developmental Disability authority/provider. The Center serves primarily indigent clients and roughly 30% of them have Medicaid.
Intervention: The project expands our current contract for telemedicine services in Wise County by providing psychiatric telephone consultation to physicians seeing patients in primary care settings. This is a new initiative.
Need for the project: The projects address regional needs identified through a needs assessment. Those needs are: CN.4 Lack of access to mental health services; CN.5 Insufficient integration of mental health care in the primary care medical care system; CN.7 Need to address geographic barriers that impede access to care and; CN.11 Need for more care coordination.
Target population: The target population are patients presenting at primary care facilities with mild to moderate psychiatric symptoms or conditions for which the primary physician desires consultation via psychiatrist to inform diagnosis, treatment, and/or referral options. The estimated number of patient served will be determined during DY2 per Milestone 1. The project represents a needed service that is currently absent in the identified service area and one that can be provided at low or no cost to Medicaid/ Indigent recipients.
Category 1 or 2 expected patient benefits: The benefit of Milestones 1-6 are the implementation of a psychiatric consultation model available to enrolled primary care physicians who report satisfaction with the service. The benefit fulfills the project's purpose by providing psychiatric guidance to participating primary care providers. A very rough estimate of patient impact would be 128 per year. There is no past utilization of telemedical psychiatric consultations upon which one can accurately base utilization. The analyses conducted in DY2 are designed to determine the number of primary care settings, potential number of patients served, and the estimated number of psychiatric consults to be performed.
Category 3 outcomes: The benefit of Category 3 milestones 1 and 2 is having local stakeholders inform the planning of the project and review the findings, lessons learned and best practices. This is related to the purpose of the project which is to ensure that local providers find the service relevant and useful. The benefit of Category 3 Improvement Targets 1 and 2 is that they set goals for having the majority of enrolled providers actually using the service.

Project Option 2.16.1 – Provide virtual psychiatric and clinical guidance to all participating primary care providers delivering services to behavioral patients Regionally (Virtual Psychiatric Consultation)

Unique Project ID: 127373205.2.2 (Pass 2)
Performing Provider Name/TPI: Helen Farabee Centers/127373205

Project Description:

The project expands our current contract for telemedicine services in Wise County (ZIP codes 76431, 76225, 76234, and 76073) by providing psychiatric telephone consultation to physicians seeing patients in primary care settings. The target population is patients presenting at primary care facilities with mild to moderate psychiatric symptoms or conditions for which the primary physician desires consultation via psychiatrist to inform diagnosis, treatment, and/or referral options. A rough estimate of the number of patients to potentially benefit from consultation would be 128 per year. The project fits within the project area since it provides for immediate access to psychiatric consultation in primary care to enhance and improve treatment for individuals with behavioral health conditions.

Goals and Relationship to Regional Goals:

Project Goals:

The project goals include establishing an infrastructure and the clinical expertise to provide remote psychiatric consultation; determining the location of primary settings with a high number of individuals with behavioral health disorders; assessing applicable models of deploying virtual psychiatric consultation; building the infrastructure needed to connect providers to the virtual psychiatric consultant; ensuring psychiatric consultation services are available 24 hours a day; identifying disciplines within primary care settings that could benefit from remote psychiatric consultation; providing outreach and communicating protocols to medical personnel in primary care settings who need telephonic behavioral health expertise; developing and implementing data collection and reporting standards; and finally, reviewing the impact on access to telephonic psychiatric consults and identifying how the model can improve. The project represents an innovative way to provide psychiatric resources to a primary care setting that has historically lacked them.

This project meets the following Regional goals:

Regional goals are in accordance with CMS' triple aim of right service, right setting, right time. This project provides virtual psychiatric consultation for primary care physicians who conduct routine mental health inquiries as opposed to delaying psychiatric interventions or possibly resulting in crisis-oriented services (right service). The services are available at any primary care

access point, eliminating the need for patients to travel to other clinics (right setting). Finally, the services are provided at the right time, which is immediately when the primary physician requests the consultation in order for that physician to begin treatments quickly if indicated (right time). This project improves patient experience by providing their primary care physicians with timely access to psychiatric consultation. It improves health by creating a system that is able to begin treatment sooner. It is designed to reduce costs by using alternative and efficient routes of access to psychiatric consultation and by providing care designed to integrate primary and psychiatric interventions.

Challenges:

The performing provider as well as primary care physicians in the Region face the challenge of meeting the growing demand for psychiatric specialty services in an efficient, cost-effective, and consumer-friendly way. This project addresses those challenges by providing an efficient means of accessing psychiatric guidance that allows the primary physician to provide more comprehensive care without unnecessary referrals. The cost associated with telephonic psychiatric consultation is less than those associated with full referrals for psychiatric evaluations.[286] Additionally, this consultation model is consumer-friendly in that it allows a patient to be treated in one setting or by preferred providers rather than receive care in multiple and potentially disconnected settings.

5-Year Expected Outcome for Provider and Patients:

The five-year goal is to have an established and effective virtual psychiatric consultation system with enrolled primary care physicians who regularly use the system and report being satisfied with it.

Starting Point/Baseline:

There are currently no virtual psychiatric consultation systems available to primary care physicians in Wise County.

Rationale:

A significant proportion of emergency department visits include patients who have either primary or concurrent behavioral health issues. AHRQ reports that one in eight of 95 million emergency department visits involved people with a mental health disorder. A quarter of these mental health disorders involved a substance Abuse problem. Nearly 41% of these mental disorder and/or substance abuse-related visits resulted in hospitalization.[287] The prevalence of behavioral health issues is not limited to emergency department presentation. The American

[286] Worth J L (2003). Benefits of an outpatient psychiatric teleconsultation unit: results of a 1-year pilot. *Primary Care Companion, Journal of Clinical Psychiatry*, *2003*, *5*(2), 80-84. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC353041/.

[287] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

Psychological Association reports data compiled by an independent actuarial firm showing that up to two-thirds of people who need behavioral health treatment are first seen in primary care settings, yet only 12.7% receive even minimally adequate treatment there.[288] A number of primary care physicians report perceiving the need for addressing behavioral health conditions in a primary care setting, and collaborative models of care are considered helpful in that treatment.[289] Due to the shortage of psychiatrists in many rural areas, this form of collaboration requires new and innovative consultation systems. Studies have shown that collaborative care models can be successfully adapted for primary care clinics without on-site psychiatrists by using virtual technology.[290] This project was selected to meet that need in local primary care settings by providing virtual psychiatric consultation services.

Project Components:

All required components have been selected. Components (a) "Establish the infrastructure and 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.", (c) "Assess applicable models for deployment of virtual psychiatric consultative", (d) "Build the infrastructure needed to connect providers to virtual behavioral health consultation.", (e) "Ensuring staff administering virtual psychiatric consultative services are available to field communication from medical staff on a 24-hour basis.", (f) "Identify which medical disciplines within primary care settings (nursing, nursing assistants, pharmacists, primary care physicians, etc.) 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.", and (h) "Identify clinical code modifiers and/or modify electronic health record data systems to allow for documenting the use of telephonic behavioral health consultation." are considered critical steps in identifying the settings that would benefit from the psychiatric consultation and what infrastructure would be required to meet those needs. Components (i) "Develop and implement data collection and reporting standards for remotely delivered behavioral health consultative services." and (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

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[288] http://www.apa.org/monitor/2010/12/patient.aspx.

[289] Levine S. et al. (2005). Physicians' satisfaction with a collaborative disease management program for late-life depression in primary care. *General Hospital Psychiatry, 27*(6), 383-391. http://www.ncbi.nlm.nih.gov/pubmed/16271652.

[290] Fortney JC et al. (2007). A randomized trial of telemedicine-based collaborative care for depression. *Society of General Internal Medicine, 2007* (22), 1086-1093. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2305730/pdf/11606_2007_Article_201.pdf.

associated with expansion of the intervention(s), including special considerations for safety-net populations" represent the necessary data collection, evaluation, and reporting activities that will ensure the consultation system is having the intended effect.

Four process milestones were selected to track progress in creating a consultation service based on existing needs in the primary care setting. An initial needs assessment will be conducted to assess the demand on primary care providers from patients with behavioral health issues, and whether they would benefit from telephonic psychiatric consultations (P-1.1). Next, psychiatric consultation services will be designed to allow primary care physicians to access behavioral health expertise (P-2.1). Interested primary care settings will then be enrolled as eligible participants to receive consultative services (P-3.1). Finally, the consultative services will be continuously evaluated for improvement purposes (P-5.1). Improvement milestone I-9 was chosen to capture primary care provider satisfaction with virtual psychiatric consultative services. Improvement milestone I-8 was chosen to capture patient satisfaction with primary care providers who had access to psychiatric consultations.

Unique community need identification numbers the project addresses:

CN.4 Lack of access to mental health services,

CN.5 Insufficient integration of mental health care in the primary care medical care system

CN.7 Need to address geographic barriers that impede access to care

CN.11 Need for more care coordination

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

The project represents a less costly, more efficient method of obtaining a psychiatric consultation while allowing the primary physician to initiate psychiatric treatment concurrently with treatments for a presenting physical issue. This is a significant enhancement to primary care and represents a new way of integrating physical and behavioral health care in Wise County.

Related Category 3 Outcome Measures:

a. **IT-9.4 Other Outcome Improvement Target** which was modified to track the percentage of enrolled primary care settings that utilize the telephonic psychiatric consultation service

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

The related Category 2 project (telephonic psychiatric consultation) helps achieve this outcome by first designing a consultation model to meet the needs of the Region as determined by primary care provider survey. Providers are enrolled, utilize the consultation service, and are asked to provide feedback. The feedback is used to improve the system by increasing efficiency and usefulness. These Category 2 activities are designed to increase the percentage of enrolled providers who regularly use the consultation service. Having providers regularly use this consultation service is important, due to the rates at which patients present to primary care

settings with behavioral health disorders[291]. The Center served approximately 1000 unduplicated clients in Wise County in 2012. The APA estimates that as many as 2/3 of patients with a behavioral health issue will present first for care at a primary care clinic[292]. Based on the 1000 patients served, 660 (2/3) of them may have presented initially in a primary care setting. Ensuring primary care sites use available psychiatric consultation will have a direct impact on these patients.

Relationship to Other Projects:

N/A

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

This project will participate in the Region's Learning Collaborative activities. Please refer to Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of all participating provider projects for each collaborative.

Project Valuation:

The valuation methodology is based on an assumed gain of 0.335 Quality Life Years gained by using the proposed project. One quality life year is commonly estimated at $50,000. Assuming 15 clients were served in the program, the annual valuation is $251,250 ($50,000 x 0.335 = $16,750. $16,750 x 15 = $251,250). We used cost-utility analysis (CUA), which measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses Quality-adjusted life years (QALY) analysis combines health quality (utility) with the length of time in a particular health state. The benefits of the proposed program are valued based on assigning a value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. One study examined collaborative care intervention for multisymptom patients including depression, diabetes, and coronary heart disease (Keaton, 2012).[293] In this study, the effect of the intervention was 0.335 incremental life years gained. This can be considered a conservative gain given that the study focused on depression, which is likely to be the most prevalent and least intense behavioral health condition presented in primary care settings.

[291] Statistical Brief #92. Healthcare Cost and Utilization Project (HCUP). July 2010. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp.

[292] http://www.apa.org/monitor/2010/12/patient.aspx.

[293] Katon W, Russo J, Lin EH, Schmittdiel J, Ciechanowski P, Ludman E, Von Korff M. (2012). Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. *Arch Gen Psychiatry, 69(5),* 506-514.

127373205.2.2	***2.16.1***	***2.16.1.A*** ***2.16.1.B*** ***2.16.1.C*** ***2.16.1.D*** ***2.16.1.E*** ***2.16.1.F*** ***2.16.1.G*** ***2.16.1.H*** ***2.16.1.I*** ***2.16.1.J***	***PROVIDE VIRTUAL PSYCHIATRIC AND CLINICAL GUIDANCE TO ALL PARTICIPATING PRIMARY CARE PROVIDERS DELIVERING SERVICES TO BEHAVIORAL PATIENTS REGIONALLY (TELEPHONIC PSYCHIATRIC CONSULTATION)***
Helen Farabee Center			*127373205*
Related Category 3 Outcome Measure(s):	*127373205.3.4*	*IT-9.4*	*Other Outcome Improvement Target*

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 and primary care providers who could benefit from telephonic psychiatric consultation. Metric 1 [P-1.1]: Conduct needs assessment including items such as the following: Numbers of patients who could benefit from project (rough estimate is 128 annually); Numbers of PCP locations that could benefit from project (estimated over 200 medical clinics in Wise County); Description of expertise that PCPs have identified they lack and that would be most helpful if offered by a telephonic consultative service; Demographics, location, & diagnoses. Baseline/Goal: No needs assessment exists at baseline. Goal is to complete one needs assessment. Data Source: Project Documentation Milestone 1 Estimated Incentive	**Milestone 3** [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: There are no primary care settings currently enrolled at baseline. Goal is to enroll 10% of settings identified through needs assessment. Data Source: Project Documentation Milestone 3 Estimated Incentive Payment: $93,855 **Milestone 4** [P-5]: Evaluate and continuously improve psychiatric consultative services. Metric 1 [P-5.1]: Project planning and implementation documentation demonstrates Plan, Do, Study Act quality	**Milestone 5** [I-9]: Primary Care Provider Satisfaction with virtual Psychiatric Consultative Services. Metric 1 [I-9.1]: Percentage of Primary Care Providers reporting improved satisfaction with virtual psychiatric consultative services. Goal: 70% of primary care providers report satisfaction Data Source: Primary Care Provider Survey data. Milestone 5 Estimated Incentive Payment: $100,567.50 **Milestone 6** [I-8]: Improved consumer satisfaction with treatment. Metric 1 [I-8-1]: Percentage of people reporting satisfaction with treatment. Goal: 70% of primary care patients report satisfaction Data Source: Primary Care Patient Survey data.	**Milestone 7** [I-9]: Primary Care Provider Satisfaction with virtual Psychiatric Consultative Services. Metric 1 [I-9.1]: Percentage of Primary Care Providers reporting improved satisfaction with virtual psychiatric consultative services. Goal: 80% of primary care providers report satisfaction Data Source: Primary Care Provider Survey data. Milestone 6 Estimated Incentive Payment: $97,167.50 **Milestone 8** [I-8]: Improved consumer satisfaction with treatment. Metric 1 [I-8-1]: Percentage of people reporting satisfaction with treatment. Goal: 80% of primary care patients report satisfaction Data Source: Primary Care Patient Survey data.

127373205.2.2	***2.16.1***	***2.16.1.A*** ***2.16.1.B*** ***2.16.1.C*** ***2.16.1.D*** ***2.16.1.E*** ***2.16.1.F*** ***2.16.1.G*** ***2.16.1.H*** ***2.16.1.I*** ***2.16.1.J***	***PROVIDE VIRTUAL PSYCHIATRIC AND CLINICAL GUIDANCE TO ALL PARTICIPATING PRIMARY CARE PROVIDERS DELIVERING SERVICES TO BEHAVIORAL PATIENTS REGIONALLY (TELEPHONIC PSYCHIATRIC CONSULTATION)***
Helen Farabee Center			*127373205*
Related Category 3 Outcome Measure(s):	*127373205.3.4*	*IT-9.4*	*Other Outcome Improvement Target*

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)
Payment : $85,458 **Milestone 2** [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: No project plans exist at baseline. Goal is to complete a comprehensive project plan. Data Source: Project Documentation Milestone 1 Estimated Incentive Payment: $85,458	improvement cycles. Baseline/Goal: No project reports exist at baseline. Goal is to complete one initial Plan, Do, Study, Act improvement cycle. Data Source: Project Reports Milestone 4 Estimated Incentive Payment: $93,855	Milestone 6 Estimated Incentive Payment: $100,567.50	Milestone 6 Estimated Incentive Payment: $97,167.50

127373205.2.2	***2.16.1***	***2.16.1.A*** ***2.16.1.B*** ***2.16.1.C*** ***2.16.1.D*** ***2.16.1.E*** ***2.16.1.F*** ***2.16.1.G*** ***2.16.1.H*** ***2.16.1.I*** ***2.16.1.J***	***PROVIDE VIRTUAL PSYCHIATRIC AND CLINICAL GUIDANCE TO ALL PARTICIPATING PRIMARY CARE PROVIDERS DELIVERING SERVICES TO BEHAVIORAL PATIENTS REGIONALLY (TELEPHONIC PSYCHIATRIC CONSULTATION)***
Helen Farabee Center			*127373205*
Related Category 3 Outcome Measure(s):	*127373205.3.4*	*IT-9.4*	*Other Outcome Improvement Target*

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)
Year 2 Estimated Milestone Bundle Amount: ***(add incentive payments amounts from each milestone):*** **$170,916**	**Year 3 Estimated Milestone Bundle Amount: $187,710**	**Year 4 Estimated Milestone Bundle Amount: $201,135**	**Year 5 Estimated Milestone Bundle Amount: $194,335**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $754,096			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.13.1 – Design, implement, and evaluate research-supported and evidence-based interventions tailored toward individuals in the target population (WRHS NTCH BH/SA Collaboration Project)

Unique Project ID: 130606006.2.1
Performing Provider Name/TPI: Wise Regional Health System / 130606006

Provider: WRHS is a health system licensed for 148 beds and NTCH is licensed at 38 beds. The service area is Wise, Montague, Jack, and parts of Tarrant County. This service area holds 64,000 residents and is expected to grow to 74,000 by 2017. In DY1 our health system's charges for providing care to our indigent population was $118.3M. These two hospitals are the only two in the county.
Intervention: This project will implement an intensive outpatient program for dual diagnosis of behavioral health and substance abuse. It is a new intervention.
Need for the project: This project is designed to fulfill the community need CN.4 Lack of access to mental health services. Currently there is a very high ratio of population to mental health specialists in Wise County, 19,495:1, so the need is very strong.
Collaboration: This project will be a collaborative project involving Wise Regional Health System and North Texas Community Hospital in Bridgeport. Wise Regional will be the main provider of resources (case managers, behaviorists) and thus will be the Performing Provider. Interventions and education will take place in the ER of both facilities. This will be transformative because there will be communication and coordination of care from both units. The IOP program will be available to all eligible residents of Wise County. Being the first of its kind of program, this project is also transformative by providing dually diagnosed residents a way to seek treatment.
Target Population: The target population is the Wise County residents with BH/SA, uninsured and Medicaid. -The number of patients exposed to education and intervention will be in DY1 3281, DY2 3300, DY3 3400, DY 3264, DY5 3145.
Expected patient benefits: Most of the patients coming through this program will be Medicaid eligible or uninsured.
Category 1 or 2 expected patient benefits: The selected milestones will walk WRHS through the implementation process by providing employees, methods for the design, plan, implementation and measure of community- based specialized interventions. They meet the need of adding mental health specialists and ensuring improvement in the target population.
Category 3 outcomes: IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate, the goal of the project is to reduce this rate through the implementation of an IOP model using a proven evidence-based treatment approach. OD-10, IT-10.1 Quality of Life, with patient survey utilizing SF-36 to determine positive outcomes of symptom improvement and increased functioning that will ultimately promote wellness and resiliency due to adherence to treatment and improve overall community recovery. Both of these measures will illustrate the effectiveness of the project's implementation and reduce cost to the health care delivery system.

Project Option 2.13.1 – Design, implement, and evaluate research-supported and evidence-based interventions tailored toward individuals in the target population (WRHS NTCH BH/SA Collaboration Project)

Unique Project ID: 130606006.2.1
Performing Provider Name/TPI: Wise Regional Health System / 130606006

Project Description:
Project Area: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting
Project Intervention: Design, implement, and evaluate research-supported and evidence-based interventions tailored toward individuals in the target population.
Wise Regional Health System (WRHS) and North Texas Community Hospital (NTCH) propose to collaborate to design and implement an Intensive Outpatient Program (IOP) for the target population of Behavioral Health/Substance Abuse (BH/SA) utilizing a disease model with evidence-based therapies and services. The major causes for disability in the U.S. are changing from medical to social and behaviorally related conditions, increasingly involving complications such as substance abuse, violence, and poor mental health. [1] Implementing a community-based IOP will provide better outcomes for patient care to address the increasing percentages of abuse and dependency on alcohol, illicit drugs, and prescription drugs and address co-occurring mental health issues.[2] These outcomes will be documented and meet the goals of the project. The program will also focus on hiring and retention of qualified mental health professionals to address the Health Professional Shortage Area in Wise County as reported by the U.S. Department of Health and Human Services.[3] Outpatient services will impact the use of higher level of care services in the ED, BH/SA Inpatient Facilitates, and decrease the need for legal interventions. A reduction of use in these facilities will be county-wide and will impact both WRHS and NTCH. There will be better patient outcomes in least restrictive appropriate setting[4], while patients remain a productive part of the workforce in their home community. A formal network with other providers will be established to provide care coordination. The number of patients exposed to education and intervention will be in DY1 3281, DY2 3300, DY3 3400, DY 3264, DY5 3145.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of this project is to reduce admission rates for substance abuse and behavioral health-related diagnosis into area hospitals acute care and Emergency Departments while improving the quality of life of the patients as exhibited by results of evidence-based surveys (i.e. SF-36). This project will develop, redesign and expand an IOP that meets the needs of persons with mental illness, substance abuse, poly substance abuse and dual diagnosis. The target population will have abroad based continuum of evidence-based services including Cognitive Behavioral Therapy,[5] psychiatric and medication services, and nutritional counseling that addresses their needs in one location. Services will also focus on co-occurring issues (i.e., use of medications,

self-medicating, symptom management) that is not addressed in self-help or traditional outpatient settings. More costly medical and legal services should be impacted when this target population has access to community-based services that are more appropriate and provide a holistic approach to treatment. Data will be collected and analyzed from both hospitals to look for trends, unduplicated and duplicated services, and opportunities for policy and intervention changes. An inquiry and referral system will be developed through the EDs and existing social workers at both hospitals and by the new case management position that will coordinate services between the facilities and within the community.

Currently, no programs provide IOP to the target population in this county. Our proposed intervention will focus on people who are high users of more costly services, are disabled, and are usually from a lower socioeconomic level. Out target population is residents of Wise County, 18 and older, who are covered under Medicaid, Medicare, dually eligible, insured and uninsured with co-occurring behavioral health and substance abuse illnesses. Treatment will include early intervention, relapse prevention, crisis and symptom management, and patient/family education.

Program participants will receive an initial evaluation and monthly follow-ups by the psychiatrist, individualized treatment planning, and therapeutic interventions by masters and specialty level staff. They will receive a minimum of three groups a day for three days a week for a period of 90 days to six months, based on treatment team recommendations and authorization by the psychiatrist in evidence-based therapy. Another goal is to increase the overall quality of life for patients and their families with treatment in their home community which allows them to continue employment and be productive citizens in their community. The service(s) will provide a continuum of care that will have an impact across medical, psychiatric, and substance abuse arenas.

This project meets the following Regional goals:
The goal is to prevent unnecessary use of services in settings such as the ED, urgent care, and the judicial system and reduce the overall admission rate for persons with BH/SA, which this project contributes to.

Challenges:
A challenge will be to coordinate services between the two hospitals and develop outreach services within the community in non-clinical settings. Outreach will be conducted by WRSH staff that focuses on education and advocacy for this target population in order to reduce stigma, and improve fragmented, episodic care. This project was selected due to the relevancy in our Region and Texas for BH/SA services with the increasing percentages of substance abuse/dependency and co-occurring mental health issues.[6] The Community Health Needs Assessment identified BH/SA and insufficient access as issues affecting population health. If services for this population are not diverted to least restrictive and less costly services, the outcome is negatively characterized by additional services and costs in acute care settings, law enforcement, and the judicial system. To address Wise County as a Health Professional Shortage

Area, WRHS will focus on hiring and retention of qualified mental health and substance abuse staff.[3] A treatment challenge will be to provide Suboxone treatment in IOP while ensuring patients' adherence to intensive therapy protocol and random drug screens. Other treatment challenges associated with the high-risk population, including relapse and recidivism, will be addressed with individualized treatment plans, crisis plans, family outreach, coordination with other service providers, and case management to address medication costs and other barriers to treatment. Data will be critical in tracking trends in order to have appropriate planning, effective interventions and forming policy decisions.

5-Year Expected Outcome for Provider and Patients:
This project will provide support for the patients, hospitals, physicians and the community by providing outpatient treatment for persons with BH/SA as an alternative to inpatient medical and psychiatric services, state hospital admissions, and incarceration in city and county jail within Wise County for single and dually diagnosed persons. It will improve a referral system that allows treatment recommendations and ongoing consultations with a psychiatrist and clinical staff to ensure continuity of care, care coordination and improved provider communications. A partnership could also be developed with MHMR and the judicial system for sliding scale services based on the fees established by DSHS. The projected impact over five-year period includes ongoing evaluations for quality improvements to ensure enhancement of outcomes and core measures in order to reduce admissions and the use of unnecessary services by 7.5% at the end of DY5 and increase IOP census from 23-40 by DY5. Functional status will increase in DY4 by 33% and in DY5 by 50% as the improvement milestone. This will result in a significant savings to the local health care system because of the impact of this project from both hospitals.

Starting Point/Baseline:
In the development of this program additional evidence-based services for substance abuse will be implemented.[4] Baseline data will be developed from October 1, 2013 to September 30, 2014 in DY3 on admissions, quality of life, and functional status using evidence-based strategies. In DY2, two licensed professional counselors, one licensed chemical dependency counselor, and one tech will be hired and trained by WRHS. They will begin implementing evidence-based interventions including cognitive behavioral therapy and relapse prevention. One case manager will be hired and trained by WRHS to coordinate referrals between the two hospitals and within the community at large. Patients will also have access to a psychiatrist for initial psychiatric evaluation and monthly follow-ups including medication services, and earlier interventions for substance abuse, behavioral and medical health needs. We will begin to assess need, size and characteristics to expand services to include nutritional counseling and healthy lifestyle(s) in order to address behavioral and medical health.

Rationale:

Currently, there is a lack of intensive outpatient BH/SA services that also have access to psychiatric services. Discharge data from both hospitals within Wise County show diagnosis of BH/SA-related disorders from acute medical and psychiatric services from October 2011 to September 2012 to be 3,281. In 2011 the judicial system had 252 cases and to date in 2012 106 cases disposed that were substance abuse-related including drug sale and manufacturing, drug possession, and felony DWI. This data reflects state and national statistics on BH/SA. As reported by the U.S. Department of Health and Human Services, mental health services, Wise County is considered a Health Professional Shortage Area (HPSA).[3] The Community Health Needs Assessment reported the need for additional mental health professionals for Wise County with a benchmark ratio of 19,495:1 and Texas ratio at 3,609:1. The Community Health Needs Assessment Stakeholder survey Regional Summary respondents reported that behavioral health, substance abuse, and insufficient access to care were top issues affecting population health. Overall, the goal is to increase access to services, provide evidence-based treatment for this specialized patient population and provide case coordination and continuity of care in the medical and judicial sector for this population.

Project Components:
All five required core components in 2.13.1 (a-e) will be addressed. Assessing size, characteristics, and needs of the population based on evaluation of data from discharges from acute care, prevalence of diagnosis, forensic encounters, number of patients enrolled in IOP, and compliance with treatment and related services. The community-based program will be designed with a range of supports. There will be ongoing review of literature/experience throughout the project to assess negative and positive outcomes and relevancy of evidence-based interventions. A project evaluation plan will be developed with qualitative metrics, design and implementation of program, and assessing impact of interventions. The functional status of the patients will be assessed utilizing standardized assessments such as the GAF, ANSA, patient surveys and encounter records.

Milestone P-2 was chosen to design a broad community-based program, hire four staff to provide specialized interventions including cognitive behavioral therapy, substance abuse services, and nutritional counseling and psychiatric and medication services for the BH/SA population. There will be flexibility to add interventions as needs are identified through an ongoing program CQI process.
P-2.1 Design of this project will be based on evidence/experience (e.g., citations throughout project) that meet the project goals and will be documented for this metric. The improvement milestone I-5 will be implemented in order to have an outcome including functional and symptom improvement utilizing standardized assessments (e.g., ANSA).[7] These were chosen to meet the goals of the project by improving access, and implementing care coordination and continuity of care in the medical and judicial sector. It will also support Category 3 as BH/SA persons represent 24% of the potentially preventable admissions.[8]

Unique community need identification numbers the project addresses:

- CN.4 – Lack of access to mental health services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new initiative to address substance abuse and co-occurring illnesses in an expanded IOP model using a proven evidence-based treatment approach. We have not received any other federal funding for this program.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
Outcome Measure 1: IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Stand-alone measure) is based on data from EMR at WRHS and NTCH.
Performing provider should report on both categories below:
1. One for BH/SA as the principal diagnosis; The ranges/intervals/brackets of BH/SA codes as principal secondary diagnosis as outlined in the project definitions for specific ICD-9 CM categories.A second category in which a significant BH/SA secondary diagnosis is present. A list of the ranges/intervals/brackets of BH/SA codes as secondary diagnosis as outlined in the project definitions for specific ICD-9 CM categories.

The project priority is to reduce unnecessary services in specific settings, reduce costs, and provide services in the least restrictive most appropriate setting. The goal is a 7.5% reduction in BH/SA admission rates to WRHS and NTCH in Wise County by the end of DY5. When compared to the residents over the age of 18 in Wise County this equates to .55% of the population. This outcome was chosen because the project will reduce admissions into the acute care setting for patients across Wise County with both primary and secondary diagnoses related to behavioral health or substance abuse.

Outcome Measure 2: OD-10, IT-10.1 Quality of life with patient survey utilizing SF-36 to determine positive outcomes of symptom improvement and increased functioning that will ultimately promote wellness and resiliency due to adherence to treatment and improve overall community recovery. The goal is to show an improvement in quality of life scores in at least 50% of patients.

Relationship to Other Projects:
This project relates to the Category 4 reporting requirement: RD-1.3Behavioral Health and Substance Abuse Admission Rate.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Our valuation approach is consistent with the method within our RHP. We have taken the values of both outcomes from this project and used those to determine an overall value for all four categories on this project. We have estimated our reduction of BH/SA admissions with either primary or secondary diagnosis at 7.5%, or 246, from both hospitals by the end of the Waiver period. We take 246 and apply a value of $7,100 per admission to give us an annual value of $1,721,718 in cost savings. We then apply this for five-years to get a total outcome value of $8,733,000. The value is then distributed proportionately across the categories and demonstration years according to the allocation described in the Funding and Mechanics Protocol. The value of $7,100 per BH/SA admission was chosen by our RHP using data from AHRQ documented in the Healthcare Cost and Utilization Project.

The additional value comes from the second outcome, improvement in Quality of Life. The second value was provided by our RHP which suggests a quality-adjusted life year for patients with co-occurring mental health and substance abuse to be a factor of 0.335 X $50,000 for each patient. This results in a value of $16,750 per patient who completes the IOP. This value comes from a factor that used research to place a value on the benefit from improved quality of life. This calculation takes into consideration current and future societal economic impacts of this proven improvement in quality of life. We used this QALY factor and multiplied it by our anticipated DY5 number of patients showing an improvement in quality of life measures then multiplied times five-years. This results in 0.335 X $50,000 X 36 patients times five-years = $3,015,000.

When combining these figures together we get a total value of $8,510,409.95 for this project.

www.samhsa.gov/data/NSDUH/2k10State/NSDUHsea2010/Index.aspx

2942 Texas department of State Health Services, Texas laws relating to Mental Health, 18th Edition. October 2011. Austin, Texas

3 Nathan, P.E., & Gorman, J.M. (2002). A Guide to Treatments That Work, Second Edition. New York: Oxford University Press

4 Centers for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment "Treatment Improvement Protocol (TIP) 47

[5] Evidence-Based Effectiveness of a Private Practice Intensive Outpatient Program With Dual Diagnosis Patients. Edward A. Wise.Journal of Dual Diagnosis,
6:25–45, 2010

6 Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal Year 2010, Texas Health and Human Services Commission (2012)

[294] Institute for Health care Improvement: *Improved Care for Patients with Congestive Heart Failure;* Institute for Health care Improvement: *Improving Care for Patients with Heart Failure — Focus on Ambulatory Care* Institute for Health care Improvement: *Transforming Care at the Bedside How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure*

130606006.2.1	***2.13.1***		DESIGN, IMPLEMENT, AND EVALUATE RESEARCH- SUPPORTED AND EVIDENCE-BASED INTERVENTIONS TOWARDS INDIVIDUALS IN THE TARGET POPULATION	
Wise Regional Health System				130606006
Related Category 3 Outcome Measure(s):	*130606006.3.1* *130606006.3.2*	*IT-2.4* *IT-10.1*	IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate 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-2]: Design community-based specialized interventions for target population to include specialized Cognitive Behavioral Therapy, psychiatric and medication services, and substance abuse services, and nutritional counseling. Metric 1 [P-2.1]: Project plans which are based on evidence/experience and which address the project goals Baseline/Goal: Establish project documentation, baseline data, hire and train staff Data Source: Documentation of plans Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,040,672 **Milestone 2** [P-X]: Designate/hire personnel or teams to support and/or manage the project/intervention. Metric 1 [P-X.1]: Hire personnel to facilitate IOP Program.	**Milestone 3** [P-2]: Design community-based specialized interventions for target population that have flexibility to expand services for nutritional counseling. Metric 1 [P-2.1]: Project plans which are based on evidence/experience and which address the project goals and the addition of nutritional counseling Baseline/Goal: Establish project documentation, baseline need for nutritional counseling and train staff, patient enrollment in IOP Data Source: EMR from WRHS and NTCH, Psychiatric evaluations and re-evaluations, treatment plans and treatment plan reviews, GAF ANSA or standardized instrument Milestone 3 Estimated Incentive Payment: $1,135,318 **Milestone 4** [P-X]: Establish baseline data for functional status. Metric 1 [P-X.1]: Establish and implement tool to assess functional status.		**Milestone 5** [I-5]:Functional Status Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g., ANSA, etc.) Goal: 10 percentage functional status improvement, increase census to 30 Data Source: patient enrollment in IOP, GAF ANSA or standardized instrument Milestone 5 Estimated Incentive Payment: $1,138,618 **Milestone 6** [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 a. Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement	**Milestone 7** [I-5]: Functional Status Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g., ANSA, etc.) Goal: 20 percentage functional status improvement, increase census to 40 Data Source: patient enrollment in IOP, GAF, ANSA or standardized instrument Milestone 5 Estimated Incentive Payment: $940,598 **Milestone 8** [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 a. Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement

130606006.2.1	***2.13.1***		DESIGN, IMPLEMENT, AND EVALUATE RESEARCH- SUPPORTED AND EVIDENCE-BASED INTERVENTIONS TOWARDS INDIVIDUALS IN THE TARGET POPULATION	
Wise Regional Health System				130606006
Related Category 3 Outcome Measure(s):	*130606006.3.1* *130606006.3.2*	*IT-2.4* *IT-10.1*	IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate 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)**
Baseline/Goal: Establish documentation, hire staff Data Source: HR Documents Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,040,672	Baseline/Goal: Establish documentation of tool and its use. Data Source: Program documents, tool scores Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,135,318		(e.g.,, how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Goal: Identify and improve project planning using PDSA to improve metrics on monthly dashboard Data Source: Dashboard Milestone 6 Estimated Incentive Payment: $1,138,618	(e.g.,, how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Goal: Identify and improve project planning using PDSA to improve metrics on monthly dashboard over DY4 Data Source: Dashboard Milestone 8 Estimated Incentive Payment: $940,598
Year 2 Estimated Milestone Bundle Amount*:* $2,081,344	Year 3 Estimated Milestone Bundle Amount: $2,270,635		Year 4 Estimated Milestone Bundle Amount: $2,277,236	Year 5 Estimated Milestone Bundle Amount: $1,881,195
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $8,510,410				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option - 2.12.1 - Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions

Unique Project ID: 130606006.2.2 (Pass 3)
Performing Provider Name/TPI: Wise Regional Health System / 130606006

Provider: WRHS is a health system that serves Wise, Montague, Jack, Parker and parts of Tarrant County. This service area holds 64,000 residents and is expected to grow to 74,000 by 2017. WRHS is the only source for health care for specific services for Medicaid in the County. In DY1 our health system's charges for providing care to our indigent population was $118.3M.
Intervention: This project is designed to reduce 30 Day All Cause Readmissions and lower CHF admissions through coordinated care models involving transition coordinators, CHF nurses, cardiac rehab, and local cardiologists. This is a new initiative.
Need for the project: This project is designed to fulfill two unique community needs, CN.11 Need for more care coordination and CN.10 Overuse of emergency department (ED) services. All patients will be eligible to participate regardless of payor status.
Target Population: All WRHS inpatients and those with a diagnosis of CHF are the target population. It is estimated -32,265 patients will be served by the program over five years. This number comes from the program targeting every inpatient discharge for follow up on the Care Transitions program. This number of patients impacted per year will be estimated at the following DY1 5285, DY2 5814, DY3 6395, DY 7034, DY5 7738.
Expected patient benefits: The goal of this project is capture patients who may susceptible to PPAs and PPRs, many Medicaid and uninsured patients are included in this population, and coordinate their care with consideration to patient's individual barriers to access care, such as transportation and financial issues.
Category 1 or 2 expected patient benefits: The milestones and metrics selected for this project will initially develop a baseline, while assessing gaps in the current process. Then, these measures will allow for the expansion of the program through the addition of staff, training, networking with other providers, and the addition of software to increase the ability of WRHS to capture inpatient admissions and coordinate those patients' care accordingly.
Category 3 outcomes: The Category 3 measures selected are IT-3.1 All cause 30 day readmission rates and IT-2.1 Congestive Heart Failure rate (CHF). Through the implementation of a care coordination program both measures should decrease by 10% at the end of DY5, resulting in a reduction of health care costs (for the patient and the facilities) and an increase in quality of care.

Project Option - 2.12.1 - Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions

Unique Project ID: 130606006.2.2 (Pass 3)
Performing Provider Name/TPI: Wise Regional Health System / 130606006

Project Description:
Our Care Transitions project will involve changing the current concept of the hospital admission and discharge process. The current transition process provides an opportunity for both human and system errors. Such errors can be a contributing factor in the re-hospitalization of patients. We also will work with local cardiologist to reduce the number of CHF admissions into the hospital. Our transition program will address the issues surrounding these potential problems (Jack &Bickmore, 2011).

Our plan will address the patient's issues upon admission. We will use a CHF trained nurse and a social services staff member for this process. Our cardiac nursing staff will initiate discharge education and conduct CVD inflammation profile and risk on admission. Cardiac rehab, PT, and dietary services will also be involved in the process. The social services staff will consult with cardiac staff prior to discharge, discuss transportation needs, and evaluate patient's need for an assistance program including the use of medication and follow-up care. We plan for at least two full time nurse employees initially to act as Transition Coordinators (TCs) who will round on each patient. Discussions will focus on patient diagnoses and treatments during inpatient admission. TCs will coordinate with physicians regarding integration of patient concerns, post discharge plans and medications. TCs will discuss with patient and family questions regarding discharge diagnoses and education, and answer questions from patient and family pertinent to anticipated discharge. Post discharge TCs will contact patient at home and review discharge guidelines and assess the patient's understanding of diagnosis and medications through return verbalization. This will allow for nurse assessment of possible discrepancies and misunderstanding prior to an issue becoming a problem. Nurses will assess telephonically patient understanding of possible problems post discharge and what to do if problem arises. TCs will verify post discharge appointments have been made, or they will make appointments for the patient with consideration to the patient's individual barriers to access care, such as transportation and financial issues, through use of Wise County Community Health Clinic. This facility uses sliding scale fees for patients who lack available financial resources for follow up visits with general practitioners. The number of patients impacted per year will be estimated at the following DY1 5285, DY2 5814, DY3 6395, DY 7034, DY5 7738.

Goals and Relationship to Regional Goals:

Project Goals:

The project goals are to identify the most frequent adverse events that occur after a hospitalization and their causes. We wish to reduce 30 Day All Cause Readmissions by 10% at the end of the waiver period and lower CHF admissions by 10% over baseline. It has been determined that 20% of discharges result in adverse patient events (Bond, 2011).

This project meets the following regional goals:
This project addresses a problem that occurs in healthcare facilities nationwide. The lack of communication between providers as well as between patient, physician and family contributes to confusion and misunderstanding.

Challenges:
Most of the challenges faced by TCs revolve around interdisciplinary issues. For instance, in the Emergency Department (ED), patients may be readmitted as inpatients without meeting inpatient criteria. In addition, patients who are already inpatient have issues related to inappropriate or early discharge, additional contributors to readmissions and admissions beyond 30 days. Patients who experienced discharge difficulties related to physician or case management services were six times more likely to be re-hospitalized (Bond, 2010).

The project would address these challenges through training and designating ED case managers to address criteria of the inpatient admission which would help decrease the readmission rate. The TCs would also positively affect the lack of communication between physicians by acting as a liaison between the parties. The ED case manager may also serve as a reference for physician to address difficulties related to discharge.

5-Year Expected outcome for Provider and Patients:
The five-year expected outcome is to improve the percentage of patients receiving TC services to 90% through early identification of possible needs as evidenced by historical information in the TC registry and database. In addition, WRHS anticipates that the implementation of a care transitions program will reduce our 30 Day All Cause Readmission rate by 10% over baseline. We also wish to reduce our CHF related admission rate by 10% through the coordination of care beginning with admission and continuing through the post discharge phase.

Starting Point/Baseline:
Our admissions in 2011 were 5285 with 295 30 day all-cause readmissions for a total readmission rate of 5.6%. However, with the increase in population and the addition of new services, that rate may increase to as much as 6000.

We currently have one transition coordinator, who started this position June 2012. Her focus has been on the 4th Floor Medical unit and the 5th floor Surgical unit. Starting in June, our TC saw 63.5% or 228 of the inpatients, 71.4% or 302 in July, 61.7% or245 in August The number of CHF related admissions from October 1, 2011 through September 30, 2012 was 138.

Rationale:

Projects should be data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance and/or disparity that is important to the population (i.e. a provider selecting a project to implement a chronic care model for diabetes should discuss local data such as prevalence of diabetes in the community and rates of preventable admissions for diabetes and describe why diabetes is an important health challenge for the community). With this in mind, please develop narratives that address the following:

The RED program has shown effectiveness in reducing certain admissions (Jack &Bickmore, 2011). For instance, if patients don't understand their disease, the importance of follow-up visits to the primary care physician and why they should follow their treatment plan, then they are destined to suffer a decline in status and subject to be readmitted with the same diagnosis. An expanded care transitions program with staff to support the project will help close these gaps in follow up care.

Project Components:

c. **Describe the reason(s) for selecting these project components** (if the selected project option includes required core project components, all required core components must included in the project, addressed as fulfilled, or the provider must otherwise justify in the narrative why all required core components were not included)
All core components will be included through the processes implemented in this project. Below are the ways in which we will achieve the Core Components:

All core components will be included through the processes implemented in this project.

a) Review best practices from a range of models (e.g. RED, BOOST, STAAR, INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.). – The Director of Case Management along with the CNO will review the models and choose the best one to implement. Milestone 1 will fall within this component.

b) Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient interviews.-Part of the follow up phone call process will include patient interviews and key drivers will be documented. Milestone 1 will fall within this component

c) Integrate information systems so that continuity of care for patients is enabled – Software from Siemens called Mobile MD will be utilized. This software allows physicians access to hospital patient information to follow up appropriately with patients. Milestone 2 will fall within this component

d) Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days – An evidence based model around CHF patients will be utilized and additional models will be added to identify patients potentially needing care post discharge. Milestone 2 will fall within this component

e) Implement discharge planning program and post discharge support program – Discharge protocols and medicine reconciliation will be used to support better patient care post discharge. Milestone 1 and 2 will fall within this component.

f) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.-This team will be assembled and meet regularly to assess the project and find ways to improve and expand what works Milestone 1, 2, and 4 will fall within this component.

g) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. – Lessons learned will be regularly discussed and documented for ongoing analysis. Milestone 5, 9, and 12 will fall within this component.

d. **Reasons for selecting the milestones and metrics** based on relevancy to the RHP's population and circumstances, community need, and RHP priority and starting point (new).

The metrics and milestones have been chosen with the goal of the project in mind. The implementation of these measures will prove logical steps in the achieving the goals that have been set forth. DY2 focuses on developing the baseline of the program and protocols for action. During the development stage, structure will be given to the concept and necessary implementation steps will be identified with specific consideration given to the population and demographics of the area. The project must be first implemented through evidence-based practices as a baseline then expanded to meet the needs of the population. This will include the addition of personnel, including TCs and case managers, and a CHF nurse, program guidelines and collaboration with local cardiologists. DY3 focuses on expanding the program through the integration and interaction of networking with other providers. This helps expand the knowledge base and adds credence to changes that may need to be made to the program. This stage may also include the addition or modification of software applications.

DY4 should show an improvement in the ability to capture a percent to be determined of all inpatient admissions, including CHF. This projected increased ability is based on training and the implementation of protocols introduced in project years DY2-3. Software should be concise with implementation protocols. In DY5 it is anticipated that 75% of the inpatient admissions and 80% of CHF admissions will be eligible for and participate in the transitions care program. Again, software should be concise with implementation protocols.

Unique community need identification numbers the project addresses:

- CN.11 - Need for more care coordination.
- CN.10 - Overuse of emergency department (ED) services.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new initiative and has not received any federal funding.

Related Category 3 Outcome Measures:

Outcome Measures and reasons/rationale for selecting the outcome measures:

IT-3.1 All cause 30 day readmission rates (>17%) – NQF

The all cause 30 day readmission rate outcome is a priority for several reasons. First, it shows a relationship between patient health and treatment. Hospital readmissions and some admissions are considered avoidable and indicators of poor care or missed opportunities to better coordinate care. This is a reflection on the total care system and should be addressed systemically. Secondly, readmissions adversely impact payer and provider costs and patient morale. Patients are sometimes discharged earlier which theoretically increases the risk of readmissions. Finally, reducing all cause 30 day readmission rates may reduce health care costs (for the patient and the facilities) and increase the quality of care.

IT-2.1 Congestive Heart Failure rate (CHF)

Focusing on the outcomes of this project will help improve the health of low-income populations in several ways. The initiative to avoid CHF admissions leads to the presumption of improved health. This is evidenced by affordable medications, affordable physician office visits, and improved patient knowledge of the need for healthy environment, healthy nutrition, exercise and avoidance of disease. These can be accomplished through a transition care program which makes this information available to populations at risk.

Relationship to Other Projects:

2.1.1 PCMH

Care transition is dependent upon care after inpatient stays. Likewise, care coordination through a PCMH will rely on communication from local hospitals. Both have shown a reduction on admissions and readmissions. Although both are unique, both projects benefit through increased communication between patient, clinic, and hospital.

RD-1.1 Congestive Heart Failure Admission Rate
RD-2.7 All Cause 30 Day Readmission Rates

As the care transitions program takes shape improved communication and care coordination will positively impact many Category 4 measures. Specifically, RD-1.1 Congestive Heart Failure Admission Rate and RD-2.7 All Cause 30 Day Readmission Rates will be directly affected by

the implementation of a care transitions program, whose goal is to reduce said admissions and readmissions by 10%.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:
Describe the approach for valuing each project and rationale/justification (e.g. size factor, project scope, populations served, community benefit, cost avoidance, addressing priority community need, estimated local funding). Supporting information may be included in the addendums].
Please let us know what information should be included in the addendum.
In order to value this project we used the combination of the values provided by our RHP for the two measures, all cause 30-day readmissions and CHF admissions. The value of $7,491 per all cause 30 day readmission was chosen by our RHP using data from the Texas Department of State Health Services. The value of $8,252 per CHF admission was chosen by our RHP using data from the Texas Department of State Health Services. Based upon 2011, data our total all cause 30 day readmissions were 295 over 5,285 total inpatient admissions, giving us a readmission rate of 5.6%. Our goal is to reduce our readmissions by 10% over baseline, or 30 total readmissions by the end of the waiver in DY5.

In addition, we wish to reduce CHF admissions by 10% or 14, with regard to the DY1 CHF admission total of 138. The total value of this project is $3,917,887.

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Wise Regional Health System has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

Wise Regional Health System defined the population that will be directly impacted by the project as All Cause 30 day Readmissions. The percentage of the population expected to be positively impacted by the project is 10**%,** which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *2***.** We believe this to be the correct number because, when a person is positively impacted, their quality of life is moderately impacted.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 2**.** We believe this to be the correct number because, when a person is positively impacted, their dependence on the community is moderately.

130606006.2.2	*2.12.1*	*2.12.1 (A-G)*	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions	
Wise Regional Health System				*130606006*
Related Category 3 Outcome Measure(s):	*130606006.3.5* *130606006.3.6*	*IT-3.1* *IT-2.1*	*All Cause 30 Day Readmissions* *Congestive Heart Failure Admission 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]: Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions Metric 1 [P-1.1]: Care transitions protocols Baseline/Goal: Establish protocols Data Source: Documentation Milestone 1 Estimated Incentive Payment *(maximum amount):* $**175,386** **Milestone 2** [P-3]: Establish a process for hospital-based case managers to follow up with identified patients hospitalized related to the top chronic conditions to provide standardized discharge instructions and patient education, which address activity, diet, medications, follow-up care, weight, and worsening symptoms; and, where appropriate, additional patient education and/or coaching as identified during discharge Metric 1 [P-3.1]: Care transition protocols Baseline/Goal: Care Transition Protocols Data Source: Documentation		**Milestone 5** [P-11]: Review project 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-11.1]: Number of new ideas, practices, tools, or solutions tested by each provider. Baseline/Goal: 1 new idea per quarter Data Source: Documentation of ideas Milestone 5 Estimated Incentive Payment: $**382,674** **Milestone 6** [P-6]: Train/designate more ED case managers Metric 1 [P-6.1]: Number of trained and/or designated ED case managers over baseline Baseline/Goal: Train at least 1 ED Case Manager Data Source: HR Documentations Milestone 6 Estimated Incentive Payment: $**382,674**	**Milestone 7** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: Capture 70% of inpatient admissions eligible for care transition Data Source: Patient Census, Records Milestone 7 Estimated Incentive Payment: $**255,857** **Milestone 8** [I-14]: Implement standard care transition processes in specified patient populations (CHF specific). Metric 1 [I-14.1]: Measure adherence to processes. Goal: Capture "-75"% of CHF inpatient admissions eligible for program Data Source: Program records Milestone 8 Estimated Incentive Payment: $**255,857**	**Milestone 10** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: Capture 75% of inpatient admissions eligible for care transition Data Source: Patient Census Milestone 10 Estimated Incentive Payment: $**211,360** **Milestone 11** [I-14]: Implement standard care transition processes in specified patient populations (CHF specific). Metric 1 [I-14.1]: Measure adherence to processes. Goal: Capture "-85"% of CHF inpatient admissions eligible for program Data Source: Program records Milestone 11 Estimated Incentive Payment: $**211,360**

130606006.2.2	***2.12.1***	***2.12.1 (A-G)***	Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions	
		Wise Regional Health System		*130606006*
Related Category 3 Outcome Measure(s):	*130606006.3.5* *130606006.3.6*	*IT-3.1* *IT-2.1*	*All Cause 30 Day Readmissions* *Congestive Heart Failure Admission 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 2 Estimated Incentive Payment: $**175,386** **Milestone 3** [P-X]: Verify a baseline, in order to measure improvement over self Metric 1 [P-X.1]: Baseline/Goal: Establish Baseline Data Source: Documentation of Baseline Milestone 3 Estimated Incentive Payment: $**175,386** **Milestone 4** [P-X]**:** Designate/hire personnel or teams to support and/or manage the project/intervention Metric 1 [P-X.1]: Baseline/Goal: Hire Personnel Referenced in Plan Data Source: HR Records Milestone 4 Estimated Incentive Payment: $**175,387**			**Milestone 9** [P-11]: Review project 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-11.1]: Number of new ideas, practices, tools, or solutions tested by each provider. Baseline/Goal: 1 new idea per quarter Data Source: Documentation of ideas Milestone 9 Estimated Incentive Payment: $**255,859**	**Milestone 12** [P-11]: Review project 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-11.1]: Number of new ideas, practices, tools, or solutions tested by each provider. Baseline/Goal: 1 new idea per quarter Data Source: Documentation of ideas Milestone 12 Estimated Incentive Payment: $**211,362**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $701,545	Year 3 Estimated Milestone Bundle Amount: $765,348		Year 4 Estimated Milestone Bundle Amount: $767,573	Year 5 Estimated Milestone Bundle Amount: $634,082
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$2,868,548				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.2.1 – Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)
Unique Project ID: 130614405.2.1
Performing Provider Name/TPI: Texas Health Resources Arlington Memorial / 130614405

Provider: Texas Health Arlington Memorial Hospital is a full-service acute-care medical center with 369 beds, serving Arlington and its surrounding communities. THAM provides emergency and acute inpatient care to the community.
Intervention: The purpose is to help individuals with diabetes who are traditionally underserved and give them access to diabetes education and regular clinical care so they can take ownership and better manage their diabetes. This project intervention is an expansion of the current diabetes education program at THAM to include a nurse practitioner run outpatient clinic for patients with diabetes.
Need of the project: According to THAM data, Medicaid and uninsured patients make up about 40% of our payer mix from the ED, and 30% from the inpatient population. Diabetes is the 4th leading cause of hospital readmissions at THAM.
Target population: The target population is the Medicaid and underserved and undocumented population in the Arlington and surrounding areas. As the Hispanic community continues to grow and makes up 31% of the service area, and since diabetes is 1.5 times more likely to develop in someone of Hispanic heritage, there is an increased opportunity to serve this group. We estimate that 2000 patients will be served over the course of the waiver period. We anticipate a growth of 5% each year beginning DY 4, with each additional year an increase in volume by 5%. More specifically, DY2 and DY3 include 500 patients each year, anticipated growth for DY4 525 patients, DY5 551 patients, (a total increase of 51 patients enrolled across waiver period). Each additional patient will be seen by the clinic practitioners at least 5 times each year. We will expand visits to the clinic by an additional 125 in DY 4, 256 additional visits in DY5, for an additional total volume of 381 patient visits during the waiver period. Of the 25 new patients in DY4, we expect 80% (20 patients) to set self-management goals. In DY5 the expectation is for 90% of the 51participants to set self management goals (46 patients).
Expected patient benefits: We have selected this project so that complications will be prevented, quality of life for our community members will improve, patients can stay healthy, and costly hospital readmissions are prevented. Ultimately we believe in serving the community, and with the increasing number of people who are uninsured and economically disadvantaged, this will be an effective program for those who do not otherwise have access to coordinated diabetes care. Increasing the number of people served by 10% over baseline with a focus on impacting those unfunded or Medicaid patients with limited access to healthcare.
Category 1 or 2 expected patient benefits: The project seeks to establish and advance the development of a comprehensive, multi-disciplinary Chronic Disease Management program utilizing Wagner's Chronic Care model to help an increasingly underserved population of patients with diabetes in our community.
Category 3 outcomes: Key metrics and goals were selected that would demonstrate improved patient outcomes as a result of the project including (1) a 15% reduction from baseline in the

number of individuals served who decrease their Hemoglobin A1C to less than 9% showing better control of their diabetes and (2) a 15% reduction from baseline in the number of diabetes related readmissions within 30 days.

Project Option 2.2.1 – Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)
Unique Project ID: 130614405.2.1
Performing Provider Name/TPI: Texas Health Resources Arlington Memorial / 130614405

Project Description:
Historically underserved patients have not been effectively educated on how to manage their diabetes. Moreover, they have not been followed to measure their outcomes and long term goals. This program will be implemented to help those who need education on managing diabetes by providing a patient-centered medical home where they have access to exceptional and coordinated care. Through implementation of a more comprehensive diabetes education center/medical home using a Wagner's Chronic Care model, we hope to reduce the rates of uncontrolled diabetes among project participants. A multidisciplinary team, including nurse practitioners, will be formed to develop protocols, processes, procedures and policies, using evidence-based practices, to improve the care and monitoring of the disadvantaged community members with diabetes. Patients will be identified by: first, partnering with primary care clinicians to utilize protocols: A1C>9, history of DKA, > one admission in the last 12 months as criteria for referrals to outpatient diabetes education. Second, ED case managers and inpatient diabetes educator will identify patients with the same criteria as above, and/or those individuals who do not currently have a patient-centered medical home, have not received diabetes education within the last five years, and all others appropriate for education due to difficulty managing their disease or understanding the care requirements.

Goals and Relationship to Regional Goals:
Project Goals:
According to THAM data, diabetes was the fourth highest readmission diagnosis. Additionally, 10% of the THAM service area has been diagnosed with diabetes. Based on THAM outpatient diabetes education data, the program is underutilized in comparison with the service area diabetic population. Our proposed intervention will help individuals who are traditionally underserved and give them access to diabetes education and regular clinical care so they can better manage their diabetes. The program staff will consist of non-physician health professionals such as certified diabetes educators, registered dietitians, nurses, clinical social workers, and support staff. Physicians and mid-level providers will be a key part of the team to provide clinical visits and medication adjustments and prescriptions.

This project meets the following Regional goals:

A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to achieving that goal by improving the access to chronic care for individuals in Tarrant County who are underserved and who need diabetes education, training and clinical interventions.

Challenges:
THAM data indicates that Medicaid and uninsured patients make up about 40% of our payer mix of those treated and released from the ED and approximately 30% of inpatient population. In our service area the Hispanic community makes up approximately 31% of the population and is the fastest growing ethnicity in Arlington. Hispanic people are about 1.5 times more likely to develop diabetes than non-Hispanic white people. In the current THAM Outpatient Diabetes Education Program, approximately 75% of those served are Caucasian, thus indicating a need for innovation and creativity to reach this population. Another area of opportunity is the cost of managing diabetes. Since a large percentage of THAM patients have limited access to insurance and other resources, it is paramount that we intervene by educating and treating the people in the community we serve.

5-Year Expected Outcome for Provider and Patients:
We anticipate an increased number of referrals of the identified patient population by 5% above baseline beginning DY4. Patients participating in the clinic will have the HbA1c maintained below 9.0 and a decrease in readmissions within 30 days.

Starting Point/Baseline:
The THAM outpatient Diabetes Education Program currently provides services for about 500 individuals each year. The expectation is an increased growth rate of 5% each year of the program beginning in DY4.

Rationale:
Currently our organization provides excellent emergency and inpatient services, but in order to be more proactive in the prevention of diabetes complications, patients need an alternative to using the emergency department for primary care. It is well known that the current inpatient health care system is reactive, and we believe being proactive by preventing complications will improve the quality of life and save money. We have selected this project so that complications can be prevented, quality of life can be improved, and patients can stay healthy and out of the hospital. Additionally, we have selected this project so that the increasing number of people who are uninsured and economically disadvantaged can have access to coordinated diabetes care.

Project Components:
Our project contains all of the required core components including:

1. Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system
2. Ensure that patients can access their care teams in person, by phone or email
3. Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources
4. Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
5. 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.

Additional components include:

- Disease-specific patient education and self-management support
- Clinically led and mission-driven team that communicates and stays in touch with program participants
- Increase access to care through coordination of efforts through the emergency department and inpatient staff.
- Conduct quality improvement for project using rapid cycle improvement. Activities may include but are not limited to, identifying project impacts, identifying "lessons learned", and identifying key challenges.

Our milestones and metrics advance development of our program to help an increasingly underserved population receive diabetes management through the Wagner Chronic Care Model and include: (1)Establishing a multidisciplinary team including physicians, nurse practitioners, diabetes educators, registered dietitians, clinical social workers, registered nurses, pharmacists, and support staff, (2) Increasing the number of patients served under this model by 10% over baseline as recorded in the database and (3) Developing policies, procedures, and data collection tools to effectively run the coordinated program and monitor effectiveness, reducing fragmented care.

Unique community need identification numbers the project addresses:

- CN.8 – Lack of access to health care due to financial barriers
- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Linking diabetes patients who present to the ED or inpatients to a primary care physician is a new initiative. All of the current diabetic educators are trained in the Stanford model of Diabetes Management and have led a number of community workshops free to the public funded by the Area Agency on Aging of Tarrant County. This project could significantly enhance the number of patients who have accessibility to diabetic education. This project has not received any other federal funding.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
1.10 Diabetes care: HbA1c poor control (>9.0%)

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or 2) who had hemoglobin Ac (HbA1c) control> 9.0%
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and 2)

3.3 Diabetes 30-day readmission rate

- Numerator: number of readmissions (for patients 18 years and older), for any cause, within 300 days of discharge from the index diabetes admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
- Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of diabetes and with a complete claims history for the 12 months prior to admission.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**: This project relates to project 2.9.1 Establish/Expand Patient Care Navigation Program. The patient navigation program assists with the identification of at risk patient who might benefit from closer monitoring. The navigator would refer the patient to the Diabetes Clinic for management of their disease.
- **Related Category 4 Population-focused improvements**: RD.1: Potentially Preventable Admissions RD.1.2: Diabetes Admission Rate should improve for at-risk patients who would not otherwise be able to access care to manage their diabetes. Diabetics whose disease is managed will decrease their risk of developing complications from their disease that would result in hospital admissions. RD 2: 30 Readmission Rate: RD 2.2 Diabetes 30-day Readmissions should improve by providing access to care and assistance in self-management of their disease, risk of admission and readmission are reduced.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology**: For every inpatient admission avoided, $9,832 in cost is saved by the health care system. Health care costs are calculated by multiplying $9,832 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

130614405.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*
Texas Health Arlington Memorial			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.1* *130614405.3.2*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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 a comprehensive care management program Metric 1 [P-3.1]: Documentation of care management program using the Wagner Chronic Care Model Goal: Complete implementation of outpatient clinic for heart failure patients to receive ongoing care. Includes procurement of equipment and supplies to run clinic, Data Source: Program description Milestone 1 Estimated Incentive Payment *(maximum amount):* $40,441 **Milestone 2** [P-2]**:** Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care)Numerator: Number of care navigation encounters Metric 1 [P-2.1]: Increase percent of staff trained a)Numerator: number of relevant staff trained in the Chronic Care Model	**Milestone 4** [P-4]: Formalize multidisciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric 1 [P-4.1]: Increase the number of multidisciplinary teams (e.g.,, teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams a)Number of teams or sites with formalized teams Baseline/Goal: Develop at least 2 multidisciplinary teams Data source: Team rosters Milestone 4 Estimated Incentive Payment: $58,734 **Milestone 5 [P-9]**: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventive tests, or	**Milestone 6** [I-17]: Apply the Care Model to targeted chronic disease, which are prevalent locally Metric 1 [I-17.1]: Additional patients receive care under the Care Model for diabetes (Chronic disease Diabetes) Goal: 5% increase over baseline (25 additional or a total of 525 patients) Data source: registry Milestone 5 Estimated Incentive Payment: $61,946 **Milestone 7** [I-18.]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patient with self-management goals a) Numerator: The number of patients with diabetes who have at least one self-management goal b) Denominator: Total number of patients with type 1 or 2 diabetes in the registry Goal: 80% (20 participants) Data Source: registry	**Milestone 8** [I-17]: Apply the Care Model to targeted chronic disease, which are prevalent locally Metric 1 [I-17.1]: Additional patients receive care under the Care Model for diabetes (Chronic disease Diabetes) Goal: 5% increase over DY4 (51 additional or a total of 551 patients) Data Source: registry Milestone 7 Estimated Incentive Payment: $50,019 **Milestone 9** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patient with self-management goals a)) Numerator: The number of patients with diabetes who have at least one self-management goal b) Denominator: Total number of patients with type 1 or 2 diabetes in the registry Goal: 90% (46 participants) Data Source: registry

130614405.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*
Texas Health Arlington Memorial			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.1* *130614405.3.2*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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)**
b)Denominator: Total Number of relevant staff Baseline/Goal: 90% of involved staff complete training Data Source: Training records Milestone 2 Estimated Incentive Payment *(maximum amount):* $40,441 **Milestone 3 [P-X]**: Customizable Process Milestone: [Establish baseline rates for DY3, DY4 and DY5 metrics a) number of patient identified as needing screening tests or clinical services b) volume of diabetic patient enrolled in Care Model c)percent of patients with self-management goals d) percent of patients monitoring weight Goal/Baseline: Baseline established Milestone 3 Estimated Incentive Payment: $40,441	other clinical services Numerator: number of patients identified as needing screening test, preventive, or other clinical services Baseline/Goal: Increase number of patient identified by 5% over baseline Data Source: Clinic registry Milestone 5 Estimated Incentive Payment: $58,734	Milestone 6 Estimated Incentive Payment: $61,946	Milestone 8 Estimated Incentive Payment: $ 50,019
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):*	Year 3 Estimated Milestone Bundle Amount: $**117,468**	Year 4 Estimated Milestone Bundle Amount: $**123,893**	Year 5 Estimated Milestone Bundle Amount: $**100,038**

130614405.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*	
Texas Health Arlington Memorial				*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.1* *130614405.3.2*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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)**
$121,324				
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $**462,721**				

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.2.1– Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases (Improving Management of Heart Failure (HF))

Unique Project ID: 130614405.2.2

Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Provider: THAM is a 369 bed acute care hospital located in Arlington, Texas. Our hospital serves the city of Arlington and surrounding communities, a 100 square mile area and a population of more than 365,000 residents. THAM provides emergency and acute inpatient care to the community.

Intervention: The primary objective of the project is to improve the HF patient's ability to effectively manage their disease and decrease the rate of HF patient hospitalizations and readmissions to the hospital. Because nearly 40% of patients seen at the hospital have no insurance or Medicaid, it is expected that a large portion these patients will be impacted by this project. Initial work has begun to implement the project on a limited scope. The HF clinic currently has one part time nurse practitioner working 16-24 hours per week. Full implementation of the project would require additional FTEs and development of an outpatient clinic space.

Need of the project: Heart failure is one of Texas Health Arlington Memorial Hospital's most common reasons for admission with 320 patients admitted with a primary diagnosis of heart failure and 1,947 patients admitted with primary/secondary diagnosis of heart failure between June 2011 and May 2012.[295] For this population, 90% were government funded or unfunded (80% Medicare/Managed Medicare; 10% Medicaid or unfunded).

Target population: The target population is indigent or government-funded patients with a diagnosis of heart failure in the community who do not have access to receive care. Over the course of the waiver, we anticipate impacting approximately 6,000 patients by assisting in management of their disease through the HF clinic and/or RN case manager intervention/telephonic support.

Expected patient benefits: An analysis of THAM data for 127 HF patients that required readmission within 30 days of discharge between October 2010 and May 2012 revealed that a majority of these patients were unfunded or had government funded insurance (88.5%). Through this project, the hospital and post acute care providers will develop protocols to more effectively identify and implement patient needs. Root causes for readmission of the low-income and underserved HF patient often related to lack of financial resources will be addressed.

Category 1 or 2 expected patient benefits: Milestones selected include hiring a multidisciplinary team of nurse practitioners, RNs, case managers, dietitians, and social workers and training them in Wagner's Chronic Care model; developing a comprehensive care management program, including the implementation of an outpatient nurse-practitioner run HF clinic and development of case manager program to navigate patients to appropriate resources and continue to support patient telephonically post hospital discharge.

Category 3 outcomes: Our project goal is to implement programs that will improve the health of patients with heart failure as evidenced by a reduction in HF patient hospital admission rates (Cat

[295] Internal hospital admissions data obtained from Premier Quality Advisor

3.2.1) by 10.5% and reduction in HF patient 30 day, all cause hospital readmission rate (Cat 3.3.2) by 15% at the conclusion of the 5 year time period.
Project Option 2.2.1– Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases (Improving Management of Heart Failure (HF))

Unique Project ID: 130614405.2.2
Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405
Project Description:
Disadvantaged, low-income patients with heart failure (HF) are often challenged to effectively manage their disease due to lack of resources to obtain necessary medications and supplies or inability to access health care. Failure to manage this chronic condition adversely impacts the patient's health, often resulting in hospitalizations. This project is based on the Institute for Healthcare Improvement (IHI)'s publications and:

1. Develops a screening process to identify barriers to effective management of the HF patient's disease (e.g., lack of ongoing monitoring by a health care professional, inability to obtain medications or inadequate understanding of their disease and self-management interventions).
2. Utilizes a RN case manager to lead a multidisciplinary team in the coordination of appropriate resources based on identified, patient-specific needs.
3. Coordinates post-acute care support through telephonic monitoring by an RN case manager, home visits provided by hospital partners including, United Way "Healthy at Home" Care Transitions coaches, PrimeMedic program paramedics, Transitions House Calls nurse practitioner or other health care providers.
4. Coordinates timely follow-up care with the patient's primary care providers (PCP), (obtain PCP for patient as needed) or with the hospital's outpatient nurse practitioner run Heart Failure Clinic, developed using the Chronic Care Model to supplement physician's care through more frequent evaluation/monitoring of high risk patients.
5. Collaborates with area health care providers including providers at nursing homes, skilled nursing facilities, and inpatient rehabilitation hospitals to develop protocols designed to effectively manage HF patients to avoid hospitalization.

Goals and Relationship to Regional Goals:
Project Goals:
Approximately one of every five HF patients (21%) at Texas Health Arlington Memorial hospital (THAM) requires readmission within 30 days of discharge. The primary goal of the project is to improve the health of low-income, underserved HF patients through more effective disease management along the continuum of care with particular emphasis on transitions through the post-acute phase. Goals are to 1) reduce overall need for HF patient hospital admission and 2) reduce HF patient hospital readmissions within 30 days of discharge.

This project meets the following Regional goals:
A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to achieving that goal by implementing a community-based innovative chronic disease management program to help low-income, disadvantaged community members of Tarrant County better manage their heart failure conditions, with a particular clinical support focus on reducing the readmission rate among project participants.

Challenges:
An analysis of THAM data for 127 HF patients who required readmission within 30 days of discharge between October 2010 and May 2012 revealed that a majority of these patients were unfunded (2.5%) or had government funded insurance (86%). Almost half (46.4%) of these patients had been discharged from the hospital to continue care through another provider (17% skilled nursing or nursing home, 9.4% inpatient rehabilitation hospital or long term acute care hospital, and 20.5% to home health care). Through this project, the hospital and post-acute care providers will develop protocols to more effectively identify patient needs and implement interventions to assist the patient in managing their illness outside the hospital. Root causes for readmission of the low-income and underserved HF patient often related to lack of financial resources (e.g.,, inability to purchase medications, healthy food or bathroom scales to monitor weight, lack of transportation to appointments, inability to obtain PCP, etc). Through this program, trained RNs screen at-risk HF patients presenting to the emergency department or admitted to the hospital and identify barriers to maintaining their health. Interventions are then implemented to reduce admission or readmission risks. The expansion of the HF Clinic would be key to providing disadvantaged HF patients with timely access to a health care provider, education and resources.

5-Year Expected Outcome for Provider and Patients:
Our project goal is to improve the health of patients with heart failure as evidenced by a reduction in HF patient hospital admission rates by 10.5% and reduction in HF patient 30-day, all-cause hospital readmission rate by 15% at the conclusion of the five-year time period.

Starting Point/Baseline:
In 2011, HF was the number one cause of readmissions in North Texas (22.6%), impacting 13,272 patients. Heart failure is one of Texas Health Arlington Memorial Hospital's most common reasons for admission with 320 patients admitted with a primary diagnosis of heart failure and 1,947 patients admitted with primary/secondary diagnosis of heart failure between June 2011 and May 2012. For this population, 90% were government funded or unfunded (80% Medicare/Managed Medicare; 10% Medicaid or unfunded). Baseline readmission rate for THAM HF patients is approximately 21%.

Currently, one part-time acute care nurse practitioner is developing protocols for management of HF patients in an outpatient clinic and beginning to assist with management of a small(~14) number of these patient in an outpatient setting. The clinic has been successful in preventing hospital admission for these disadvantaged, high-risk patients over the 3 months (July – September 2012) the nurse practitioner has been operating the clinic. Partnerships with community members have been established. There is one United Way "Healthy at Home" coach trained in the Coleman Care Transitions model available to make home visits to Medicare HF patients. The hospital also has two PrimeMedic paramedics available through the city ambulance service to make home visits to Arlington residents and provide telemonitoring through the ambulance service's central dispatch station. PrimeMedic responds when a patient's weight or vital signs fall outside the established parameters and then coordinates with the hospital community case manager or HF Clinic nurse practitioner in conjunction with the PCP. Early intervention can prevent decompensation and avert hospital admission.

Initial work has been started with area health care providers. Three primary care physicians (PCPs) that also care for patients in area nursing homes and skilled nursing facilities are working with the hospital to develop protocols at their facilities that will assist in intervention outside of the hospital when a patient develops of early signs of HF exacerbation.

Rationale:

In 2011, HF was the number one cause of readmissions in north Texas (22.6%), impacting 13,272 patients. Heart failure is one of Texas Health Arlington Memorial hospital's most common reasons for admission with 320 patients admitted having a primary diagnosis of heart failure and 1,947 patients admitted with a secondary diagnosis of heart failure between June 2011 and May 2012. For this population, 90% were government funded or unfunded (80% Medicare/Managed Medicare; 10% Medicaid or unfunded). Baseline readmission rates for these patients are near 21%. The Arlington/Southeast Tarrant County area has had an increase of 42% over the last year in community member identified as unable to pay for their health care. Our project is designed to target the HF population within our Region and intervene to prevent hospitalization with those low-income, disadvantaged HF patients.

Project Components:

Our project contains all of the required core components including:

- Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system
- Ensure that patients can access their care teams in person, by phone or email

- Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources
- Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
- 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.

Additional key components of the project based on IHI recommendations include:

1. Development of a screening process and enhanced multidisciplinary team approach to discharge process to address potential barriers to effective post-acute management
2. Early post-discharge follow-up. High risk patient evaluation will be completed by a provider within three days of hospital discharge.
3. Working with home health agencies that front-load home care visits for at-risk patients to include care transitions coaches, paramedics, and/or nurse practitioners
4. Ability to provide telemonitoring in conjunction with PrimeMedic program.
5. Care Transitions coaches to engage patients in their own care as well as clarify and/or follow-up on post-discharge instructions.
6. Implementation of a chronic disease management clinic with a dedicated HF nurse practitioner.
7. Ongoing post-discharge follow-up monitoring through telephonic assessments by RN case manager to respond to questions and evaluate for emerging needs.
8. Collaboration with post-acute facilities to more effectively manage HF patients throughout the continuum of care.

Our milestones were selected to advance the development of the chronic care management program designed to assist our target population. Milestones include (1) identifying/hiring and training a multidisciplinary team, (2) developing and implementing a plan for the HF clinic based on the Wagner's Chronic Care Model, (3) establishing a multi-disciplinary team approach to the identification of and intervention with patients at risk for ineffective management of their HF, (4) collaborating with area health care providers to assure effective management of the high-risk HF patient along the health care continuum, (5) increasing the number of at-risk patients in the program, and (6) implementing interventions key to improving the patient's health (weight monitoring, medication management, self-management), thus reducing their risk for hospital admission or readmission. These milestones and metrics will measure the number of patients receiving ongoing chronic care management through an evidence-based, coordinated model (rather than not receiving care, or receiving fragmented care).

Unique community need identification numbers the project addresses:

- CN.1
- CN.3
- CN.8

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

This project is a new initiative for THAM. No funding from the U.S Department of Health and Human Services is used to fund project initiatives or related activities.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

- **Outcome Measure 1:** IT-3.2 Congestive Heart Failure 30-day readmission rate (Stand-alone measure)
- **Outcome Measure 2**: IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8 (Stand-alone measure)

Data discussed in Section 4 (a) provides evidence supporting the need to improve our management of heart failure patients. Studies cited throughout the narrative support the effectiveness of a multidisciplinary team approach to providing support and post-acute care monitoring of HF patients to reduce readmissions. By focusing on readmission rates and overall hospital admission rates as outcomes, we will be able to determine whether or not our project has been successful in improving the health of our target population.

Relationship to Other Projects:

This project relates to project 2.9.1 Establish/Expand Patient Care Navigation Program. The patient navigation program assists with the identification of at risk patient who might benefit from closer monitoring. The navigator would refer the patient to the HF Clinic for management of their disease.

Related Category 4 population-focused improvements with the unique RHP project identification number based on the requirements above:

RD.1: Potentially Preventable Admissions RD.1.1: Congestive Heart Failure Admission rate and RD 2: 30 Readmission Rate: RD 2.1 Congestive Heart Failure (HF) 30-day Readmissions are Category 3 Outcome Measures selected to evaluate the effectiveness of this project. This project also impacts RD.4 Patient-centered Health Care: RD.4.2 Medication Management as enhanced inpatient screening and discharge processes will verify completion of medication reconciliation and assist patient in understanding and/or obtaining necessary medications prior to discharge.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $8,252 in cost is saved by the health care system. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.

- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).

- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.

- **Individual benefits** were calculated using lost wages, caretaker expense and extension of life (if applicable).

130614405.2.2	*2.2.1*	*Project Components: 2.9.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.3* *130614405.3.4*	*3.IT-2.1* *3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate* *Congestive Heart Failure Admission rate (CHF) - PQI #8*

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]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1]: Multidisciplinary team including nurse practitioners, RN, dietitians, and social workers hired and trained in chronic care model Baseline/Goal: Increase percent of staff trained to 100%. Data Source: Training records Milestone 1 Estimated Incentive Payment: $**49,889** **Milestone 2** [P-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of care management program using the Wagner Chronic Care Model Baseline/Goal: Implement the Chronic Care Model based Heart failure clinic including policies/ procedures, data collection process	**Milestone 5** [P-9]: Develop program to identify and manage chronic care HF patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of HF patients identified as needing screening test, preventive tests, or other clinical services Goal: Develop screening process to identify HF patients at high risk for readmission and process to engage them in program/provide necessary services Data source: Patient registry Milestone 5 Estimated Incentive Payment: $64,405 **Milestone 6** [P-16]: 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	**Milestone 8** [I-17]: Apply the Chronic Care Model to targeted chronic diseases (Heart failure), which are prevalent locally Metric 1 [I-17.1]: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC (Heart Failure) Goal: 50 additional patients Data Source: Registry Milestone 8 Estimated Incentive Payment: $ **50,946** **Milestone 9** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patients with self-management goals Goal: 75% of patients will have documented self-management goal Data Source: Registry Milestone 9 Estimated Incentive Payment: $ **50,946** **Milestone 10** [I-19]: Implement	**Milestone 12** [I-17]: Apply the Chronic Care Model to targeted chronic diseases (Heart failure), which are prevalent locally Metric 1 [I-17.1]: X additional patients receive care under the Chronic Care Model for a chronic disease or for MCC (Heart Failure) Goal: 75 additional patients Data Source: Registry Milestone 12 Estimated Incentive Payment: $ **41,136** **Milestone 13** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patients with self-management goals Goal: 90% of patients will have documented self-management goal Data Source: Registry Milestone 13 Estimated Incentive Payment: $ **41,136**

130614405.2.2	*2.2.1*	*Project Components: 2.9.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.3* *130614405.3.4*	*3.IT-2.1* *3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate* *Congestive Heart Failure Admission rate (CHF) - PQI #8*

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)**
and obtain/design a dedicated space to see patient in an outpatient clinic setting. Data Source: Program description Milestone 2 Estimated Incentive Payment: $**49,889** **Milestone 3** [P-4]: Formalize multidisciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric 1 [P-4.1]: Increase the number of multidisciplinary teams (e.g.,, teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams Baseline/Goal: Establish a team Data Source: Clinic records Milestone 3 Estimated Incentive Payment: $**49,889** **Milestone 4** [P-16]: Participate in face-to-face learning (i.e. meetings or	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-16.1]: semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in 2 meeting annually Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $64,405 **Milestone 7** [P-X]: Customizable Process Milestone: [Establish baseline rates for DY4 and DY5 metrics a) volume of patients receive care under the Chronic Care Model for a chronic disease or for MCC (Heart Failure), b) percent of patients with self-management goals, c)percent of patients on medication specific for	disease-specific or MCC Medical Home Metric 1 [I-19.1]: Use of appropriate medication for specific disease (Heart Failure use of ACEI or ARB) a. Numerator: Number of individuals with heart failure and EF <40% who receive ACEI or ARB b. Denominator: Number of Heart Failure patients appropriate to receive an ACEI or ARB Goal: 80% Data Source: Clinic records Milestone 10 Estimated Incentive Payment: $**50,946** **Milestone 11** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option Metric 1 [I-21.4]: Improved compliance with recommended care regimens (Heart Failure: weight monitoring). a. Numerator: Number of individuals with heart failure that have documentation of weight monitoring b. Denominator: Number of Heart	**Milestone 14** [I-19]: Implement disease-specific or MCC Medical Home Metric 1 [I-19.1]: Use of appropriate medication for specific disease (Heart Failure use of ACEI or ARB) a. Numerator: Number of individuals with heart failure and EF <40% who receive ACEI or ARB b. Denominator: Number of Heart Failure patients appropriate to receive an ACEI or ARB Goal: 95% Data Source: Clinic records Milestone 13 Estimated Incentive Payment: $**41,136** **Milestone 15** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option Metric 1 [I-21.4]: Improved compliance with recommended care regimens (Heart Failure: weight monitoring). a. Numerator: Number of individuals with heart failure that have documentation of weight monitoring

130614405.2.2	*2.2.1*	*Project Components: 2.9.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.3* *130614405.3.4*	*3.IT-2.1* *3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate* *Congestive Heart Failure Admission rate (CHF) - PQI #8*

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)**
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. Metric 1 [P-16.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in 2 meeting annually Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $ **49,889**	heart disease, d) percent of patients monitoring weight Metric 1 [P.X]: Determine the baseline metrics for the 4 identified measures noted in Milestone 7. Baseline/Goal: Baseline metrics will be determined Data Source: Clinic records Milestone 7 Estimated Incentive Payment: $64,405	Failure patients seen in clinic. Goal: 90% Data Source: Clinic records Milestone 11 Estimated Incentive Payment: $**50,946**	b. Denominator: Number of Heart Failure patients seen in clinic. Goal: 95% Data Source: Clinic records Milestone 15 Estimated Incentive Payment: $**41,136**

130614405.2.2	*2.2.1*	*Project Components: 2.9.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*	
Texas Health Arlington Memorial Hospital				*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.3* *130614405.3.4*	*3.IT-2.1* *3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate* *Congestive Heart Failure Admission rate (CHF) - PQI #8*	
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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $**199,558**	Year 3 Estimated Milestone Bundle Amount: $**193,215**		Year 4 Estimated Milestone Bundle Amount: $**203,784**	Year 5 Estimated Milestone Bundle Amount: $**164,546**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ **761,102**				

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.7.4 – Implement innovative evidence-based strategies to reduce low birth weight and preterm birth

Unique Project ID: 130614405.2.3

Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Provider: THAM is a 369 bed acute care hospital located in Arlington, Texas. Our hospital serves the city of Arlington and surrounding communities, a 100 square mile area and a population of more than 365,000 residents. THAM provides emergency and acute inpatient care to the community.

Intervention: The goal of this project is to provide prenatal care to women in the community without access to this care. This is a new project.

Need of the project: In Arlington, the infant mortality rate is the highest in zip codes 76010, which is adjacent to the hospital and less than 75% of pregnant women in this East Arlington area receive prenatal care.[296]

Target population: The target population is pregnant women with Medicaid or no insurance in need of prenatal care. Over the course of the waiver, we anticipate the potential to intervene with approximately 900 patients per year (based on annualized 2012 figures for unfunded and Medicaid women delivering infants) through the provision of ongoing prenatal care or education.

Expected patient benefits: Between January and August 2012, there were 1,382 (2,073 patients annualized) infant deliveries performed at THAM. 45.2% (937 annualized) of these women were unfunded or Medicaid funded patients. There are increasing numbers of at-risk, disadvantaged women in our geographic area with a limited number of physicians willing to care for these patients and the current county funded clinic located in our community is scheduled for relocation to another part of the city.

Category 1 or 2 expected patient benefits: Milestones selected include implementation of an evidence-based prenatal clinic, using the CenteringPregnancy model. A process for tracking the volume of patients, monitoring interventions and evaluating outcomes will be developed.

Category 3 outcomes: By providing prenatal care and education to those who would otherwise receive no care, we expect to decrease the number of low birth weight babies by 10% and reduce early elective deliveries by 95% from baseline.

[296] Community Health Report 2008 for the City of Arlington; Tarrant County Public Health; M.A.P.II Monitoring andAssessment Project 2002-2004

Project Option 2.7.4 – Implement innovative evidence-based strategies to reduce low birth weight and preterm birth

Unique Project ID: 130614405.2.3

Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Project Description:

Babies born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care. This project includes the development of an advanced practice nurse run prenatal clinic located in the area within our community which has the highest rate of women that do not receive prenatal care. The clinic plans to incorporate elements of the Centering Pregnancy model that was designed to reduce racial disparities in birth outcomes and was successful in decreasing preterm infants to rates as low as 1 in 28 births (compared to a national rate of 1 in 8 births).

Centering Pregnancy is a multifaceted model of group care that integrates three major components of care: 1) health assessment, 2) education and 3) support into a unified program within a group setting. Using this unique model, women are empowered to choose health promoting behaviors. Outcomes from this approach resulted in increased birth weights of infants and high satisfaction of patients. Pregnant teenagers are often among the population without access to health care due to lack of funding. Tarrant County has a high teen pregnancy rate and would provide these young women with access to health care at no or reduced cost in a unique environment where they could learn and receive support.

Goals and Relationship to Regional Goals:

Project Goals:

The purpose of the project is to implement an advanced practice nurse managed prenatal clinic at a location in the community that is geographically convenient for the women in the community who do not have access to prenatal care. The project incorporates innovative elements of the Centering Pregnancy model which has demonstrated success in improving health outcomes for women/infants with racial disparities in infant outcomes will be developed. The ultimate goal of the program is to increase the number of disadvantaged pregnant women who receive prenatal care and decrease the rate of low birth weight and preterm births in our community.

This project meets the following Regional goals:

A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to achieving that goal by implementing a prenatal clinic to help low income, disadvantaged pregnant women in the community obtain the care they need to improve their health and the health of their unborn child, with a goal of reducing low birth weight and preterm babies.

Challenges:

The most significant challenge to the success of the project is the ability to entice the target population of disadvantaged pregnant women to obtain prenatal. Outreach programs at area schools, churches, community centers and through other venues would be initiated to communicate the availability of the clinic to those in need. A second challenge is to retain the women in the program to continue to receive prenatal care throughout their pregnancy. The dynamic environment created using the Centering Pregnancy program has demonstrated success in improving compliance with women maintaining their prenatal care. Group members provide support to other members while motivating individuals to learn and make positive changes.

5-Year Expected Outcome for Provider and Patients:

At the conclusion of the 5-year project, we expect a 10% reduction in the number of low birth weight infants delivered at our hospital.

Starting Point/Baseline:

There is currently no prenatal clinic available at Texas Health Arlington Memorial to serve these patients. Between January and August 2012, there were 1,382 (2,073 patients annualized) infant deliveries performed. 45.2% (937 annualized) of these women were unfunded or Medicaid funded patients. There is an increase in numbers of at-risk, disadvantaged women in our geographic area with a limited number of physicians willing to care for these patients. This results in many women being unable to obtain prenatal care. Conversations with area obstetricians have been initiated and there is support from the physician community for the clinic, including a willingness of the physicians to assume care of the women at 36 weeks gestation in order to transition them for delivery of the infant.

Rationale:

Between 2000 and 2009, infant mortality rates were on the rise in Tarrant County. The national infant mortality rate is 7.6 deaths/ 1,000 births. In Tarrant County there were 15.3 deaths per 1,000 live births in African-Americans, 6.7 deaths per 1,000 live births in whites and 5.9 deaths per 1,000 live births in Hispanics. The Centering Pregnancy model has demonstrated effectiveness in reducing racial disparities in birth outcomes.

Healthy People 2020 reports that in 2009, only 52.1% of mothers in Tarrant County received prenatal care and that 8.4% of infants born were low birth weight babies. In Arlington, the infant mortality rate is the highest in ZIP code 76010 (8.9 of 1,000 live births) and less than 75% of pregnant women in this East Arlington area receive prenatal care.

Evidence supports that women receiving early and regular prenatal care have healthier outcomes for both mother and baby. The development of a prenatal clinic would provide an option for patients in our community who do not have financial resources to receive prenatal care. Texas Health Arlington Memorial Hospital is close in proximity to an area where a large percentage of

expectant mothers have been identified as not receiving prenatal care. The county hospital system is moving the clinic currently available to these women to an area of the city not as easily accessible to the at-risk population with the highest infant mortality. A hospital-based prenatal clinic would be geographically convenient for the population needing the service.

Prenatal Care and Infant Outcomes

Category	Arlington 2009 Rate	Texas 2009 Rate
Low Birth Weight infant	8.7	8.5
Preterm infant	11.2	12.1
Late/no Prenatal care	16.9	12.3
Infant mortality	8.6	6.2

Project Components:

This model allows for better cost effectiveness, while providing practitioners that can handle the array of obstetrics and non-obstetric issues during pregnancy. Patients are encouraged to become engaged in their care, learn to manage their health and supported throughout the process. Ongoing evaluation for opportunities to improve the care and service provided utilizing the Plan Do Study Act (PDSA) continuous improvement methodology will assist in progressing the program and achieving better patient outcomes.

Our milestones provide a structure for project improvement and implementing a prenatal clinic program in order to address an identified need within our community. By increasing the number of low-income pregnant women who receive prenatal care, studies show we can positively impact the number of low birth weight babies and preterm infants being born.

Milestones and metrics support:

(1) developing and implementing a prenatal clinic that uses the Centering Pregnancy model,
(2) engaging and enrolling patients in the program to increase numbers of at-risk patients receiving prenatal care, and
(3) improving quality of life while decreasing overall cost of care as evidenced by decreasing the number of patients who deliver low birth weight or preterm infants.

Unique community need identification numbers the project addresses:

- CN.1
- CN.3
- CN.8
- CN.10
- CN.13

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

This project is a new initiative and we have not received any federal funding.

Related Category 3 Outcome Measures:

Outcome Measures:

- IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382) (Stand-alone measure)
- IT-8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Stand-alone measure)

Reasons/rationale for selecting the outcome measures:

Data discussed as outlined above supports the need to improve the delivery of prenatal care to women in our community. Two of the most significant benefits of early and ongoing prenatal care are the decrease in risk of low birth weight babies and preterm deliveries. According to the March of Dimes, the average cost of medical care for a premature or low birth weight baby is approximately $49,000 during the first year of life, compared to $4,550 for a normal newborn. Because approximately 45% of women delivering babies at our hospital are unfunded or government-funded and a very limited number of physicians in the area will accept these patients for prenatal care, implementation of a low-cost/no-cost prenatal clinic in the area would provide access to the timely, quality care in order to optimize health outcomes for the women in our community who cannot afford health care for themselves and their unborn baby. The Centering Pregnancy model used to develop the program should draw disadvantaged women to continued prenatal care at the clinic.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**: This project is related to the Establish/Expand Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care 2.9.1. The patient navigation program will assist with the identification of at risk patients who might benefit from closer monitoring/support and refer them to use the resources available in the prenatal clinic.

- **Related Category 4 Population-focused improvements**: This project is related to RD-3 Potentially Preventable Complications (PPCs): Risk adjusted PPC rates. The Prenatal Clinic provides an avenue for those who might not otherwise obtain prenatal care to receive this care. Complications associated with obstetrics can be reduced through the provision of prenatal care and early identification of/intervention with patients at risk for obstetrical complications.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

- **Approach/Methodology**: For every low birth-weight birth avoided, $29,000 in cost is saved by the health care system. Health care costs are calculated by multiplying $29,000 by the total individuals affected.
- **Rationale/Justification:** Low birth-weight birth outcome improvement targets are dependent on the target population, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place. There are no individual and community savings for this outcome.

130614405.2.3	*2.7.4*	*N/A*	*Implement Evidence-based Disease Prevention Program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth.*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.5* *130614405.3.6*	*3.IT-8.2* *3.IT-8.3*	*IT-8.2 Percentage of Low Birth-weight births (CHIPRA/NQF # 1382) (Stand-alone measure)* *IT-8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Stand-alone 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 (prenatal clinic) for targeted population. Metric 1 [P-1.1]: Document innovational strategy and plan. Baseline/Goal: Plan including projected staffing requirements, hours of operations, identified location/building, equipment needs, key operational policies, clinical practice guidelines and marketing/awareness plan developed. Data Source: Performing Provider documents describing innovational plan Milestone 1 Estimated Incentive Payment: $747,577	**Milestone 2** [P-2]: Implement evidence-based innovational project for targeted population Metric 1 [P-2.1]: Document implementation strategy and testing outcomes. Goals: Obtain necessary funding to hire required staff including advanced practice nurse, RN and ancillary staff to open prenatal clinic. Open clinic by 9/30/2014. Data Source: Documentation of prenatal clinic opening prior to 9/30/2014. Milestone 2 Estimated Incentive Payment: $241,272 **Milestone 3** [P-4]: Execution of evaluation process for project innovation. Metric 1 [P-4.1]: Document evaluative process, tools and analytics. Goal: Documentation of process	**Milestone 5** [I-5]: Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Number of women enrolled in the prenatal care. Goal: Approximately 200 patients enrolled in prenatal care. Data Source: Patient medical records (pregnant women who are uninsured or have government-funded insurance) enrolled in the prenatal care. Milestone 5 Estimated Incentive Payment: $381,704 **Milestone 6** [I-7]: Increase access to disease prevention programs using innovative project option. Metric 1 [I-7.2]: Increased number of encounters as defined by intervention (Total number of target population receiving education for reporting	**Milestone 7** [I-5]: Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Number of women enrolled in the prenatal care. Goal: Approximately 400 patients enrolled in prenatal care. Data Source: Patient medical records (pregnant women who are uninsured or have government-funded insurance) enrolled in the prenatal care. Milestone 7 Estimated Incentive Payment: $308,208 **Milestone 8** [I-7]: Increase access to disease prevention programs using innovative project option. Metric 1 [I-7.2]: Increased number of encounters as defined by intervention (Total number of target population

130614405.2.3	*2.7.4*	*N/A*	*Implement Evidence-based Disease Prevention Program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth.*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.5* *130614405.3.6*	*3.IT-8.2* *3.IT-8.3*	*IT-8.2 Percentage of Low Birth-weight births (CHIPRA/NQF # 1382) (Stand-alone measure)* *IT-8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Stand-alone 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)
	to evaluate effectiveness of the program including key performance indicators and data collection/reporting process is completed. Data Source: Documents that outline the evaluation process developed. Milestone 3 Estimated Incentive Payment: $241,272 **Milestone 4** [I-5]: Identify percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Number of women enrolled in the prenatal care. Goal**:** 25 enrolled in prenatal care. Data Source: Patient medical records (pregnant women who are uninsured or have government-funded insurance) enrolled in the prenatal care.	period) Goal: Number of participants in education program increased by 20% from previous year Data Source: Clinic patient records Milestone 6 Estimated Incentive Payment: $381,704	receiving education for reporting period) Goal: Number of participants in education program increased by 20% from previous year Data Source: Clinic patient records Milestone 8 Estimated Incentive Payment: $308,208

130614405.2.3	*2.7.4*	*N/A*	*Implement Evidence-based Disease Prevention Program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth.*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.5* *130614405.3.6*	*3.IT-8.2* *3.IT-8.3*	*IT-8.2 Percentage of Low Birth-weight births (CHIPRA/NQF # 1382) (Stand-alone measure)* *IT-8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (Stand-alone 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 4 Estimated Incentive Payment: $241,272		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $**747,577**	Year 3 Estimated Milestone Bundle Amount: $**723,815**	Year 4 Estimated Milestone Bundle Amount: $**763,408**	Year 5 Estimated Milestone Bundle Amount: $**616,416**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: $**2,851,216**			

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.9.1– Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)

Unique Project ID: 130614405.2.4

Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Provider: THAM is a 369 bed acute care hospital located in Arlington, Texas. Our hospital serves the city of Arlington and surrounding communities, a 100 square mile area and a population of more than 365,000 residents. THAM provides emergency and acute inpatient care to the community.

Intervention: Goals for the project include improved management of patient health care needs resulting in a reduction of inappropriate ED utilization for non-emergent conditions and increased navigation of patients to appropriate health care resources, including establishing a PCP. Initial work has begun to implement the project on a limited scope. One full time RN case manager has recently been hired to assist in navigation and telephonic follow-up with at risk patients. Additional FTEs would be needed for full implementation of the project.

Need of the project: The volume of patients cared for in the emergency department has increased by 20% since 2010, with a 27.9% increase in indigent and Medicaid patients. An analysis of the 4,936 June 2012 THAM ED patients indicated that 53% of the patients presenting for care in the ED were unfunded or Medicaid. Over half of these patients (55%) had diagnoses that did not require emergency care, but came to the ED because they felt they had no other healthcare options. During January through June 2012, over 61% of the patients who came to the emergency department for care indicated they had no PCP[297].

Target population: The target population is patients, primarily those patients without insurance or with government funded insurance, who present to the ED for care that could be provided at a lower level or those with frequent utilization of the ED routine healthcare. Over the course of the waiver, we anticipate being able to intervene with over 3,000 patients. (DY2: 200 patients; DY3: 400 patients; DY4: 1,400 patients; DY5: 1,500 patients)

Expected patient benefits: The ED case manager will navigate patients to appropriate healthcare facilities or community programs, refer to area resources or assist in establishing a medical home. The ED case manager may continue to follow the patient post discharge as appropriate to provide necessary education, re-enforce discharge plans and monitor patient compliance with follow-up care to improve their health.

Category 1 or 2 expected patient benefits: Milestones selected include expansion of the ED health care navigation program to include hiring, training and providing ongoing education to RN case managers acting as navigators with the support of social workers and other health care team members. A process for tracking and reporting on the patients enrolled, interventions implemented would be developed. Tracking outcomes of the programs including PCP referrals for patients without a medical home and decrease in avoidable patient use of the ED would be monitored.

Category 3 outcomes: Our project goal is to implement programs that will improve the health of patients who are most at risk of receiving disconnected and fragmented care by improving appropriate use of the ED by 18% over the course of the project.

[297] Internal organizational data from EPSI database

Project Option 2.9.1– Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)

Unique Project ID: 130614405.2.4

Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Project Description:

The project implements an emergency department- (ED-) based case management program to identify high-frequency ED patients and navigate them to more appropriate care settings, particularly primary care. The project uses highly-skilled nurse case managers to lead a collaborative process of assessment, planning, facilitation and advocacy for options. The project promotes quality cost-effective outcomes by providing services to meet an individual's health needs through enhanced communication and increased access to available resources. The ED RN case manager will work with a multidisciplinary health care team to assist disadvantaged patients without primary care access to:

1) Navigate patients to obtain necessary community resources to meet identified patient needs.
2) Facilitate finding and obtaining a primary care provider (PCP) or enroll in a nurse practitioner -run chronic disease management clinic to more effectively manage their disease on an ongoing basis.
3) Intervene as necessary to provide education, monitor identified patients post-discharge to encourage compliance with their follow-up plan, and provide ongoing care/support for their health care needs.
4) Facilitate arrangements for care, as clinically appropriate, at a less resource intense level, such as an outpatient clinic or skilled nursing facility to avoid hospital admission and reduce risk of ongoing utilization of ED for non-emergent care needs.

Goals and Relationship to Regional Goals:

Project Goals:

Goals for the project include a reduction in inappropriate ED utilization for non-emergent conditions and increased navigation of patients to appropriate health care resources, including establishing a PCP. We anticipate that improved management of health needs through navigation of at-risk patients to appropriate resources and to establishing the patient's relationship with a PCP who can monitor and manage their health on an ongoing basis will reduce the number of potentially avoidable hospitalizations and ED visits as well as lower overall health care costs for this target population.

This project meets the following Regional goals:

Regional goals are aligned with the triple aim of health care reform, namely, to improve clinical outcomes and the patient experience while lowering per capita health care costs. Additionally, a major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to achieving that goal by implementing a RN

navigator based in the ED to help at risk, disadvantaged community members obtain access to preventive, primary and chronic health care services in order to more effectively manage their health.

Challenges:

During January through June 2012, over 61% of the patients living in the North Arlington area who came to the emergency department for care indicated they had no PCP. The ED case manager will provide these patients with a resource to facilitate enrollment in appropriate community programs or establish a medical home. The ED case manager will continue to follow the patient post-discharge to provide necessary education, re-enforce discharge plan and monitor patient compliance with follow-up care to improve their health.

Challenges include the availability of PCPs in the area that accept new unfunded or government-funded patients. The hospital has recently aligned with the county health care system, JPS Health Network (JPS), to have a representative appointed to our hospital. The JPS Health Network Representative will work with the ED case manager to enroll patients in the JPS Health Network system, establish a PCP, and expedite appointments. In addition, PCPs accepting disadvantaged patients are being recruited to align with the hospital. One physician has been recruited and will be housed in a new medical office building scheduled to open in spring 2013. THAM nurse-practitioner run outpatient clinics for chronic disease management and follow-up care are being developed. The implementation of an ED case manager to navigate disadvantaged patients to these and other resources in the area will assist in more appropriately managing the health care needs of disadvantaged patients in a cost-effective manner, while relieving the emergency department.

5-Year Expected Outcome for Provider and Patients:

Goal is to reduce inappropriate utilization of the emergency department or hospitalization by 18% over the five-year time period.

Starting Point/Baseline:

Utilization of the Texas Health Arlington Memorial hospital emergency department has been steadily increasing over the last several years with an 11% increase in ED patient volume between 2010 (57,400 visits) and 2011 (64,600 visits). Estimates for 2012 (72,000 visits) indicate an additional 12.5% increase in volume will be noted from 2011 to 2012. Approximately 50% of the patients currently utilizing our ED are unfunded or government patients, many of whom routinely use the ED for management of their chronic condition or episodic care.

The new JPS Health Network liaison, working only Monday through Friday, 9 a.m. until 5 p.m., has made contact with 667 disadvantaged patients over the last two months. She has only been successful in enrolling 17 of these patients in the JPS Health Network system for care. The

addition of ED case managers with expanded hours (24/7 coverage) and the availability of additional PCPs or nurse practitioner run clinics will provide new options to assist patients in obtaining care and avoid emergency department visits or hospitalizations.

Rationale:

An analysis of the 4,936 June 2012 Texas Health Arlington Memorial ED patient visits indicated that 53% of the patients presenting for care in the ED were unfunded or Medicaid. Of this disadvantaged low income target population, over half (55%) had diagnoses that did not require emergency care, including conditions such as chronic back pain, prescription refills, follow-up exams or dental disorder. Additional diagnoses, such as limb pain or urinary tract infection might have been managed at a lower level of care or prevented with appropriate primary care. This program will guide the disenfranchised medically complex patient more appropriately through and across our system, from provider to provider, ensuring they can get to and make multiple appointments, get prescriptions filled, access community services for people with special needs (such as getting cancer patients access to support groups), etc. The patient navigator represents the liaison between primary, secondary, tertiary and quaternary health care.

Project Components:

All required core project components, which are listed below, are included in the project:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying lessons learned, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety net populations

Our process milestones and metrics will facilitate our project to moving chronically ill, low income patients at risk of receiving fragmented care into a program that will allow them to more effectively manage their disease and obtain timely and appropriate level of care. We are committed to participating with other RHP providers to continually evaluate and improve our program effectiveness. Milestones and metrics measure navigator assistance provided through the program to our high need population and include:

1) Hiring and training staff including RN case managers to cover the ED seven days a week who will coordinate a multidisciplinary team including social workers, RNs and

physicians/nurse practitioners to more effectively address anticipated needs (social and clinical)

2) Developing policies, procedures, data collection tools and equipment to effectively run the program and monitor effectiveness
3) Increasing the number of patients served under this model by 20% over the five-year period. These milestones and metrics will measure the volume of at-risk patients receiving navigation services through an effective, coordinated model, and thus able to access care at the appropriate level for ongoing management of their health (rather than receiving fragmented care).

Unique community need identification numbers the project addresses:

- CN.10 – Overuse of emergency department (ED) services
- CN.11 – Need for more care coordination

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

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-9.2 Right Care, Right Setting – ED appropriate utilization (Stand-alone measure)

This project will reduce inappropriate ED visits for the following target conditions CHF, diabetes, ESRD, CV/hypertension, behavioral health/substance abuse, COPD, asthma.

This project provides navigation services so the patient gets the right care, in the right setting and in a timely fashion, avoiding unnecessary ED visits and avoidable hospital admissions. (See data discussed in Section 4.a). Many studies have demonstrated the effectiveness of case management/navigation program to improve management of patient health, reduce risk of avoidable readmissions and provide better primary care access. RN Navigators will assist patients in obtaining resources necessary to more effectively manage their chronic condition or maintain their health. Patients with effectively managed disease and access to a dedicated health care provider will be less likely to utilize the ED for non-emergent conditions and will manage their health through primary and non-emergency health care providers. The program also assists in avoiding inpatient hospitalizations by providing patients with more appropriate alternatives to receive care and coordinating the necessary services from the ED.

Relationship to Other Projects:

Related Category 1 and 2 projects: This project is related to project 2.2 Expand Chronic Care Management Models. The ED case manager will utilize the chronic care clinics as a resource to refer patients needing assistance with management of their chronic condition.

Related Category 4 population-focused improvements

- RD1: Potentially Preventable Admissions 1.Congestive Heart Failure Admission Rate; 2. Diabetes Admission Rate; 3. Behavioral Health and Substance Abuse Admission Rate; 4.

Chronic Obstructive Pulmonary Disease Admission Rate; 5. Hypertension Admission Rate

- RD-5 Emergency Department: 1. Admit decision time to ED departure time for admitted patients (NQF 0497)

The ED Case Management program will help navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care. Through the navigation of patients to available resources, patient admissions can be avoided increasing the availability of inpatient beds for those in need of hospitalization. Increased bed availability impacts ED patient throughout and improves time for ED patients to receive their inpatient bed.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology:** For every inappropriate inpatient admission avoided, $9,302 in cost is saved by the health care system. The average length of stay per inpatient admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inappropriate inpatient admissions outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with greater than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent inappropriate inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

130614405.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.7*	*3.IT-9.2*	*IT- 9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department visits for target conditions* *CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*

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]: 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-2.3]: Frequency of contact with care navigators for high risk patients. Baseline/Goal: 200 encounters Data Source: Patient navigation program materials and database, EHR Milestone 1 Estimated Incentive Payment: $328,503 **Milestone 2** [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The	**Milestone 5** [P-8]: 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. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Attend 2 programs/year Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes.	**Milestone 7** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: 85% of identified patients Data source: Administrative data on patient encounters and scheduling records from patient navigator program Milestone 7 Estimated Incentive Payment: $670,919 **Milestone 8** [I-8]: Reduction in ED use by identified ED frequent users receiving navigation services Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users (based on program enrollment).	**Milestone 9** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: 90% of identified patients Data source: Administrative data on patient encounters and scheduling records from patient navigator program Milestone 9 Estimated Incentive Payment: $541,736 **Milestone 10** [I-8]: Reduction in ED use by identified ED frequent users receiving navigation services Metric 1 [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users. Goal: 18% reduction from baseline

130614405.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.7*	*3.IT-9.2*	*IT- 9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department visits for target conditions* *CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*

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)
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 represents the liaison between primary, secondary, tertiary and quaternary health care. Metric [P-5.1]: Collect and report on all the types of patient navigator services provided. Baseline/Goal: Data collection completed with at least one report produced Data Source: Provider developed database	Milestone 5 Estimated Incentive Payment: $636,123 **Milestone 6** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: 80% of identified patients Data source: Administrative data on patient encounters and scheduling records from patient navigator program Milestone 6 Estimated Incentive Payment: $636,123	Goal: 10% reduction Data Source: Claims and EHR/registry Milestone 8 Estimated Incentive Payment: $670,919	(based on program enrollment). Data Source: Claims and EHR/registry Milestone 10 Estimated Incentive Payment: $541,736

130614405.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.7*	*3.IT-9.2*	*IT- 9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department visits for target conditions* *CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*

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 2 Estimated Incentive Payment : $328,503 **Milestone 3** [P-8]: 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. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Attend 2 programs/year Data Source: Documentation of semiannual meetings including meeting agendas, slides from			

130614405.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.7*	*3.IT-9.2*	*IT- 9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department visits for target conditions* *CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*

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)
presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment: $328,503 **Milestone 4 [P-X]**: Customizable Process Milestone: Establish baseline rates for DY4 and DY5 metrics a) number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services b) volume of ED frequent users receiving navigation services Metric 1 [P.X]: Determine the baseline metrics for the 2 identified measures noted in Milestone 4. Baseline/Goal: Baseline metrics will be determined Data Source: Clinic records Milestone 4 Estimated Incentive Payment : $328,503			

130614405.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 3 Outcome Measure(s):	*130614405.3.7*	*3.IT-9.2*	*IT- 9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department visits for target conditions* *CHF, Diabetes, ESRD, CV /Hypertension, Behavioral Health/Substance Abuse, COPD, Asthma*

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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,314,011	Year 3 Estimated Milestone Bundle Amount: $1,272,246	Year 4 Estimated Milestone Bundle Amount: $1,341,838	Year 5 Estimated Milestone Bundle Amount: $1,083,472
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $5,011,567			

Project Summary

Project Option 2.15.1– Integrate Primary and Behavioral Health Care Services- Collaboration with indigent clinics and site-based primary care

Unique Project ID: 130724106.2.1
Performing Provider Name/TPI: Pecan Valley Centers for Behavioral and Developmental Healthcare / 130724106

Provider: Pecan Valley Centers is the Local Authority for mental health and developmental disability services for a six county region (5 of which are included in RHP 10). The total area covers 4267 sq miles and has a total population of 442,719. In the last 12 months, provider has served an average of 2173 individuals (adults and youth). Pecan Valley Centers, as the local authority for the service area, is the safety net for mental health services for individuals without Medicaid or other funding source. Although we serve individuals with Medicaid, Medicare and other funding sources more than half of our population served do not have a funding source and would go without mental health services without the local authority.
Intervention: Project will aim to integrate primary health care with behavioral health care by co-locating primary care services in existing behavioral health clinics as well as placing mental health staff in community indigent clinics. The project is new to Pecan Valley as currently no integration of primary and behavioral healthcare is present.
Need for the project: Insufficient integration of mental health care in the primary care medical system was identified as a need in the community needs assessment for Region 10. The lack of integration adversely affects both the medical system and behavioral health system and treatment becomes fragmented. By increasing access to primary care services and expanding the system of care, early detection of chronic health conditions and mental health conditions will diminish the disconnect between services. Individuals with behavioral health issues experience higher risk of mortality and poor health outcomes, largely due to a lack of preventive health services and poorly controlled co-morbid medical disease. The risk increases with the severity of the behavioral health diagnoses. Since more than half of the 2100 individuals receiving services at Pecan Valley do not have Medicaid or other funding sources, these same number of people most likely do not have a primary care physician, due to the inability to pay for such services. They may utilize the indigent clinics or just lack healthcare services. Collaboration between primary and behavioral healthcare providers is important to ensure adequate monitoring.
Target population: The target population is adults and youth with severe mental illness. Estimated number of patients to be served over course of waiver period: 720. Approximately 55% (1210) of our population has no funding source or are indigent and 25% (500) of adults and 75% (150) of youth have Medicaid, so this project will impact a large portion on uninsured individuals by providing primary care access.
Category 1 or 2 expected patient benefit: Our goal is to provide;

1) DY 2-Discussion with community providers to identify three potential sites for integration in the community
2) DY 3- 25% or estimated 300 referrals will occur between providers; two providers in the community will be identified as potential sites for Level 4 interaction

3) DY 4-50% or estimated 600 individuals will receive coordination of care; and 15% or estimated 180 individuals will receive integrated services.
4) DY 5-30% or estimated 360 will receive integrated services from a site; 30% or estimated 360 will show an increase in health metrics as evidenced by the CANS or ANSA assessments

The goals identify the effectiveness of the healthcare integration.

Category 3 outcomes: IT-6.1 Percent improvement over baseline of patient satisfaction scores- By the end of the waiver the expected results is to see 70% of individuals receiving integrated services reporting satisfaction with their overall health and functional status. Patient satisfaction is a critical component in the success of integration in order to keep the client engaged in both behavioral and physical healthcare. Studies show that patients with high satisfaction scores are more likely to remain engaged in services as opposed to those with low satisfaction scores in which tend to drop out of services. By achieving high patient satisfaction, patients will continue to utilize lower costing services available in the community to manage and improve their illnesses, saving tax payers an estimated $3.04 million over the life of the grant. In addition, clients receiving integrated services will create a benefit for primary care patients with non-behavioral health issues valued at $1.2 million, by allowing more time available for primary care physicians to see additional patients due to the lower intensity service needed by behavioral health clients for primary care. The integration of care will be reflected in the overall health of individuals by providing access to services and assessments. Integrating care between primary and behavioral health care can impact patient satisfaction because individuals will receive a holistic approach and receive the right service at the right time. By removing barriers to primary care, for individuals with behavioral health issues, an expected overall improvement in health care status and functioning can be expected. The valuation of this project is aimed at assessing patient satisfaction as it relates to patient experiences with integrated health care.

Project Option 2.15.1– Integrate Primary and Behavioral Health Care Services- Collaboration with indigent clinics and site-based primary care

Unique Project ID: 130724106.2.1
Performing Provider Name/TPI: Pecan Valley Centers for Behavioral and Developmental Healthcare / 130724106

Project Description:
Integrated care project will be a combination of co-location of primary care services in existing behavioral health clinics as well as locating mental health staff in existing primary care and indigent care clinics. Currently an indigent care clinic and behavioral health clinic exists in four counties. By increasing access to primary care services and expanded system of care, early detection of chronic health conditions and mental health conditions will diminish the silo model of disconnected services.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of this project is to link individuals with primary care services, while also receiving services to address their behavioral health needs. Currently services for both primary and behavioral health care are not integrated. This is complicated by multiple providers, as well as lack of continuity of elements such as medication monitoring, health records and screenings. By integrating services, individuals will be able to receive their services in one location. This will provide continuity of services and result in early detection of conditions that are detrimental to their well being. The five year goals are 1) to integrate primary and behavioral health care services in three community sites, and 2) close collaboration in a partly integrated system in one site.

Challenges:
People with chronic medical conditions have high rates of behavioral health problems. Individuals in Texas with psychiatric illnesses die 29 years earlier than the normal population. Nearly two-thirds of these deaths are caused by treatable physical illness including diabetes, cardiovascular disease and cancer. In behavioral health settings, more than half of medical conditions go unrecognized. Many individuals who experience mental illness experience challenges in accessing primary care. As a result, many tend to seek medical care through the ED and have little continuity of care. By integrating health care with behavioral health will result in increased access to primary care. By embedding mental health professionals into existing community-based settings, better care coordination will occur for both behavioral and medical health needs.

5-Year Expected outcome for Provider and Patients:
The five year goals are 1) to integrate primary and behavioral health care services in three community sites, and 2) close collaboration in a partly integrated system in one site. Multidisciplinary treatment by both primary and behavioral health professionals, providing needed continuity of treatment to ensure adequate follow up so the full benefit of health care treatment is achieved.

Starting Point/Baseline:
Currently no integrated services exist for Pecan Valley. Fifty percent (1,200) of the current behavioral health population of individuals with severe mental illness served by Pecan Valley does not have Medicaid, Medicare or private insurance. This population will be the target for this project. This baseline will assist in making the determination as to which site represents the most need for co-location.

According to the 2009 Texas County statistics, 24.46% of individuals in five counties Pecan Valley serves do not have insurance and unlikely to have a primary care provider. A baseline will be determined as to how many individuals currently in behavioral health services do not have a primary care provider.

Rationale:
Behavioral health conditions, including mental illness and substance abuse, are frequent with Medicaid-eligible individuals with chronic medical conditions. These individuals with common chronic conditions and mental illness makeup approximately 75% of health care costs. Recent studies show that integration of behavioral health and physical health services should be standard for advanced health care systems resulting in more cost-effective and comprehensive patient care. Patients with behavioral health issues experience higher risk of mortality and poor health outcomes, largely due to a lack of preventive health services and poorly controlled co-morbid medical disease. Risk increases with the severity of the behavioral health diagnoses. The measures chosen for this project would identify the level of need for primary care services, develop relationships with providers and community setting for co-location and integrating mental health professionals into the primary care setting. Mental health professionals can play a key role in assisting individuals in developing self-management goals, managing chronic conditions, promoting wellness. Complex medical and social issues including multiple chronic health conditions, low income, housing, insecurity, social isolation, and lack of natural supports systems severely impact health and social functioning for persons with more severe behavioral health diagnoses such as schizophrenia, bipolar disorder and major depressive disorder. Substance use disorders, alone or in combination with mental health conditions, have significant physical consequences, leading to disability and increased acute and long term service expenditures.

Project Components:
Our project contains all the core elements, including:

- Sites for potential integrated sites will be in the individual's community to provide ease of access. These sites are currently being used by either indigent care clinics or behavioral health services. Discussions have occurred with community providers and are agreeable to shared space and staff.
- Provider agreements and legal arrangements will define scheduling and information sharing processes as well as contracts defining locations, cost sharing of building usage and utilities.
- Protocols and processes for sharing information for scheduling, data sharing, communication and electronic health information will be established. An anticipated upgrade of an electronic heath record in FY13 will result in more efficient information sharing
- Ten additional providers will be recruited to provide and support of integrated services. These staff will be located in multiple locations.
- Training will be integral for the success of this project. Both primary and behavioral health care providers will be trained together to create a shared vision of service delivery and continuum of care. Team consultations will be implemented in order for all team members to communicate and co-develop care plans.
- The upgrade of an electronic heath record in FY13 will result in more efficient information sharing in order to track utilization of services and outcomes. The quality and utilization management departments will be active in tracking expanded data collection, including primary care integration.
- Minimally of quarterly quality improvement reviews to include project impact, penetration of patient population, and challenges with program expansion.

The Community Needs Assessment identified a need to better achieve integration of primary care and mental health care services in the primary care setting through heightened awareness of medical models for mental health integration. The measures chosen for this project will 1) identify level of need for primary care services 2) develop relationships with providers and community settings for co-location and integrating mental health professionals into the primary care setting 3) co-located primary care services in behavioral health setting. These measures will measure the number of individuals who receive both primary and behavioral health care in integrated settings.

Unique community need identification numbers the project addresses:

- CN.5 – Insufficient integration of mental health care in the primary care medical care system
- CN.11 – Need for more care coordination
- CN.10-Overuse of emergency department (ED) services.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:
Outcome Measure 1: IT-6.1 Percent improvement over baseline of patient satisfaction scores

According to the Integrated Behavioral Health Project integrating primary and behavioral health care allows for a more "cohesive service delivery system and better continuity of care". The document goes on to state that integrated care has the ability to produce significant positive results due to both physical and behavioral health needs are addressed. Data also shows that those suffering with behavioral health issues are more likely to have co-occurring physical ailments as well. In order to retain patients with both physical and behavior health needs, patient satisfaction must be maintained. By the end of the Waiver project, our goal is to show 70% of individuals reporting satisfaction with their overall health and functional status.

Relationship to Other Projects:
Integration of primary and behavioral health care will support the expanding access project (1.9.2 Expand specialty care access) by providing a link to necessary health care.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:
Integrating care between primary and behavioral health care can impact patient satisfaction because individuals will receive a holistic approach and receive the right service at the right time. By removing barriers to primary care, for individuals with behavioral health issues, an expected overall improvement in health care status and functioning can be expected. The valuation of this project is aimed at assessing patient satisfaction as it relates to patient experiences with integrated health care. The population of this project will be those individuals in the identified sites for integration. Only those individuals enrolled in this program will be included in the project scope of the project. According to Integrated Behavioral Health Project integrating primary and behavioral health care allows for a more "cohesive service delivery system and better continuity of care." The document goes on to state that integrated care has the ability to produce significant positive results due to both physical and behavioral health needs are

addressed. Data also shows that those suffering with behavioral health issues are more likely to have co-occurring physical ailments as well. In order to retain patients with both physical and behavior health needs, patient satisfaction must be maintained. Utilizing the Region 10 Pricing Model, Pecan Valley Centers' places a value of customer satisfaction to equal $87,427. This calculation is based on a 70% favorable rating of the population at a value of 2% of billing over the five-year period of the Waiver. In addition, Pecan Valley Center's recognizes that integrated health will lead to lower level intervention needed to address the patients' on-going physical needs. By reducing the CPT billing codes from a level 5 to a level 2, a cost savings value of $2,956,200 can be achieved. With both physical and behavioral health needs being achieved on a routine bases and a lower physical intervention being required to maximizing the patients' health care needs, greater access to additional patients in the community with needs can be addressed, resulting in a community benefit of $1,200,572 over the life of the grant and a total project value of $4,244,200.

130724106.2.1	*2.15.1*	*2.15.1.A-J*	***Integrate Primary and Behavioral Health Care Services- Collaboration with indigent clinics and site-based primary care***
Pecan Valley Centers for Behavioral and Developmental Health Care			*130724106*
Related Category 3 Outcome Measure(s):	*130724106.3.2*	*3.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 determine areas where the co-location of services has the potential to benefit a significant number of people who have physical/behavioral health needs. Metric1 [P-1.1]: Number of patients in various areas who might benefit from co-located services. Demographics, location, and diagnoses Baseline/Goal: Baseline will be established for need level, and locations Data Source: Inpatient, discharge and ED records; survey of primary care providers; survey of behavioral health providers; state demographic information relating to treated health conditions; Medicaid claims data Milestone 1 Estimated Incentive Payment $ 163,100 **Milestone 2 [**P-2]: Identify existing clinics or other community-based settings where integration could be supported. Metric 1 [P-2.1]: Discussion/interviews with three community health care providers (physical and behavioral), city and	**Milestone 3 [**P-3]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. Metric 1 [P-3.1]: Number and types of referrals that are made between providers at the location Baseline/Goal: 25% of 1200 or 300 increase in referrals Data Sources: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results Milestone 3 Estimated Incentive Payment: $376,997 **Milestone 4 [**P-6]**:** Develop integrated behavioral health and primary care services within co-located sites. Metric1 [P-6.1]: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). Baseline/Goal: 2 providers Data Source: Project data Milestone 4 Estimated Incentive Payment: $376,998	**Milestone 5** [I-9]: Coordination of Care Metric 1 [I-9.1]: Percent of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Numerator: Number of individuals receiving both physical and behavioral health care in project sites Denominator: Number of individuals receiving services in project sites Goal: 50% of 1200 or 600 Data Source: Project data, medical records, encounter data Milestone 5 Estimated Incentive Payment: $460,211 **Milestone 6** [I-8]: Integrated Services Metric 1 [I-8.1]: Percent of Individuals receiving both physical and behavioral health care at the established locations. Goal: 15% of 1200 or 180 Data Source: Project data; claims and encounter data; medical records Milestone 6 Estimated Incentive Payment: $460,212	**Milestone 7 [**I-8]: Integrated Services Metric 1 [I-8.1]: Percent of individuals receiving both physical and behavioral health care at the established locations. Goal: 30%-360 individuals Data Source: Project data; claims and encounter data; medical records Milestone 7 Estimated Incentive Payment: $ 503,815 **Milestone 8** [I-11]: Health Metrics Metric 1 [I-11.1]: Percent of increase in Positive Results of Standardized Health Metrics to include CANS and ANSA assessments Goal: 30%-360 individuals Data Source: Project Data; Medical Records; Claims and Encounter Data. Milestone 8 Estimated Incentive Payment: $ 503,815

130724106.2.1	***2.15.1***	***2.15.1.A-J***	***Integrate Primary and Behavioral Health Care Services-Collaboration with indigent clinics and site-based primary care***
Pecan Valley Centers for Behavioral and Developmental Health Care			*130724106*
Related Category 3 Outcome Measure(s):	*130724106.3.2*	*3.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)**
county governments, charities, faith based organizations and other community-based helping organizations. Baseline/Goal: Identify at least three locations for integration. Identify at least three internal staff positions and types of services needed to be co-located in the locations. Data Source: Information from persons interviewed Milestone 2 Estimated Incentive Payment $163,100			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $326,200	Year 3 Estimated Milestone Bundle Amount: $753,995	Year 4 Estimated Milestone Bundle Amount: $920,423	Year 5 Estimated Milestone Bundle Amount: $1,007,630
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $3,008,248			

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option – 2.2.2 – Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program
Unique Project ID: 135036506.2.1
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506
Provider: Baylor All Saints Medical Center at Fort Worth, located near downtown Fort Worth, is a full-service hospital dedicated to providing for the health care needs of the community. Baylor Fort Worth is among Tarrant County's oldest not-for-profit hospitals and celebrated 100 years of service in 2006. The medical center has 525 licensed beds and offers a broad range of medical services including programs of excellence in cardiology, transplantation, neurosciences, oncology and women's services. Baylor Fort Worth's service area represents a population of 1.2 million.
Intervention: The project purpose is to provide focused education and point of care testing for underserved patients who have diabetes, CVD and/or Respiratory disease that are in need of education, clinical management and training within a primary care setting. We will co-locate primary care and chronic disease management services to improve clinical outcomes. This will be a new project for the Medicaid and Uninsured populations in Fort Worth.
Need for the project: Underserved patients experience multiple barriers to effectively manage their chronic illnesses. Two of the needs identified by the Community Health Needs Assessment for Region 10 included components of patient education and helping patients to understand their illness, how to better manage it and how to coordinate their lifestyle choices to achieve optimal health outcomes
Target population: The target population is PCMH patients with diabetes, CVD and Respiratory disease in Fort Worth. 570 new patients from DY3-DY5 will receive chronic disease education and point of care services. The Community Health Needs Assessment identified the top 5 most prevalent conditions as: diabetes, obesity, hypertension, heart failure and COPD. This project addresses 3 of these illnesses directly and 2 indirectly, it aligns exactly with the needs of the Region by increasing the availably of chronic care services and self-management training/education.
Category 1 or 2 expected patient benefits: Develop Chronic Care model; increase number of patients seen by Chronic Disease program; and improved patient compliance with care regimens. These milestones and metrics tie into the project purpose through identifying patients with chronic diseases and providing comprehensive education for Diabetes, CVD and Asthma/COPD.
Category 3 outcomes: (all baselines will be reevaluated and reestablished in DY2)

- IT-1.10: Diabetes Care: HbA1c Poor Control. Our goal is to decrease the number of patients with uncontrolled HbA1cs (> 9.0%) from 25% currently to 21.4% in DY5.
- IT-11.1: Diabetes Care: BP Control (< 140/80 mmHg). Our goal is to increase the number of diabetic patients in good BP control from 50.9% currently to 57.9% in DY5.
- IT-1.13 Diabetes care foot exam: Our goal is to increase the number of patients with diabetes receiving foot exams/screenings from 96% currently to 97.2% in DY5.

Project Option – 2.2.2 – Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program

Unique Project ID: 135036506.2.1
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506
Project Description:
The Baylor Clinic on the Baylor All Saints Medical Center at Fort Worth campus will house a carved out chronic disease management program to provide focused and dedicated education and care for patients (including uninsured and Medicaid) with diabetes, cardiovascular diseases (CVD) (i.e., congestive heart failure) and respiratory diseases (asthma/chronic obstructive pulmonary disease) within a primary care setting. Community health workers and nurse care managers will address the complex clinical and prevention needs of these patients and spend time specifically on management of these diseases – providing both clinical counseling and a focus on lifestyle issues and self-management. Patients will also receive point of care testing for diabetes (HbA1c testing and glucose testing using test strips) and asthma (peak flow meter assessments). We believe this program will reduce patients' noncompliance with completing lab orders and address their financial and transportation barriers to access. We will leverage the expertise and experience of both the Diabetes Health and Wellness Institute (Baylor entity in South Dallas) and Baylor Clinics to provide the staff education, develop competencies and create protocols that will result in a complete and robust program tailored for multiple community settings. The Diabetes Health and Wellness Institute will house this staff and appropriately triage and manage providers to see patients at Baylor Clinics based on volume and demand parameters. Baylor Clinics have had previous success in managing patients with chronic disease through the creation and development of a community health worker model. These successes and competencies will be leveraged to create programs around CVD and respiratory illnesses.

Goals and Relationship to Regional Goals:
Project Goals:
Project goals for this program include: (1) increase health literacy around chronic illnesses for patients in the community, (2) educate and teach self-management techniques for patients with chronic diseases, (3) augment RN care managers with CHWs to serve a greater number of patient through a carved out, focused care model, (4) increase the number of patients screened and monitored for their chronic diseases using point of care testing and (5) increase education for patients with CHF and asthma/COPD. The project will identify patients with chronic diseases and provide them with treatment and education so that downstream complications are avoided and unnecessary ED/inpatient utilization decreases.

This project meets the following regional goals:

This project addresses the Region 10 needs for improved patient education about how lifestyle choices affect health outcomes as well as access to chronic disease management . Project implementation will lower ED visits for acute chronic disease symptoms.

Challenges:

Underserved patients experience multiple barriers to effectively manage their chronic illnesses. These include lack of knowledge, lack of social support, poor diets, insufficient physical activity, and limited access to care due to financial and transportation issues. By co-locating the chronic care management program within the primary care clinic, patients can receive medical care and chronic disease support at the same time. Additionally, the PCP's medical management is informed by the chronic care management team's interactions with the patient, which, in our experience, elicits new information regarding lifestyle and barriers to health. The RN/CHW model will be structured so that patient education is delivered in a format and context that is understandable and enjoyable for the patient. Lastly, the education and counseling will include lifestyle and self-management techniques so that this population can find ways to care for themselves that is relevant to their daily lives.

5-Year Expected Outcome for Provider and Patients:

Expected 5-year outcomes are: 1) at least 370 patients will receive care according to the Chronic Care Management model at the Baylor Clinic, 2) better clinical outcomes around HbA1c, foot exam completion and BP control, 3) more patients with a point of care test completed for their diabetes or asthma, 4) increased patient chronic disease, and 5) decreased rates of avoidable/unnecessary complications due to chronic disease.

Starting Point/Baseline:

Currently, the Baylor Clinic at the Baylor All Saints Medical Center at Fort Worth offers a limited program focused on diabetes education. Of the patients enrolled in the program, approximately 25% of clinic patients have an HbA1c > 9.0. This baseline is not directly comparable to the proposed project for chronic care management because we will be including CHF and asthma/COPD patients as well as part of the initiative. Our project will serve approximately 570 new patients over the course of the Waiver.[298]

Rationale:

We selected this project option because of chronic disease in region 10's underserved population. Through co-locating primary care, behavioral health and chronic disease management services, we can improve clinical outcomes. By increasing the availability of chronic care services and utilizing a team based approach, more patients can receive focused attention for their complex needs and learn to self-manage their illnesses in an effective way. We have demonstrated

[298] We estimated a target population based on the Community Health Needs Assessment. Eight percent of all Tarrant County residents have diabetes, which equates to almost 148,000 individuals in the county. Using the same 8% applied to the uninsured in Tarrant County, equates to approximately 35,000 individuals with just diabetes. This does not take into account CHF, asthma/COPD.

statistically significant reductions in mean HbA1c measures with a CHW model currently embedded in Baylor Clinics[299]. Thus expanding the educational services to serve more diabetes patients, and beginning to serve CHF and Asthma/COPD patients will improve care of the population. The Community Health Needs Assessment identified the top five most prevalent conditions as: diabetes, obesity, hypertension, heart failure and COPD.[300] This project addresses three of these illnesses directly and the other two indirectly and aligns with the needs of the Region and identified access challenges.

Project Components:

- We will engage in continuous quality improvement activities: (1) identifying key challenges with the expansion of this project, (2) determine opportunities to scale all or part of the project, depending on available resources and financial constraints, (3) find ways to continuously integrate the chronic disease management program into the care team as much as possible. We have chosen chronic care management metrics and milestones focus on finding the appropriate model for addressing multiple chronic illnesses in Tarrant County. We structured our metrics to focus on increasing access, awareness and education for individuals in the Region and in the latter years included metrics around increased compliance to recommended clinical protocols. We believe it will take time for patients to demonstrate improved self-management behaviors and yield clinical outcome improvements. We do anticipate some clinical improvement for those patients who have been engaged in the chronic care management program for an extended period of time. We have not historically completed programs for CHF and asthma/COPD. This project is an opportunity to create a continuous improvement environment for refining and modifying our approach.

Unique community need identification numbers the project addresses:

- CN.15 – Need for more education, resources and promotion of healthy lifestyles
- CN.13 – Necessity of patient education programs

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: We currently do not receive any federal funding for chronic disease education and providing services for CHF and Asthma/COPD are new to the Baylor Clinic. This project coincides with the need to focus on chronic illnesses, as they are the main drivers of health care costs in the US. Diabetes alone costs the US almost $174 billion dollars a year. [301]

<u>Related Category 3 Outcome Measures</u>:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

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[299] Walton, J, Snead, C. et.al. Reducing diabetes disparities through implementation of a community health worker led diabetes self-management education program. Journal of Family and Community Health. 2012: 35(2): 161-71.
300 RHP 10 Community Health Needs Assessment Number of hospitalizations in Region 10 for chronic diseases: 4736 CHF; 1049 hypertension; 1558 asthma; 3300 COPD; 1136 short term diabetes; 1986 long term diabetes.

[301] http://www.diabetes.org/diabetes-basics/diabetes-statistics/

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

IT-1.10 Diabetes care: *HbA1c poor control (>9.0%) – NQF 0059*

More than 8% of Tarrant County's population has a diagnosis of diabetes with more than 37% of the population classified as obese and at risk for developing diabetes[302]. Bodenheimer, et al. have found that patient self-management of chronic disease conditions, such as diabetes, when undertaken in a primary care setting led to significant improvement in HbA1c control in patients.[303] A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5,000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2,700 in hospitalization costs.[304] Focusing efforts on increasing improvement of good glycemic control will result diminishing in other comorbid conditions and improve complication rates for these patients. We expect that at least 5 to 7% of regular Baylor Clinic patients will have improved HbA1c levels.

IT-1.11 Diabetes care: *BP control (<140/80mm Hg) – NQF 0061*

At Baylor Health Care System, blood pressure control and management is a required part of the diabetes care bundle in order to avoid other comorbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman et al. showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic patients.[305] Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic-based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic as part of the primary care expansion project.

IT-1.13 Diabetes care foot exam - NQF 0056

An innovative part of this project is that the educators (CHWs and RN care managers) will be able to conduct diabetic foot exams as part of their patient education sessions. This will increase screening rates and allow these providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low-cost, highly effective way to avoid costly interventions such as wound care and management, amputations, neuropathy and other complex issues. This is better utilization and management of resources through early identification and prevention of

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[302] RHP 10 Community Health Needs Assessment

[303] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).

[304] Menzin J, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. *J Manag Care Pharm*. 2010; 16(4):264-275.

[305] Cushman WC, Evans, GW, et al. Effects of intensive blood pressure control in type 2 diabetes mellitus. *N Engl J Med*. 2010. Apr 29; 362(17): 1575-85

serious diabetes foot-related issues. It is recommended by the American Diabetes Association that diabetic patients receive yearly foot exams to determine if there are predisposing factors for ulceration and amputation.[306]

Relationship to Other Projects:

135036506.1.1: *Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion* This chronic care management project is directly related to the expansion of primary care capacity project as new staff will be brought in as part of this expansion to create more services for patients and allow more appointment availability.

135036506.2.2- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment The project involving developing care management functions to integrate primary and behavioral health needs of individuals is related to this project of chronic care management, because patients often have co-occurring chronic disease and mental health issues that require attention.

Several projects by other Region 10 providers also focus on Chronic Care Management program development: John Peter Smith has proposed a project to focus on diabetes education (126675104.2.10). Our project, which also includes Asthma and CHF, is focused more broadly on chronic disease management. University of North Texas Health Sciences Center will implement a school-based prevention program focused on Asthma (138980111.2.3). Baylor does not see many children in our clinics, thus we serve a different population.

This project will help to support, reinforce and enable Category 4 population focused improvements through project design and appropriate intervention for targeted populations: RD-1.1, RD-1.2, RD-1.4, RD-1.5; RD-2.1, RD-2.2, RD-2.4, RD-2.5, RD-2.7; RD-3.1, RD-3.2, RD-3.3, RD-3.4, RD-3.5, RD-3.6, RD-3.8, RD-3.10, RD-3.11, RD-3.12, RD-3.13, RD-3.14, RD-3.15, RD-3.24, RD-3.25, RD-3.26, RD-3.31.

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and

[306] American Diabetes Association: http:www.diabetes.org

outcomes by computing the total value of the Category 3 outcomes connected to each project. Baylor All Saints Medical Center at Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Baylor All Saints Medical Center at Fort Worth defined the population that will be directly impacted by the project as underserved patients who have diabetes, asthma, and/or CHF that are in need of education and treatment. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3 We believe this to be the correct number because when a person is positively impacted, she increases her ability to self-manage her illness(es) and maintain her health rather than relying on the physician or ED to manage her conditions.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his propensity to understand his illness, share his knowledge with others and help spread health literacy increases. Patients learn to manage their illnesses and escalations themselves rather than relying on expensive resources such as the ED.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

135036506.2.1	***2.2.2***	***2.2.2.1***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor All Saints Medical Center at Fort Worth				***135036506***
Related Category 3 Outcome Measure(s):	*135036506.3.9* *135036506.3.10* *135036506.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%)* ***(Stand-alone measure)*** *Diabetes care: BP control (<140/80mm Hg)* ***(Stand-alone measure)*** *Diabetes care Foot exam-* ***(Non-stand-alone 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-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Baseline/Goal: Determine exact care model to be used for CHF, Diabetes and COPD/Asthma patients Data Source: Documentation of plan and report showing detailed plans for addressing chronic disease education program Milestone 1 Estimated Incentive Payment *(maximum amount):* $306,786 **Milestone 2** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventive tests, or other clinical services	**Milestone 3** [P-2]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1]: Increase percent of staff trained Baseline/Goal: Train 100% of clinic staff on Chronic Care Model Data Source: Documentation of in-service or signed proclamation of education Milestone 3 Estimated Incentive Payment *(maximum amount):* $223,125 **Milestone 4** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventive tests, or other clinical services Baseline/Goal: Compare patients with at least (1) or more chronic diseases from CHF, Diabetes, Asthma/COPD that have uncontrolled clinical metrics over DY2 to determine prevalence of		**Milestone 6** [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 served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 368 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 15% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report /E.H.R Milestone 7 Estimated Incentive	**Milestone 7** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. The following metrics are suggested for use with an innovative project option but are not required. Metric 1 [I-21.2] : Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 571 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R Metric 2 [I-21.4]: Improved compliance with recommended care regimens. Goal: 20% of patients in Chronic Care Management program (for at least 6 months) will have improved compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey,

135036506.2.1	***2.2.2***	***2.2.2.1***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor All Saints Medical Center at Fort Worth				***135036506***
Related Category 3 Outcome Measure(s):	*135036506.3.9* *135036506.3.10* *135036506.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%)* ***(Stand-alone measure)*** *Diabetes care: BP control (<140/80mm Hg)* ***(Stand-alone measure)*** *Diabetes care Foot exam-* ***(Non-stand-alone 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)**
Baseline/Goal: Determine current baseline of Baylor Clinic patients with at least (1) or more chronic diseases from CHF, Diabetes, Asthma/COPD that have uncontrolled clinical metrics Data Source: E.H.R., Report documenting current patients in need of Chronic Care Management program Milestone 2 Estimated Incentive Payment *(maximum amount):* $306,786	these chronic diseases at the Baylor Clinic Data Source: E.H.R, Report documenting DY3 patient needs Milestone 4 Estimated Incentive Payment: $223,125 **Milestone 5** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. <u>Metric 1</u> [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: At least 173 unduplicated patients will be served by Chronic Care Management program over DY2 Data Source: E.H.R <u>Metric 2</u> [I-21.4]: Improved compliance with recommended care regimens. Goal: 10% of patients in Chronic Care Management program (for at least 6 months) will have improved		Payment: $ 671,320	Educator Report/E.H.R Milestone 8 Estimated Incentive Payment: $554,569

135036506.2.1	***2.2.2***	***2.2.2.1***	***EXPAND CHRONIC CARE MANAGEMENT MODEL-****CREATE CHRONIC DISEASE MANAGEMENT AND PREVENTION PROGRAM*	
Baylor All Saints Medical Center at Fort Worth				***135036506***
Related Category 3 Outcome Measure(s):	*135036506.3.9* *135036506.3.10* *135036506.3.11*	*3.IT-1.10* *3.IT-1.11* *3.IT.1.13*	*Diabetes care: HbA1c poor control (>9.0%)* ***(Stand-alone measure)*** *Diabetes care: BP control (<140/80mm Hg)* ***(Stand-alone measure)*** *Diabetes care Foot exam-* ***(Non-stand-alone 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)**
	compliance with recommended regimens by the educators (non-physician regimens) Data Source: Patient survey, Educator Report/E.H.R Milestone 5 Estimated Incentive Payment: $223,125			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* **$613,572**	Year 3 Estimated Milestone Bundle Amount: **$669,374**		Year 4 Estimated Milestone Bundle Amount: **$671,320**	Year 5 Estimated Milestone Bundle Amount: **$554,569**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ **2,508,834**				

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option – 2.19.1 – Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment
Unique Project ID: -135036506.2.4 (Pass 3b)
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 13503650
Provider: Baylor All Saints Medical Center at Fort Worth, located near downtown Fort Worth, is a full-service hospital dedicated to providing for the health care needs of the community. Baylor Fort Worth is among Tarrant County's oldest not-for-profit hospitals and celebrated 100 years of service in 2006. The medical center has 525 licensed beds and offers a broad range of medical services including programs of excellence in cardiology, transplantation, neurosciences, oncology and women's services. Baylor Fort Worth's service area represents a population of 1.2 million.
Intervention: This project will co-locate and integrate outpatient behavioral health services using an LCSW to provide counseling services. Screenings for depression, substance abuse and anxiety will also be an integral part of the program. This is a new project that has not been done before. It will serve the BH needs of the Uninsured/Medicaid population.
Need for the project: This project will help provide care related to substance abuse, anxiety and depression. Behavioral and mental health issues are a large unmet need. Over 25% of Tarrant County residents experienced 5 of more days in which their mental health was not good during the past 30 days.
Target population: The target population is the Medicaid eligible and indigent PCMH patients at Baylor All Saints with underlying behavioral health issues. 500 new patients from DY3-DY5 will receive behavioral health interventions and services. In the indigent/uninsured community, patients do not see their behavioral health issues as a medical condition, thus the problems are often ignored and results in these patients use the ED.
Category 1 or 2 expected patient benefit: Data matching to find BH patients; patient engagement in BH program; and improved screening rates for depression, anxiety and substance abuse. These milestones and metrics tie into the project purpose through identifying patients with underlying BH issues, engaging those patients in BH interventions and increase the screenings for these patients.
Category 3 outcomes: (all baselines will be reevaluated and reestablished in DY2)

- **IT-11.1: Improvement in Clinical Indicator in Identified Disparity Group: Improvement in Diabetes Metrics (HbA1c, LDL, BP) for disparate group of uninsured/Medicaid patients with an underlying BH issue.** Our goal is to have 5% of patients in DY3 achieve improvement in Diabetes Metrics (HbA1c, LDL BP), 10% in DY4 and 15% in DY5.
- **IT-11.3: Improve utilization rates of clinical preventive services in target population with identified disparity: Improve utilization of BH services for patients who have been screened/identifed and diagnosed with an underlying BH issue.** Disparate population is underserved population with BH issue. Our goal is to increase the patients who engage in BH treatment rates from 10% in DY3 to 20% in DY5. These outcomes reinforce participation in the BH program and treats the co-morbid diseases often associated with BH issues.

Project Option – 2.19.1 – Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment

Unique Project ID: -135036506.2.4 (Pass 3b)

Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 13503650

Project Description:

This project will co-locate and integrate behavioral health services into the outpatient primary care setting. The model that we aim to develop would consist of providing a LCSW to provide basic counseling services to address behavioral health needs such as: anxiety, depression, and substance abuse issues. The screening tools we plan to use are evidence based and will most likely include: PHQ2 or 9, GAD-7 and alcohol and substance abuse screeners. Additionally, the LCSW would have the support of a Community Health Worker (CHW) to help with the screening and referral processes. The training for the CHWs , LCSWs and model development would occur at the Diabetes Health and Wellness Institute (Baylor entity in South Dallas) where the competencies and expertise would be created. From there, this staff can be triaged to clinics and community locations to provide behavioral health services. The behavioral health program would require that the LCSW and CHW to work together with the primary care team to: 1) identify the patients who have behavioral health issues, 2) coordinate the patient's care and appointments to fit both the behavioral health and primary care appointment in the same visit and 3) help the primary care team to identify those patients whose behavioral health issues are impeding the management of their acute/chronic disease management models

Goals and Relationship to Regional Goals:

Project Goals:

The goals of this project are to increase the baseline of behavioral health services provided and screenings conducted in an outpatient primary care setting to the underserved population in Tarrant County. By co-locating the behavioral health service with a patient's PCMH, we anticipate increased compliance and adherence to attending behavioral health appointments. Through increased screening, awareness and intervention, we also anticipate that behavioral health issues such as anxiety, depression and substance abuse will be proactively identified and addressed and allow the clinician and patient to focus on more acute/chronic illnesses that require protocol adherence. This project will lead to decreased ED visits related to behavioral health issues manageable in the outpatient setting. Treating the underlying barriers associated with behavioral health will result in better health outcomes.

This project meets the following regional goals:

The RHP 10 Community Needs Health Assessment identified access to behavioral and mental health care as critical needs. Most important aspects of behavioral health access improvement are early interventions for targeted populations to prevent unnecessary use of services, increasing the number of providers and enhancing service availability. This project is directly aligned with the

regional need and is positioned to help facilitate care related to substance abuse, anxiety and depression.

Challenges:

The challenges with behavioral health initiatives are that identification of patients and willingness of those patients to participate in a formal program do not coincide. There is a stigma associated with receiving counseling or behavioral health services which makes it difficult for providers to identify patients that have these underlying behavioral health issues and even more difficult for providers to get patients to come in for these types of appointments. In the community, patients do not see their behavioral health issues as a medical condition, thus the problems are often ignored and results in these patients using the ED for their acute behavioral health escalations. While this program would not focus on serious psychiatric issues such as schizophrenia or bipolar disorders, identifying depression or anxiety can have a significant impact on the patient's propensity to comply with medication and clinical recommendations/protocols. The way we plan to address the challenges mentioned above is through providing these services in a non-threatening way by individuals (CHWs/LCSWs) that come from the community they are serving. By using CHWs or LCSWs over physicians or other higher level providers, this should put the patient at ease. The program will also be presented in a counseling type environment rather than a psychiatric evaluation environment. Lastly, we will make behavioral health screenings a routine part of most primary care visits so that the assessments coincide with the patient's typical care.

5-Year Expected Outcome for Provider and Patients:

The five-year expected outcome is that at least 20% of the total unduplicated patients (approximately 570 patients) will receive behavioral health services at the Baylor Clinic. By identifying underlying behavioral health issues, acute and chronic medical issues can be addressed and compliance/adherence to clinical protocols should increase as well.

Starting Point/Baseline:

The baseline for this project would be 0 because there is no program for behavioral health offered at the Baylor Clinic at Baylor All Saints Medical Center at Fort Worth. The target population in the Tarrant county area is over 101,000 underserved individuals who suffer from a mental illness. We calculated this number taking the uninsured population in Tarrant County (443,000)[307] and a 2011 statistic taken from the Centers for Disease Control and Prevention that found 23% of uninsured patients suffer from a mental illness.[308]

[307] http://quickfacts.census.gov/qfd/states/48/48439.html
[308] CDC: http://www.cdc.gov

Rationale:

Behavioral health is a major regional need and Baylor Clinics have the infrastructure to effectively manage these types of issues within its PCMH framework. Many of our patients have underlying behavioral health issues which physicians simply do not have time to address during a typical primary care visit. This project model would allow patients to receive personalized attention for their behavioral health specific issues and allow physicians to spend time on managing clinical issues. By implementing a behavioral health component as part of the PCMH we have established patients will have improved overall health outcomes.. Lastly, adding a behavioral health component to our primary care team will allow for cross communication between providers to understand all of the complex needs prevalent in this particular population.

Project Components:

a. Conduct data matching to identify individuals with co-occurring disorders who are:
   - not receiving routine primary care-*Patients who enter in to the behavioral health program will be automatically part of a PCMH*
   - not receiving specialty care according to professionally accepted practice guidelines: *We will be tracking this metric as part of our specialty care project- 1.9.2- Improving Access to Specialty Care*
   - over-utilizing ER services based on analysis of comparative data on other populations: *This is a metric that we already track and will continue to do so*
   - over-utilizing crisis response services. *This particular factor may be difficult to gather data on and is not typically a data point we collect*
   - Becoming involved with the criminal justice system due to uncontrolled/unmanaged symptoms. *This particular factor may be difficult to gather data on and is not typically a data point we collect*

b. Review chronic care management best practices such as Wagner's Chronic Care Model and select practices compatible with organizational readiness for adoption and implementation. *We plan to review the most effective models that address both chronic care and behavioral health to determine which model would easily address the intersection of both programs*

c. Identification of BH case managers and disease care managers to receive assignment of these individuals: We plan on hiring LCSWs and CHWs to act as BH care managers

d. Develop protocols for coordinating care; identify community resources and services available for supporting people with co-occurring disorders: As part of identifying which patients would be eligible and appropriate for this BH program, we will be developing clinical protocols to identify patients and coordinate their care within the Baylor Clinic PCMH

e. Identify and implement specific disease management guidelines for high prevalence disorders, e.g. cardiovascular disease, diabetes, depression, asthma. *We plan to address this criteria through our Chronic Care Management project (2.2.1- Expand Chronic Care Management Models)*

f. Train staff in protocols and guidelines. *All staff will be made aware of this program and be trained on scheduling and identifying patients who could be part of this BH program*

g. Develop registries to track client outcomes. *We currently have a robust E.H.R in which we track other patient clinical metrics and measures, it would be redundant and inefficient to create a separate registry to track outcomes of this specific project. We intend to track outcomes in the current E.H.R.*

h. Review the intervention(s) impact on quality of care and integration of care 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. *As part of our monthly review of project status, this will be*

included as will review of the other DSRIP projects the Baylor Clinic will be engaged in. We will focus on the key challenges associated with expansion and determine how and if the BH needs to be scaled to meet patient needs.

Unique community need identification numbers the project addresses:
CN.5 - Insufficient integration of mental health care in the primary care medical system
CN.10 – Overuse of ED services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project does not receive any federal funding and is a brand new initiative. There is currently no outpatient based behavioral health program offered to the underserved population at the Baylor Clinic at the Baylor All Saints Medical Center at Fort Worth.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/rationale for selecting the outcome measures:
Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.
IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Stand-alone measure)
We will measure the impact of diabetes management and control for patients who have enrolled in the proposed behavioral health program. A recent study conducted in early 2012, by Jeffery Johnson, et al. showed a direct correlation between diabetes and depression. They cited that depression is the most common comorbid condition present in 15-30% of patients with type 2 diabetes and less than 50% are recognized as having depression.[309] Depression is associated with poorer self-care behaviors, decreased quality of life and substantially higher health care costs. Both diabetes and behavioral health issues are prevalent across the region, warranting measurement of the efficacy of a behavioral health program on chronic diseases.
Numerator : Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter.
Denominator: Total number of patients with a Behavioral Health intervention/encounter.
Because this is a new program, we do not have any historical data on the actual diabetes improvement for those patients who receive a behavioral health intervention. We only have

[309] Johnson, JA, Sayah, FA, et.al. Controlled trial of a collaborative primary care team model for patients with diabetes and depression: rationale and design for a comprehensive evaluation. BMC Health Services Research. 2012, 12:358.

literature which has shown improvement in diabetes with interventions related to depression. Thus, the improvement targets we have listed for Category 3 may differ as we implement the program.

IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-stand-alone measure)
We plan to focus on the treatment component of this metric, defining treatment as those patients who engage in the behavioral health program. We anticipate that patients who enter our Baylor Clinic and are identified as individuals who would benefit from a behavioral health intervention will have improved treatment and utilization rates. Numerator: patients who are a Baylor Clinic patient and engage in the behavioral health program Denominator: patients who are a Baylor Clinic patient, eligible for behavioral health services

Relationship to Other Projects:
135036506.2.1- Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program The Chronic Care Management Model expansion is related to this project because the educational services would be provided the Baylor Clinic PCMH model. Additional staff that will be hired under this project of primary care capacity expansion will be utilized in providing education and management of CHF, diabetes and Asthma/COPD disease states. Lastly, services would be co-located and integrated to ensure that high risk patients with chronic disease would be identified, addressed and managed. The National Association of State Mental Health Program Directors (NASMHPD) reported that people with co-occurring behavioral health and medical illness incur the most cost, this combination of projects will help to resolve these patients' issues.[310]
135036506.1.1: *Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion* This behavioral health project is directly related to the expansion of primary care capacity project as new staff will be brought in as part of this expansion to create more services for patients and allow more appointment availability. Through the expansion project, we intend to integrate the behavioral health team with the overall primary care team to facilitate complete care for the patient. These services, chronic care management, behavioral health and expansion of primary care capacity are all interrelated and involve co-locating for maximizing effectiveness and efficiency.

This project will help to support, reinforce and enable Category 4 population focused improvements through project design and appropriate intervention for targeted populations. Impacts to Category 4 are listed below: RD-1.3, RD-1.7, RD-1.8, RD-1.1, RD-1.2; RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.7; RD-3.36, RD-4.1, RD-4.2 RD-5.

[310] National Association of State Mental Health Program Directors: http://www.nasmhpd.org/index.aspx

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

Other performing providers that have projects in this area: 126675104.2.8- John Peter Smith Hospital: embed behavioral health managers; 081599501.2.3- Tarrant County MHMR: increase referrals to specialty and primary care. Our project differs from the two above because our focus is on counseling and screening. We will focus on disorders such as depression, anxiety and substance abuse.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Baylor All Saints Medical Center at Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*Baylor All Saints Medical Center at Fort Worth defined the population that will be directly impacted by the project as the underserved PCMH Baylor Clinic patients with an underlying behavioral health issue(s). We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when people are positively impacted, their compliance and adherence to clinical protocols increases, their satisfaction increases and self-management of their illnesses increases. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her productivity in the community increases as mentioned in the Community Health Needs Assessment. Twenty-five percent of the population reported lost work days due to a mental health issue. In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects.[311]

For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration

-135036506.2.4 (Pass 3b)	***2.19.1***	***2.19.1 (A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
Baylor All Saints Medical Center at Fort Worth				*135036506*
Related Category 3 Outcome Measure(s):	***-135036506.3.16*** ***135036506.3.17***	*3.IT-11.1* *3.IT-11.3*	*Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider* ***(Stand-alone measure)*** *Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.* ***(Non-stand-alone 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]: Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis conducted to identify over and under utilization patterns. Metric 1 [P-4.1]: Data analysis report produced. Baseline/Goal: Determine number of patients with dual diagnosis- either self identified or through previous medical history- to understand actual need in community Data Source: E.H.R/patient survey Milestone 1 Estimated Incentive Payment: $197,167 **Milestone 2** [P-5]: BH case managers and disease care managers are identified. Metric 1 [P-5.1]: Number of staff identified with the capacity to support the targeted population. Baseline/Goal: Hire 1 LCSW and 0.5 FTE of support staff (MA/POR) to handle case	**Milestone 4** [P-4]: Data matching is performed identifying service utilization patterns of people with co-occurring disorders and analysis conducted to identify over and under utilization patterns. Metric 1 [P-4.1]: Data analysis report produced. Baseline/Goal: Determine number of current patients who have a dual diagnosis and compare to DY2 data collected Data Source: E.H.R/patient survey Milestone 4 Estimated Incentive Payment: $161,324 **Milestone 5** [P-6]: Care coordination protocols are developed. Metric 1 [P-6.1]: Written protocols are easily available to staff. Baseline/Goal: Educate 100% of clinic staff on BH protocols/standing order Data Source: Documentation of education completed through in-service sheets or signed documentation by staff	**Milestone 8** [I-26]: Patient engagement in BH program Metric 1 [I-26.1]: Number of patients enrolled/engaged in BH program Goal: 368 unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 8 Estimated Incentive Payment: $323,586 **Milestone 9** [I-27]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-27.1]: % of patients screened with at least one BH tool Goal: 20% of all patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R (% is the same to account for attrition in patient population) Milestone 9 Estimated Incentive Payment: $323,586	**Milestone 10** [I-26]: Patient engagement in BH program Metric 1 [I-26.1]: Number of patients enrolled/engaged in BH program Goal:571 unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 10 Estimated Incentive Payment: $267,310 **Milestone 11** [I-27]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-27.1]: % of patients screened with at least one BH tool Goal: 25% of all patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R (% is the same to account for attrition in patient population) Milestone 11 Estimated Incentive Payment: $267,310

-135036506.2.4 (Pass 3b)	***2.19.1***	***2.19.1 (A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*	
Baylor All Saints Medical Center at Fort Worth				*135036506*
Related Category 3 Outcome Measure(s):	***-135036506.3.16*** ***135036506.3.17***	*3.IT-11.1* *3.IT-11.3*	*Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (**Stand-alone measure**)* *Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (**Non-stand-alone 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)**
management of BH patients Data Source: Documentation of hired staff Milestone 2 Estimated Incentive Payment *(maximum amount):* $197,167 **Milestone 3** [P-6]: Care coordination protocols are developed. Metric 1 [P-6.1]: Written protocols are easily available to staff. Baseline/Goal: Develop protocols for identifying BH patients and protocols for making appointments. Ensure that executive physician committee signs off on protocols for LCSW. Data Source: Documentation of clinical protocols and processes Milestone 3 Estimated Incentive Payment *(maximum amount):* $197,167	Milestone 5 Estimated Incentive Payment: $ 161,324 **Milestone 6** [I-26]: Patient engagement in BH program Metric 1 [I-26.1]: Number of patients enrolled/engaged in BH program Goal: 173 unduplicated patients will be identified and seen for a BH issue over DY2 Data Source: E.H.R Milestone 6 Estimated Incentive Payment: $161,324 **Milestone 7** [I-27]: Improve screening rates for depression, anxiety and substance abuse Metric 1 [I-27.1]: % of patients screened with at least one BH tool Goal: 15% of all clinic patients will be screened with PHQ2/9 or GAD-7 or Substance Abuse screening Data Source: E.H.R Milestone 7 Estimated Incentive		

-135036506.2.4 (Pass 3b)	***2.19.1***	***2.19.1 (A-H)***	***DEVELOP CARE MANAGEMENT FUNCTION THAT INTEGRATES PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS-*** *BEHAVIORAL HEALTH COUNSELING, SCREENING AND TREATMENT*
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 3 Outcome Measure(s):	***-135036506.3.16*** ***135036506.3.17***	*3.IT-11.1* *3.IT-11.3*	*Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (**Stand-alone measure**)* *Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (**Non-stand-alone 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)**
	Payment: $161,324		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $**591,501**	Year 3 Estimated Milestone Bundle Amount: $**645,296**	Year 4 Estimated Milestone Bundle Amount: $**647,172**	Year 5 Estimated Milestone Bundle Amount: $**534,620**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $2,418,588			

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option – 2.9.1 – Establish/Expand a Patient Care Navigation Program- Care Connect
Unique Project ID: 135036506.2.3 135036506.2.5 (Pass 3b)
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Provider: Baylor All Saints Medical Center at Fort Worth, located near downtown Fort Worth, is a full-service hospital dedicated to providing for the health care needs of the community. Baylor Fort Worth is among Tarrant County's oldest not-for-profit hospitals and celebrated 100 years of service in 2006. The medical center has 525 licensed beds and offers a broad range of medical services including programs of excellence in cardiology, transplantation, neurosciences, oncology and women's services. Baylor Fort Worth's service area represents a population of 1.2 million.
Intervention: This project will identify and connect underserved patients in the hospital to a PCP/PCMH, create a multi-disciplinary care plan for frequently admitted patients and provide comprehensive follow up calls to patients to ensure they have an appointment and transportation to get to it. This project would be a new initiative to Baylor All Saints Medical Center at Fort Worth.
Need for the project: Our database shows about 12,000 (Medicaid funded or indigent) patients annually come to the Baylor All Saints Medical Center at Fort Worth's emergency department (ED) and say they do not have a medical home which results in these patients revisiting the ED because they lack appropriate medical care.
Target population: patients who visit the emergency department (ED) that need connection to medical homes. We estimate at least 70% of these patients are Medicaid eligible or indigent. Estimated number of patients to be served over course of waiver period: 5000 new patients from DY3-DY5 will receive services from Care Connect. The project will help patients connect to primary care thus reducing ED visits/costs to Medicaid and patients.
Category 1 or 2 expected patient benefits: Provide reports on types of navigation services provided to patients using the ED; and provide primary care referrals; and increase number of patients served by innovative program. These milestones and metrics tie into the project purpose connecting uninsured and Medicaid patients to PCMHs in the community.
Category 3 outcomes: all baselines will be reevaluated and reestablished in DY2)
IT-5.1: Improved Cost Savings. Our goal is to increase cost savings of healthcare utilization (total cost of care in one year) of patients who have been connected to a PCP/PCMH appointment from 15% in DY3 to 25% in DY5.
IT-6.1: ED Appropriate Utilization. Our goal is to decrease all ED visits (including ACSC) from 25% in DY3 to 35% in DY5 and targeted conditions ED utilization (CHF, Diabetes, ESRD, CVD/Hypertension, BH/SA, COPD, Asthma) from 10% in DY3 to 20% in DY5.
We will be excluding pediatric emergency visits as part of this metric measurement because Baylor All Saints Medical Center at Fort Forth does not see a large volume of pediatric patients in the ED. These outcomes reinforce connecting patients to appropriate resources and decrease overall cost utilization.

Project Option – 2.9.1 – Establish/Expand a Patient Care Navigation Program- Care Connect
Unique Project ID: 135036506.2.3 135036506.2.5 (Pass 3b)
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506
Project Description:
This project creates a fluid care navigation program at Baylor All Saints Medical Center at Fort Worth Emergency Department for patients without a primary care physician and/or patient-centered medical home to address their postacute care needs. Staff will provide patients with real-time assistance in finding a provider and connecting them with the appropriate discharge resources. We will include weekend staff coverage to ensure that patients are able to be seen and connected to resources seven days/week. Staff also will follow-up with patients to ensure they attend scheduled appointments. Staff will also be responsible for resolving transportation barriers that my otherwise stop patients from going to scheduled follow-up visits. Care Connect staff will receive email notifications anytime a patient revisits the hospital and proactively visit with the patient to ensure the patient can access their PCP/PCMH and/or recommended community resource(s). Care plans will be developed for patients with high hospital utilization (especially patients with frequent emergency department visits) and complex needs. Care plans will be reviewed by a social work supervisor, hospital medical director and other hospital staff. Patients with care plans will be contacted to ensure continuity of the care.

Goals and Relationship to Regional Goals:
Project Goals:
The goals for this project are: 1) to connect patients to a PCP/PCMH, 2) ensure patients have needed postdischarge resources, 3) reduce unnecessary ED visits and 4) create care plans for high risk patients that ensure follow-up care and identification upon future hospital admissions.

This project meets the following regional goals:
The project addresses two regional goals – to decrease unnecessary ED utilization and reduce costs of care in the region. The project's focus is care coordination and ensuring patients are triaged to appropriate community and outpatient based resources. This project will help patients connect to essential primary care to maintain their health and will better focus community health care resources on lower cost, more appropriate service delivery.

Challenges:
One of the greatest challenges for the underserved population is lack of continuity of care across the continuum. This program aims to address this challenge (and the various reasons for it) by identifying patients who do not have a PCP/PCMH, finding one for them, ensuring they have the resources they need to keep their appointment, and following up with the patient.

5-Year Expected Outcome for Provider and Patients:

The five-year expected outcomes for this project include: (1) a minimum of 2,100 patients connected to a PCP, PCMH or community resource, (2) 35% of these patients will have confirmed appointments within 14 days postdischarge. We expect that there will be fewer ED visits and readmissions for this population that was connected through this program and will experience overall improved health outcomes due to receiving appropriate and adequate postacute care.

Starting Point/Baseline:
This program will be brand new to the hospital and will start from a baseline of 0. About 849 patients were served in nine months for the same program recently implemented at Baylor Medical Center at Garland. We will have to establish the baseline of this project and determine the potential number of patients who would benefit from this program at Baylor All Saints in DY2 and DY3. 2010 data indicates that approximately 12,000 Medicaid and self-pay patients reported not having a PCP/PCMH. We anticipate that the targeted population for the entire region is approximately 133,000 underserved/uninsured patients.[312]

Rationale:
This project is a low-cost, effective way to promote continuity of care for the underserved by connecting them to community resources that address their complex needs. This project helps patients who do not have a PCP/PCMH connect to one and also offers continuous improvement to ensure further refinement. We selected this project for Baylor All Saints Medical Center because our experience in some of our other Baylor facilities has demonstrated its effectiveness in reducing readmissions and lowering ED utilization. This project will also create multidisciplinary care plans for the highest risk patients to identify and address triggers that cause them to (re)admit. This intervention enables staff to be involved with the patient at a grassroots level and gives patients a way to seek assistance with ongoing care and navigation needs.

Project Components:
This project includes components from the protocol: 1) identify frequent ED users and use navigators as part of a preventable ED reduction program, 2) train health care navigators in cultural competency, 3) deploy innovative health care personnel, as patient navigators, 4) connect patients to primary and preventive care, 5) increase access to care management and/or chronic care management, including education in chronic disease self-management, and 6) conduct quality improvement for project using methods such as rapid cycle improvement We will connect with all ED patients without a PCP/PCMH. Our Care Plans will be developed for

[312] This is calculated by taking the average rate of patients who are uninsured that do not have a PCMH/PCP (30%) multiplied by the total number of uninsured 443,956 (24% uninsured x total population of 1,849,815).

patients who are frequent ED utilizers as well. Lastly, the CHWs we will hire come directly from the communities they serve so they understand patients' challenges/issues.

The selected milestones and metrics relate directly to two regional goals: 1) need for more care coordination and 2) overuse of ED services. The metrics we have in place increase the number of the target population served over the Waiver period and emphasize the connection rate to a PCP/PCMH. In addition, we have added a metric that creates regular reports that show comparative analyses year over year of the program. We believe detailed reports on what services were provided and how these coincide with the needs of the community will allow for maximum effectiveness and positive outcomes of the project. This project also will be part of a systemwide Baylor initiative that analyzes and evaluates progress and challenges/barriers for all DSRIP projects. We will focus on identifying key challenges associated with the expansion and opportunities to scale the project where appropriate.

Unique community need identification numbers the project addresses:

- CN.11 – Need for more care coordination
- CN.10 - Overuse of ED services

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project does not receive any federal funds and is a new initiative.

Related Category 3 Outcome Measures:

The project's Stand-alone and Non-stand-alone metrics come from 2 different domains because the true impact of this project is through ED appropriate utilization and cost savings. Both are Region 10 priorities.

Outcome Measures and Reasons/rationale for selecting the outcome measures:

IT-9.2 ED appropriate utilization (Stand-alone measure)

According to region 10's Community Health Needs Assessment, there were 798,904 emergency department visits in 2011, comprising a majority of the 1 million plus visits in the region[313]. The stakeholder survey of Region 10 providers indicated significant overuse of emergency department services due to patients' inability to access primary care. This metric is at the heart of the care navigation project and will have a direct impact on patients in Tarrant County utilizing the ED at a decreased rate. This project uses the popular concept created by Dr. Atul Gawande, referred to as "hot spotting" indicating a focus on finding the high risk/high utilization rates of the ED and determining the root cause for these visits, and then working to remedy those issues.

[313] RHP 10 Community Health Needs Assessment

Issues such as transportation, navigation of community and appropriate resources are just two examples that can lead to more effective use of the ED.[314]

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (Non-stand-alone measure)

Financial constraints are a major region 10 barrier to providing high-quality care to the underserved. Cost savings and effectiveness are a key part of the overall Waiver and require providers to be good stewards of their resources. This metric is appropriate because it emphasizes appropriate utilization of resources and reinforces the concept of cost effectiveness. We plan to measure the project's cost effectiveness and cost utilization. According to the Texas Medical Association, a condition that could be treated in the doctor's office for $56.21 (including lab and x-ray), costs $193.92 in the ED[315]. This cost differential multiplied by the 443,000 uninsured in Tarrant County creates a significant additional cost to the county and Region. On a more global level, AHRQ found that the average cost in 2006 for an uninsured patient stay in the hospital cost was about $19,400.[316].

Relationship to Other Projects:

This Care Navigation project is related to:

Project 135036506.1.1: Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion. The navigation program is located in the hospital and will be connecting patients to the Baylor Clinic that are identified by the staff to not have a PCP/PCMH. Additionally, the navigation program includes a follow-up component which will ensure that patients have made the connection the Baylor Clinic. There will be increased capacity for the clinic to take on a greater number of patients identified through the navigation program. Coordination will be required between the navigation program and the Baylor Clinic to ensure that patients are connected and seen.

This project will help to support, reinforce and enable Category 4 population focused improvements through project design and appropriate intervention for targeted populations through lower utilization of high cost hospital-based resources and higher utilization of more appropriate community-based resources: RD-1.1, RD-1.2, RD-1.3, RD-1.4, RD-1.5, RD-1.7, RD-1.8; RD-2.1, RD-2.2, RD-2.3, RD-2.4, RD-2.5, RD-2.7; RD-4.1, RD-4.2; and, RD-5.1..

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

[314] Gawande, A. The hot spotters: can we lower medical costs by giving the neediest patients better care? The New Yorker. (2011).
[315] Texas Medical Association: http://www.texmed.org
[316] AHRQ: http://www.ahrq.gov

Care Coordination models require an initial connection but also require community-based resources to which patients can be referred. Once a patient is identified to need a PCP/PCMH or another community resource, it becomes the region's responsibility to ensure community resources. Care Navigation programs serve the patients located in the specific EDs/inpatient units of the performing providers and thus do not duplicate patients on a per visit basis. While our geographies overlap, these programs are localized to individual hospitals. Related projects are: 130614405.2.4: Texas Health Resources- Arlington Memorial Hospital; 112677302.2.1: Texas Health Resources- Harris Methodist Hospital Fort Worth; 136326908.2.5: Texas Health Resources- Harris Methodist Hurst Euless Bedford; and, 120726804.2.3: Texas Health Resources- Harris Methodist Hospital Southwest Fort Worth.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Baylor All Saints Medical Center at Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Baylor All Saints Medical Center at Fort Worth defined the population that will be directly impacted by the project as the underserved/uninsured patients who do not have a PCP/PCMH that present in our Baylor All Saints ED or inpatient units. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is connected to community and primary care resources, she can find ways to manage her illnesses on a daily basis and have a contact for her care needs. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her ED utilization decreases, community resource burdens are relieved and a greater number of people have a PCMH.

In conjunction with determining the value to the individual and community, we used a qualitative grading system to determine relative values that can be compared to like projects within our health care system and regional projects. These criteria took factors such as: transformational impact, population served by project, alignment with community needs, cost avoidance, sustainability and partnership collaboration into account. This weighted scoring

criteria combined with the aforementioned literature based econometric approach helped to determine funding allocations for each of our projects. For example, based on the approach to value Category 3 outcomes for each project in an econometric way, the sum of values for our projects would be $300 million. By taking this information in combination with the weighted scoring criteria, we were able to determine how to allocate dollars by project. If a project had a relative score of 7.6 versus a 6.5, the project with a score of 7.6 would be allocated a greater portion of the dollars taking the regional cap of funding into consideration.

- 135036506.2.5	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM-*** *CARE CONNECT*
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 3 Outcome Measure(s):	*135036506.3.18* *135036506.3.19*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Stand-alone)*** *ED appropriate utilization (**Stand-alone 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-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.1]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators Baseline/Goal: Hire appropriate staff- 3 FTEs Data Source: Documentation of employment Metric 2 [P-2.2]: Number of unique patients enrolled in the patient navigation program; Baseline/Goal: Establish baseline of patients seen in DY2 Data Source: E.H.R./Navigation database Metric 3 [P-2.3]: Frequency of contact with care navigators for high risk patients. Baseline/Goal: Track frequency of	**Milestone 3** [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. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided Baseline/Goal: Provide completed report to compare types of navigation offered in DY2 v. DY3 Data Source: E.H.R/Navigation notes and database Milestone 3 Estimated Incentive Payment: $**305,793** **Milestone 4** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 30% of patients identified by care navigation	**Milestone 5** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric 1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 40% of patients identified by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 1800 patients Data Source: E.H.R./Patient Navigation program database Milestone 5 Estimated Incentive Payment: $**613,364**	**Milestone 6** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. The following metrics are suggested for use with an innovative project option to increase access to the services but are not required. Metric1 [I-10.2]: Increased number of primary care referrals. Goal: Provide primary care referrals to at least 50% of patients identified by care navigation program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 2160 patients Data Source: E.H.R./Patient Navigation program database Milestone 6 Estimated Incentive Payment: $ **506,692**

- 135036506.2.5	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM-*** *CARE CONNECT*	
Baylor All Saints Medical Center at Fort Worth				*135036506*
Related Category 3 Outcome Measure(s):	*135036506.3.18* *135036506.3.19*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Stand-alone)*** *ED appropriate utilization (**Stand-alone 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)**
patient contact with navigator while in ED setting Data Source: E.H.R./Patient Navigation program database Milestone 1 Estimated Incentive Payment *(maximum amount):* $**280,301** **Milestone 2** [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. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided Baseline/Goal: Create report format and educate navigators about data points to be collected Data Source: Documentation of report created Milestone 2 Estimated Incentive Payment *(maximum amount):* $**280,301**	program Data Source: E.H.R./Patient Navigation program database Metric 2 [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Identify at least 1080 patients Data Source: E.H.R./Patient Navigation program database Milestone 4 Estimated Incentive Payment: $**305,793**			

- 135036506.2.5	***2.9.1***	***2.9.1 (A-E)***	***ESTABLISH/EXPAND A CARE NAVIGATION PROGRAM-*** *CARE CONNECT*
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 3 Outcome Measure(s):	*135036506.3.18* *135036506.3.19*	*3.IT-5.1* *3.IT-9.2*	*Improved cost savings: Demonstrate cost savings in care delivery* ***(Non-Stand-alone)*** *ED appropriate utilization (**Stand-alone 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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $560,602	Year 3 Estimated Milestone Bundle Amount: $**611,586**	Year 4 Estimated Milestone Bundle Amount: $**613,364**	Year 5 Estimated Milestone Bundle Amount: $**506,692**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $**2,292,244**			

Attachment 1: Project Summary Template to be completed for each Category 1 and 2

Project Option 2.2.1 – Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)
Unique Project ID: 136326908.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital HEB / 136326908

Provider: Texas Health Harris Methodist Hospital Hurst-Euless-Bedford has nearly 300 beds and more than 550 active physicians on its medical staff. THHEB provides emergency and acute inpatient care to the community. Nineteen percent of our patients are indigent, uninsured or covered by Medicaid.
Intervention: The goal of this project is to provide seamless care for low income and uninsured +management competency, prevent unnecessarily reduced quality of life, and decrease inappropriately high reliance on acute and emergent care community resources. Linking diabetes patients that present to the ED or as inpatients to a primary care physician is a new initiative, and could significantly enhance the number of patients who have access to diabetes education and support.
Target population: The target population is indigent or government-funded patients with a diagnosis of diabetes in the community who do not have access to receive care to manage their disease or those who need additional support in the management of their diabetes. Estimated number of patients to be served over course of waiver period is 567 based on 2011 figures. We expect to enroll 10% (56) of the target population in DY 4 and anticipate a 5% increase in subsequent years.
Expected patient benefits: A major goal of the region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to that goal by linking low income / uninsured residents of Tarrant County to a medical home and available Diabetes Self-management Education / Support resources to actively engage them in their self-care and reduce the likelihood of an acute condition that would require ED care and / or inpatient admission. The care providers will follow up with the clients on a regular basis. Clients will also have access to the team through email, phone and office visits.
Category 1 or 2 expected patient benefits: Development of a comprehensive care management program with a formalized multidisciplinary CARE team, combined with development / implementation of a program to assist patients to better self-manage their chronic condition will lead to improved access to care and an increased percentage of patients with self-management goals. These patients, linked to a medical home and actively engaged in their self-care, will experience improved health outcomes and rely less on acute and emergent care community resources.
Category 3 outcomes: Diabetes patients who benefit from this program will demonstrate improvement in HbA1c, compared to their initial or baseline value, thereby decreasing the percentage of patients age 18-75 with HbA1c >9%. By providing access to care and assistance in self-management of their disease, risk of admission and readmission is reduced, thereby

improving the Diabetes 30 day readmission rate and saving an estimated $8,297 cost for every inpatient admission avoided.

Project Option 2.2.1 – Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)
Unique Project ID: 136326908.2.1
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital HEB / 136326908

Project Description:
Historically underserved patients have not been effectively educated on how to manage their diabetes. Moreover, they have not been followed to measure their outcomes and long term goals. This program will be implemented to help those who need education on managing diabetes by providing a patient-centered medical home where they have access to exceptional and coordinated care. Patients will be identified by: first, partnering with primary care clinicians to utilize protocols: A1C>9, history of DKA, > one admission in the last 12 months as criteria for referrals to outpatient diabetes education. Second, ED case management and inpatient diabetes educator will identify patients with the same criteria as above, and/or do not currently have a patient-centered medical home, have not received diabetes education ever or within the last five years, and all others appropriate for education

Goals and Relationship to Regional Goals:
Project Goals:
Challenge or issue being addressed: Linking diabetes patients who present to the ED or inpatients to a primary care physician and diabetes management resources to provide seamless care for this patient population, making diabetic education accessible to all individuals regardless of their financial situation as well as identifying pre-diabetics and providing education geared to prevent/prolong diagnosis of diabetes

This project meets the following Regional goals:
A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to achieving that goal by improving the access to chronic care for individuals in Tarrant County who are underserved and who need diabetes education, training, and clinical interventions.

Challenges:
Some components of this program already exist, but the linking of the patients to the resources is lacking. A clinical nurse specialist would assist with coordination of efforts of ED and inpatient with the outpatient resources. In addition, nurse navigators and care managers would facilitate the transition of patients to resources in the community. Additionally, because large percentage of THHEB patients are uninsured/underinsured or otherwise have limited access to health

resources, it is paramount that we intervene by educating and treating the people in the community we serve.

5-Year Expected outcome for Provider and Patients:
Patients with diabetes would be linked to primary care and diabetes resources to actively engage them in their self-care and assist in the management of their disease therefore decrease readmissions and ED visits. This would decrease LOS for diabetes inpatients, decrease ED visits, and improve patient outcomes such as self-care goals, improvement in HgbA1c, referrals for eye exams, foot exams, and medication management

Starting Point/Baseline:
Currently, 407 patients were seen in the past year for outpatient diabetes education. Approximately 300 plus diabetic patients were seen as inpatients in the hospital. At least 50% of the inpatients seen are uninsured or underinsured and may not be able to come to afford outpatient diabetic education classes. Currently, we have one full time RN nurse diabetic educator (.8), and two part-time certified diabetic educator dieticians (.6)

Rationale:
One out every 12 individuals age 18 or older in Tarrant County have been told that they have diabetes. As the age of community increases, the percentage of diabetes increases. From the Community Needs Assessment data it was found that 28% of those individuals who report that they cannot work have a diagnosis of diabetes, therefore this disease impacts a large percentage of the community as well and can be financially devastating. An estimated 79 million adults, age 20 years or older, currently are pre-diabetic. In addition, a large population of patients are uninsured or underinsured and do not have access to adequate outpatient diabetic education resulting in a greater number of readmissions to the hospital and an increased number of diabetic complications. Therefore, there needs to be a link from ED and inpatient to outpatient resources and education.
The rational for selecting the category 3 outcome measures is clear. Evidence indicates that reducing HbA1c 1% can result in a significant decrease in diabetes-related long term complications. The Center for Healthcare Quality and Payment Reform estimates that 15-25% of patients discharged from the hospital will be readmitted within 30 days or less, and that many of these readmissions are preventable. Not only are these re-admissions costly but they negatively impact clients who may miss work and experience other consequences as a result of the hospitalization.

Project Components:
This project will address all required core components:

a) Multi-disciplinary care teams will be designed and implemented to address the targeted diabetic patient's healthcare needs.

b) THHEB will ensure patients have access to their care team in person, by phone and by email.
c) Patient engagement will be increased through education classes, self-management support, improved patient-provider communication and better coordination with community resources.
d) THHEB will empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions through education, support and goal setting,
e) Continuous quality improvement will be conducted using Plan, Study, Do, Act (PSDA) cycles.

This project would provide referrals to primary care physicians in the community therefore increase their practice. We would expand our comprehensive diabetes education program to include Medicaid, underinsured and unfunded individuals. The program would be staffed by a diabetes clinical nurse specialist, case managers and diabetes educators to provide comprehensive diabetes care. We will also consider partnering with THHEB Faith Community Nursing to provide resources to patients identified in these outreach programs.

Our milestones and metrics advance development of our program to help an increasing underserved population receive diabetes management through the Wagner Chronic Care Model and include: (1)Establishing a multidisciplinary team including Physicians, Nurse Practitioners, Diabetes Educators, Registered Dietitians, Clinical Social Workers, Registered Nurses, Pharmacists, and support staff. (2)Increasing the number of patients served under this model by 10% over baseline as recorded in the database. (3)Developing policies, procedures, and data collection tools to effectively run the coordinated program and monitor effectiveness, reducing fragmented care

Unique community need identification numbers the project addresses:

- CN.8 – Lack of access to health care due to financial barriers
- CN.11 – Need for more care coordination

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

Linking diabetes patients who present to the ED or inpatients to a primary care physician is a new initiative. All of the current diabetic educators are trained in the Stanford model of Diabetes Management and have led a number of community workshops free to the public funded by the Area Agency on Aging of Tarrant County. This project could significantly enhance the number of patients who have accessibility to diabetic education. This project has not received any other federal funding.

Related Category 3 Outcome Measures:

Outcome Measures:

- 1.10 Diabetes care: HbA1c poor control (>9.0%)
- 3.3 Diabetes 30-day readmission rate

Relationship to Other Projects:

- **Related Category 1 and 2 projects:** This project relates to project 2.9.1 Establish/Expand Patient Care Navigation Program. The patient navigation program assists with the identification of at risk patient who might benefit from closer monitoring. The navigator would refer the patient to the Diabetes Clinic for management of their disease.
- **Related Category 4 Population-focused improvements:** RD.1: Potentially Preventable Admissions RD.1.2: Diabetes Admission Rate should improve for at-risk patients who would not otherwise be able to access care to manage their diabetes. Diabetics whose disease is managed will decrease their risk of developing complications from their disease that would result in hospital admissions. RD 2: 30 Readmission Rate – RD 2.2 Diabetes 30-day Readmissions are Category 3 Outcome Measures selected as an anticipated outcomes to measure the effectiveness of this project. By providing access to care and assistance in self-management of their disease, risk of admission and readmission are reduced.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology:** For every inpatient admission avoided, $8,297 in cost is saved by the health care system. Health care costs are calculated by multiplying $8,297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale**: Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).

- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

136326908.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*	
Texas Health Harris Methodist Hospital HEB				*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.1* *136326908.3.2*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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 a comprehensive care management program Metric 1 [P-3.1]: Documentation of Care management program. Best practices such as the Wagner Chronic Care Model and the Institute of Chronic Illness Care's Assessment Model may be utilized in program development. Data Source: Program Description Milestone 1 Estimated Incentive Payment: $12,151 **Milestone 2** [P-2]**:** Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1: [P-2.1] Increase percent of staff trained a) Numerator: number of relevant staff trained in the Chronic Care Model	**Milestone 6** [P-4]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric 1[P-4.1]: Increase the number of multi-disciplinary teams (e.g.,, teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams a) Number of teams or sites with formalized teams b) Data source: Team Rosters Baseline/Goal: develop 1 multidisciplinary team Milestone 6 Estimated Incentive Payment: $29,411 **Milestone 7** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention		**Milestone 8** [I-17]: Apply the Care Model to targeted chronic disease, which are prevalent locally Metric 1 [I-17.1]: 5% additional patients receive care under the Care Model for diabetes. a) Chronic disease Diabetes b) Data source: registry Goal: 5% increase over baseline Milestone 8 Estimated Incentive Payment: **$**31,020 **Milestone 9** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patient with self-management goals a) Increase self-management goals by 5% over baseline in DY2. numerator is total number of patient goals b) Denominator: Total number of patients with type 1 or 2 diabetes c) Data source: registry Milestone 9 Estimated Incentive	**Milestone 10** [I-17]: Apply the Care Model to targeted chronic disease, which are prevalent locally Metric 1 [I-17.1]: 5% additional patients receive care under the Care Model for diabetes. a)Chronic disease Diabetes b)Data source: registry Goal: 5% increase over DY4 Milestone 10 Estimated Incentive Payment: $25,047 **Milestone 11** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patient with self-management goals a) Increase self-management goals by 5 % over DY4. Numerator: the number of patients with diabetes X goal to reduce HbA1c below 9.0%. numerator is total number of patient goals b) Denominator: Total number of patients with type 1 or 2 diabetes

136326908.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*	
Texas Health Harris Methodist Hospital HEB				*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.1* *136326908.3.2*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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)**
b) Denominator: Total Number of relevant staff Milestone 2 Estimated Incentive Payment: $12,151 **Milestone 3** [P-x]: Increase FTEs from 2.2 – 4.5 Data Source: HR internal documents Milestone 3 [P-x] Estimated Incentive Payment (maximum amount): $12,151 **Milestone 4** [P-x]: Establish baseline. Current patients enrolled in diabetes education. Data Source: Class Rosters Milestone 4 [P-x] Estimated Incentive Payment: $ 12,151 **Milestone 5** [P-x] Establish baseline current self-management goals. a) Numerator is total number of self-management goals. b) Denominator is total number of	Metric 1 [P-9.1]: Increase the number of patients identified as needing screening test, preventive tests, or other clinical services Numerator: number of patients identified as needing screening test, preventive tests, or other clinical services a) Data source: Clinic registry Baseline/Goal: Increase # of patients identified by 5% over baseline Milestone 7 Estimated Incentive Payment: $29,411		Payment: $31,020	c) Data source: registry Milestone 11 Estimated Incentive Payment: $25,047

136326908.2.1	*2.2.1*	*Project Components: 2.2.1 (a-e)*	*Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases*	
Texas Health Harris Methodist Hospital HEB				*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.1* *136326908.3.2*	*3.IT-1.10* *3.IT-3.3*	*Diabetes care: HbA1c poor control (>9.0%)* *Diabetes 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)**
patients enrolled in the program Data source: internal documents Milestone 5 Estimated Incentive Payment: $12,151				
Year 2 Estimated Milestone Bundle Amount: $60,753	Year 3 Estimated Milestone Bundle Amount: $**58,821**		Year 4 Estimated Milestone Bundle Amount: $**62,039**	Year 5 Estimated Milestone Bundle Amount: $**50,093**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ **231,706**				

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 2.2.1 – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – Improving management of heart failure patients and preventing readmissions
Unique Project ID: 136326908.2.2
Performing Provider Name/TPI: Texas Health Harris Methodist HEB (THHEB) / 136326908

Provider: Texas Health Harris Methodist Hospital Hurst-Euless-Bedford has nearly 300 beds and more than 550 active physicians on its medical staff. THHEB provides emergency and acute inpatient care to the community. Nineteen percent of our patients are indigent, uninsured or covered by Medicaid.
Intervention: The primary goal of the program is to improve the health of patients with heart failure through more effective disease management along the continuum of care with particular emphasis on transitions through post-acute phase
The program's goal is to improve delivery of care to patients with government-funded insurance, the uninsured and undocumented patient population resulting in improved management of their disease with corresponding reduction in readmissions to the hospital. The behavioral health clinic addressing depression/anxiety in those with chronic illness exists. The other initiatives are all new initiatives.
Need of the project: Most recent (YTD 2011) indicates a heart failure 30 day, all cause, readmission rate of 20.36% for the 301 (annualized) patients admitted with a principal diagnosis of heart failure. In 2012, 9.6% of our CHP readmissions were indigent; 6.7% were Medicaid patients; and 60% were Medicare patients. Without this funding, 75% of these patients (government-funded/uninsured) will have difficulty managing their disease.
Target population: The target population is indigent or government-funded patients with a diagnosis of heart failure in the community who do not have access to receive care to manage their disease or those who are need additional support in the management of their HF. Estimated 301 total patients and 225 of these government-funded will be served over course of waiver period.
Expected patient benefits: Medicaid beneficiaries and the uninsured will benefit from other root causes for readmission of the low-income and underserved HF patient often related to lack of financial resources (e.g., inability to purchase medications, healthy food or bathroom scales to monitor weight, lack of transportation to appointments, inability to obtain PCP, etc).
Category 1 or 2 expected patient benefits: Milestones include: 1) develop a comprehensive care management program utilizing best practices and 2) develop program to identify and manage chronic care patients needing further clinical interventions and disease self-management tools at the time of transitioning to an outpatient setting, ensuring that the patients understand their disease of CHF and have access to monitoring, physicians and other clinicians will decrease the CHF readmission rate for this population.
Category 3 outcomes: 1) disseminate findings including lessons learned at best practices to stakeholders 2) decrease 30-day readmission rate in patients with CHF which is the ultimate purpose of the project.

Project Option 2.2.1 – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – Improving management of heart failure patients and preventing readmissions

Unique Project ID: 136326908.2.2

Performing Provider Name/TPI: Texas Health Harris Methodist HEB (THHEB) / 136326908

Project Description:

This project uses the Institute for Healthcare Improvement's publication on Effective Interventions to Reduce Rehospitalizations to develop strategies to improve patient outcomes. This program will develop a process to identify heart failure patients and assess them for risk factors or barriers to effective management of their disease (e.g., lack of ongoing monitoring by a health care professional, inability to obtain medications or inadequate understanding of their disease and self-management interventions). Once barriers or risk factors are identified, RN navigators (case managers) will work with a multidisciplinary team including dietitians, pharmacists, nurses, social workers, and nurse practitioners/physicians to provide comprehensive patient education and coordinate appropriate resources based on identified needs. Resources might include obtaining prescribed medications the patient cannot afford to purchase, providing scales to help the patient monitor their weight, consulting a dietitian to provide education on the appropriate diet or assisting the patient in obtaining a primary care physician. Postacute monitoring will also include home visits provided by hospital partners including United Way Healthy at Home Care Transitions coaches (trained coaches using Dr. Eric Coleman model to empower patient to effectively manage their disease), Transitions House Calls nurse practitioner, the primary care providers and/or the treating cardiologists. The RN navigator will continue to monitor the progress of high-risk patients through telephonic communications to reinforce the plan of care and respond to any emerging needs of the patient. Ongoing evaluation and assistance with management of their disease will be provided on an outpatient basis using a multidisciplinary team approach (physicians, licensed mental health care givers, social workers, nurse practitioners, dietitians, pharmacists, registered nurses)coordinated by the RN case manager. Postacute monitoring of high risk for readmission patients will be completed in cooperation with the patient's PCP and/or cardiologist. Other programs that will be developed as a result of lessons already learned are:

- A multidisciplinary intense outpatient group therapy model to address the depression and social isolation identified in 100% of a small study performed in 2012 of patients with heart failure readmissions. Patients will be enrolled in this clinic while still hospitalized. If necessary, transportation to and from their home to the clinic and back will be provided. The program will consist of two weeks of intensive outpatient group therapy led by a licensed mental health counselor who is overseen by a psychiatrist. In addition to addressing their depression, a multidisciplinary team of dieticians, pharmacists, physical therapists and cardiac rehab specialists will provide specific education and interventions targeted to individual needs.

- Implement a CHF Clinic that improves transition to self-care through medication management. In-house medication reconciliation by pharmacists will be performed prior to discharge. Pharmacists also will provide adjunct education on medication and disease state and perform incremental postdischarge follow-up in person or via phone, ensuring proper medication regimen (dosing/appropriate medication). Initially the pharmacists will communicate with appropriate practitioner regarding medication adjustments but ultimate goals are to develop physician-approved protocols.
- Implement 24/7 pharmacists in ED to address medication reconciliation and education of medications with CHF patients who frequently visit ED and don't require admission.
- Enhance chronic disease case management and social worker in ED to identify high risks patients and intervene to address issues related to patients' recurrent visits/admissions to ED and/or hospital.
- Dedicated CHF Case Manager for CHF patients with recurrent readmissions who will follow the patient from the inpatient setting into their homes.
- Develop a community outreach program with APN, case managers and social workers who visit the most high-risk patients in their homes on a regular basis or as needed in order to prevent readmissions.

Goals and Relationship to Regional Goals:

Project Goals:

The primary goal of the program is to improve the health of patients with heart failure through more effective disease management along the continuum of care with particular emphasis on transitions through postacute phase. Evidence of the effectiveness of the program will be demonstrated through reduced readmissions of the patients (for all causes) within 30 days of hospital discharge.

This project meets the following Regional goals:

A major goal of the Region is to provide improved access to ongoing preventive, primary and chronic care. This project would contribute to achieving that goal by implementing an innovative chronic disease management program to help unfunded, including undocumented community members and government-funded community member of Tarrant County better manage their heart failure conditions, with a particular clinical support focus on reducing the readmission rate among project participants.

Challenges:

There are two primary challenges in reducing readmissions for inappropriate heart failure readmissions. The first challenge is ensuring that the patient has the necessary resources to receive evidence-based recommendations and is compliant with the recommendations. Barriers for a patient include limited financial resources to obtain health care, scales, transportation to/from health care providers and appropriate nutrition – along with adequate education

regarding their disease and ability to self-manage their disease. Also recognized is that patients with heart failure and frequent readmissions frequently are depressed and isolated.

The second challenge is funding multidisciplinary projects already described, which addresses the patient-dependent challenges. Resources including the Texas Health System as well as external sources will be considered.

5-Year Expected outcome for Provider and Patients:
Improved health of patients with heart failure as evidenced by a 20% reduction in hospital 30-day, all-cause readmissions by the conclusion of the five-year time period.

Starting Point/Baseline:
Most recent (YTD 2011) indicates a heart failure 30-day, all-cause, readmission rate of 20.36% for the 301 (annualized) patients admitted with a principal diagnosis of heart failure. The goal of the project is to reduce readmissions for this patient population by 20% over the five-year course of the project to a readmission rate of <16%. Currently, one licensed professional counselor is working on developing an intensive outpatient clinic to address depressed, non-compliant heart failure patients with recurrent readmissions.

Rationale:
The target population includes individuals with heart failure diagnosis who are at risk for readmission due to inadequate monitoring or management of their chronic disease, specifically, CHF patients in our community who are underserved, unfunded and government-funded insurance populations, and patients with concomitant depression/anxiety. Heart failure is among Texas Health HEB hospital's reasons for admission with 301 patients admitted with a primary diagnosis of heart failure and 2,812 patients admitted with primary/secondary diagnosis of heart failure between June 2011 and May 2012. Readmission rates for these patients are 20%. According to **Key Findings: Readmissions in North Texas,** *a report from the Dallas-Fort Worth Hospital Council (DFWHC) Foundation on hospital readmission in 2011 for patients 18 years and older,* In 2011, patients admitting for congestive heart failure (CHF) had the highest number of readmissions with a readmission rate of 22.6%. Heart failure was also the number one reason for readmission for both the Medicare and uninsured patient demographics. There were 13,272 hospitalizations of North Texas heart failure patients who were followed by a readmission in 2011. Tarrant County Public Health Department *Behavioral Risk Factor Surveillance System 2009/2010* notes that among Tarrant County adults in 2007, heart disease ranked as the leading cause of death for both men and women. Also, during the years 2000 to 2005, Tarrant County residents spent about $500 million on preventable hospitalizations due to angina, congestive heart failure, and high blood pressure.

Project Components:

Our project contains all of the required core components including:

- Design and implement care teams tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system. Our care team also includes the addition of mental health providers.
- Ensure that patients can access their care teams in person or by phone or email
- Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources
- Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions
- 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.

The project was developed based on the Institutes for Healthcare Improvement **Effective Interventions to Reduce Rehospitalizations:** ***A Survey of the Published Evidence*** published 2009. Key components of the project include:

- Identification of HF patients by RNs through the development of a screening process including an enhanced multidisciplinary team approach to discharge process which addresses any potential barriers to effective postacute management
- Early postdischarge follow-up through coordination of health care provider home visits or provision of appointment with primary care provider or cardiologist or heart failure clinic PharmD or multidisciplinary intensive outpatient mental health clinic specializing in chronic diseases. Postdischarge assessment will include optimization of medication management, reinforcement of patient education regarding heart failure disease management. High risk patients will be evaluated by a health care provider within seven days of their hospital discharge.
- Front-loading home care visits to include care transitions coaches, home health nurses and/or nurse practitioners
- Front-loading follow-up with PharmD pre- and postdischarge to ensure medications received, medication education, and development of physical protocols that enable PharmD to adjust medications as required either in heart failure clinic or telephonically.
- Care Transitions coaches, based on Coleman model, in cooperation with United Way Healthy at Home program, can be coordinated by the CHF RN navigator to assist patients

post hospital discharge. Coaches focus on engaging patients in their own care as well as clarify and/or follow-up on postdischarge instructions.

- Ongoing postdischarge follow-up monitoring through telephonic assessments by RN case manager to respond to questions and evaluate for emerging needs.
- Implementation of intensive outpatient psychiatric clinic for chronic disease with a multidisciplinary approach including a licensed professional counselor, dieticians, specialists in cardiac rehabilitation.

Our milestones measure an increased population receiving chronic care management through a proven, effective model of care: (1) we are establishing a multidisciplinary team approach to identification of/ intervention with patients at risk for readmission, patient education, and postacute monitoring and (2) we are improving quality of life while decreasing cost of care as evidenced by decreasing the number of patients requiring readmission to the hospital within 30 days of discharge.

Unique community need identification numbers the project addresses:

- CN.1 – Lack of provider capacity
- CN.8 – Lack of access to health care due to financial barriers
- CN.10 – Overuse of emergency department services
- CN.11 – Need for more care coordination
- CN.13 – Necessity of patient education programs

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

This project is a new initiative and we have not received any other federal funding for it other than access to a Transitions APN funded by area Agency on Aging.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

IT-3.2 Congestive Heart Failure 30-day readmission rate (Stand-alone measure)

We have selected IT-3.2 CHF 30-day readmission rate as an outcome. It is a priority for the RHP because CHF is the number one cause of readmission in both Medicare and uninsured patients in our demographic area. Evidence shows that patients who have transitional support from the in-to outpatient arena, patients who have the tools to participate in their own care, and patients where anxiety and/or depression are addressed and treated have fewer readmissions.

Relationship to Other Projects:

Related Category 1 and 2 projects

Expand Chronic Care Management Models (136326908.2.1)

Patients with heart failure often also have diabetes. Diabetics, who also have heart failure, would be referred to the Chronic Care Management (Diabetes) Clinic for improving management of their diabetes.

Establish/Expand Patient Care Navigation Program (136326908.2.5)

Patient navigation program will assist with the identification of at-risk patient who might benefit from closer monitoring and support of the patient's disease management and refer them to heart failure chronic care program.
Integration of Behavioral Health into Primary Care (136326908.2.3)
Associated behavioral health hospital with a multidisciplinary outpatient clinic dedicated to chronic disease will assist patients who have frequent readmissions triggered by depression/ anxiety.

Related Category 4 Population-focused improvements: **TBD**

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $8,252 in cost is saved by the health care system. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).

Community benefits were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax. Individual benefits were calculated using

136326908.2.2	*2.2.1*	*PROJECT COMPONENTS 2.2.1 A-E*	*REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES – IMPROVING MANAGEMENT OF HEART FAILURE PATIENTS AND PREVENTING READMISSIONS*	
Texas Health Harris Methodist HEB				*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.3*	*3.IT – 3.2*	*Congestive Heart Failure 30-day Readmission Rate (Stand-alone 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-3]**:** Develop a comprehensive Care Management Program utilizing best practices Metric 1 [P-3.1]: Documentation of Care Management Program Baseline/Goal: Multidisciplinary program development complete Data Source: Program materials Milestone 1 Estimated Incentive Payment: $12,163 **Milestone 2** [P-4]**:** Formalize multidisciplinary team Metric 1 [P-4.1]: Add RN Project Manager, PharmD, CHF disease-specific Case Manager, Medical Director Baseline/Goal: 100% team hired Data Source: HR records Milestone 2 Estimated Incentive Payment: $12,163 **Milestone 3** [P-9]**:** Develop program	**Milestone 6** [P-3]: Develop a comprehensive Care Management Program utilizing best practices Metric 1 [P-3.1]: Documentation of Care Management Program Baseline/Goal: Increase by 20% over baseline Data Source: Program materials Milestone 6 Estimated Incentive Payment: $19,628 **Milestone 7** [P-16]: Participate in face-to-face learning at least twice per year with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1 [P-16.2]: Implement the "raise the floor" improvement initiatives established at the semiannual meeting Baseline/Goal: TBD at the semiannual meeting Data Source: Documentation of		**Milestone 9** [I-17]: Apply the Chronic Care Model to patients at risk for readmission Metric 1 [I-17.1]: Additional CHF patients at risk for readmission receive care under the Chronic Care Model Baseline/Goal: Increase by 10% from Year 3 Data Source: Internal patient database Milestone 9 Estimated Incentive Payment: $31,053 **Milestone 10** [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 CHF patients served by innovative program. Demonstrate improvement over prior reporting period. Baseline/Goal: Increase by 10%	**Milestone 11** [I-17]: Apply the Chronic Care Model to patients at risk for readmission Metric 1 [I-17.1]: Additional CHF patients at risk for readmission receive care under the Chronic Care Model Baseline/Goal: Increase by 10% from Year 4 Data Source: Internal patient database Milestone 11 Estimated Incentive Payment: $25,074 **Milestone 12** [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 CHF patients served by innovative program. Demonstrate improvement over prior reporting period. Baseline/Goal Increase by 10%

136326908.2.2	*2.2.1*	*PROJECT COMPONENTS 2.2.1 A-E*	*REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES – IMPROVING MANAGEMENT OF HEART FAILURE PATIENTS AND PREVENTING READMISSIONS*	
Texas Health Harris Methodist HEB				*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.3*	*3.IT – 3.2*	*Congestive Heart Failure 30-day Readmission Rate (Stand-alone 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)**
to identify and manage chronic care patients needing further clinical intervention. Metric 1 [P-9.1]: Increase number of inpatients with CHF identified as needing other clinical services or intervention once discharged Baseline/Goal: TBD longitudinal Year 2 Data Source: EHR, internal patient database Milestone 3 Estimated Incentive Payment: $12,163 **Milestone 4** [P-12]**:** Develop and implement plan for standing orders or protocols for medication management by PharmD Metric 1 [P-12.1]: Documentation of plan for standing orders Baseline/Goal: Complete longitudinal Year 2 Data Source: Approved proto-cols/standing orders	"raise the floor improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented "raise the floor" improvement initiative after the semiannual meeting. Milestone 7 Estimated Incentive Payment: $19,628 **Milestone 8** [I-17]: Apply the Chronic Care Model to patients at risk for readmission Metric 1 [I-17.1] Additional CHF patients at risk for readmission receive care under the Chronic Care Model Baseline/Goal: Determine baseline in Year 2 and increase by 15% in Year 3 Data Source: Internal patient database Milestone 8 Estimated Incentive		over the baseline determined in Year 3 Data Source: Internal patient database/EHR or patient chart demonstrating encounters Milestone 10 Estimated Incentive Payment: $31,053	over Year 4 Data Source: Internal patient database/EHR or patient chart demonstrating encounters Milestone 12 Estimated Incentive Payment: $25,074

136326908.2.2	*2.2.1*	*PROJECT COMPONENTS 2.2.1 A-E*	*REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES – IMPROVING MANAGEMENT OF HEART FAILURE PATIENTS AND PREVENTING READMISSIONS*
Texas Health Harris Methodist HEB			*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.3*	*3.IT – 3.2*	*Congestive Heart Failure 30-day Readmission Rate (Stand-alone 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 4 Estimated Incentive Payment: $12,163 **Milestone 5** [P-16]**:** Participate in face-to-face learning at least twice per year with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1 [P-16.1]: Participate in semiannual face-to-face meetings or seminars organized by RHP Baseline/Goal: Attend two face-to-face meetings or seminars Data Source: Documentation of semiannual meetings via sign-in sheets or TBD in Year 2 Milestone 5 Estimated Incentive Payment: $12,163	Payment: $19,628		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $**60,817**	Year 3 Estimated Milestone Bundle Amount: $**58,884**	Year 4 Estimated Milestone Bundle Amount: **$62,105**	Year 5 Estimated Milestone Bundle Amount: **$50,147**

136326908.2.2	***2.2.1***	***PROJECT COMPONENTS 2.2.1 A-E***	***REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES – IMPROVING MANAGEMENT OF HEART FAILURE PATIENTS AND PREVENTING READMISSIONS***
Texas Health Harris Methodist HEB			*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.3*	*3.IT – 3.2*	*Congestive Heart Failure 30-day Readmission Rate (Stand-alone 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)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*:**$231,954**			

Attachment 1- Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.15.1 – Decrease readmissions through the integration of behavioral health into primary care

Unique Project ID: 136326908.2.3

Performing Provider Name/TPI: Texas Health Harris Methodists Hospital HEB/Springwood / 136326908

Provider: THHEB is a 300 bed hospital serving Tarrant County. THHEB provides emergency and acute inpatient care to the community. Nineteen percent of our patients are indigent, uninsured or covered by Medicaid."

Intervention: To integrate behavioral health services in the D/FW Metroplex with primary care services to help patients that have mental illness but also suffer from chronic medical co-morbidities. This will help these patients better manage their mental illness and chronic medical conditions by increasing access to needed services. Through the integration of behavioral health and physical health care services, opportunities will open for these patients to address both conditions during a single visit. This is a new project

Need of the project: A major goal of the region is to avoid unnecessary ED and acute care visits for patients due to a lack of ongoing preventive, behavioral, primary and chronic care. This project will integrated primary and behavioral health care in one setting so patients do not have to utilize higher cost acute and ED care or readmit to the hospital.

Target population: Patients in Tarrant County who have behavioral health illness with medical co-morbidities. Estimated 5,000 patients will be served over course of waiver period.

Expected patient benefits: They will be able to control their behavioral and medical issues allowing them to function outside of the hospital setting

Category 1 or 2 expected patient benefits: Milestones 1 [P-2], Milestone 2 [P-3] Milestones 3 and 4 [I-8] Our milestones measure the increase in patients receiving behavioral health care and physical healthcare in one site for an integrated model of care. These milestones and metrics will measure how many patients are receiving care at our integrated site (rather than fragmented behavioral and physical health care). The first milestone P-2 will help us identify existing clinics where we can begin integration. The second milestone P-3 will help us implement a set of standards that we can use to show effective data sharing through the EHR and that we are ensuring the most physically and mentally chronic patients are referred to an integrated site. Milestone 1.8 will allow us to track how many chronic mentally ill patients are receiving care at the integrated site and milestone 1-10 will show how many no shows we have and could possibly need more intensive case management to encourage integrated follow up appointments to prevent readmissions

Category 3 outcomes: IT.3.8 Evidence shows delivering specialty mental health in primary care settings produces greater engagement of patients in mental health care, which is a prerequisite for better patient outcomes. Emerging literature on co-located treatment and primary care has shown that patients have better outcomes, with the greatest improvement for those with poorer health.[317] Medical cost offset may occur when patients use less medical care because they are receiving mental health services. The reduced physical health care cost offsets the cost of the mental health care.[318] And diagnosis and treatment may significantly improve in co-located

[317] Craven & Bland 2006
[318] Strosahl and Sobel 1996

Project Option 2.15.1 – Decrease readmissions through the integration of behavioral health into primary care

Unique Project ID: 136326908.2.3

Performing Provider Name/TPI: Texas Health Harris Methodists Hospital HEB/Springwood / 136326908

Project Description:

More than a third of patients who receive treatment for mental health disorders rely solely on primary care physicians. Additionally, many health insurers contract out psychiatric benefits to different companies. Unlike most referrals from physicians, this approach often requires patients to find an available psychiatrist by making calls from a list provided by their insurer. The Primary Care Behavioral Health Program will integrate behavioral health into the medical mindset and clinical setting through THPG primary care. This program will offer psychiatric consultative, referral, educational and administrative services to the primary care physician and their staff. This will result in medical providers being better suited to address the emotional illnesses found so frequently in the average primary care and medical practices. This model will guide the intentional, ongoing, and committed coordination and collaboration between all providers treating the individual. Ideally, a designated team of behavioral and physical health care providers will develop a common treatment plan that identifies and addresses both physical health and behavioral health care needs.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to integrate behavioral health services in the Dallas/Fort Worth Metroplex with primary care services to help patients who have mental illness but also suffer from chronic medical comorbidities. This will help these patients better manage their mental illness and chronic medical conditions by increasing access to needed services. Co-location of behavioral and physical health providers when coupled with protocols, training, technology and team building will improve communications and enhance coordination of care for these patients. The medical and behavioral health conditions will be monitored and these patients will no longer have the inappropriately high reliance on acute medical and behavioral services or emergent care resources. These patients will be monitored to decrease their readmissions to psychiatric facilities. Additionally, access to care is enhanced because individuals do not have to incur the cost or inconvenience of arranging transportation or making multiple trips to different locations to address physical and behavioral health needs. Finally, given the ever-increasing cost of transportation, a “one stop shop” approach for health care improves the chances that individuals with multiple health needs will be able to access the needed care in a single visit and thereby overcome the negative synergy that exists between physical and behavioral health conditions.

This project meets the following Regional goals:

A major goal of the Region is to avoid unnecessary ED and acute care visits for patients due to a lack of ongoing preventive, behavioral, primary and chronic care. This project would contribute to achieving that goal by implementing integrated primary and behavioral health care in one setting so patients do not have to utilize higher cost acute and ED care or readmit to the hospital.

Challenges:

- Policy and regulation—Policies at both the federal and state levels are seldom structured to encourage and support collaborative practice; instead they frequently act as barriers. This is particularly true of state regulations regarding behavioral health treatment planning and service documentation, which result in lengthy and time consuming paper and work processes that is not a good match to the pace of primary care, in either the behavioral health or the primary care setting. Despite the recent documentation of the chronic health conditions and early death experienced by people living with serious mental illnesses, people living with serious mental illnesses are not designated as a health disparities population.
- Workforce— skills needed to work in an integrated team are not generally part of academic training for clinicians, and as noted above, the success of person-centered health care homes will depend on bridging the cultural differences between primary care and behavioral health practitioners—an issue that requires attention in clinical training programs at all levels.
- Clinical information sharing—HIPAA is perceived as (but isn't necessarily) a barrier to communication—sharing information for the purposes of care collaboration is a permitted use under HIPAA, with the exceptions of HIV status and receipt of substance abuse treatment. The evolving electronic health record (EHR) systems for behavioral health and primary care do not easily intersect, and some of the EHRs being developed for use in behavioral health settings do not have data fields for health status and the health care services provided to people with serious mental illnesses.

- Physical facilities—integrated models of care rely on teams working in close physical proximity, difficult to accomplish in facilities which are frequently fully occupied when an integration initiative begins. The requirements for developing primary care in behavioral health settings are space and capital intensive, necessitating constructing and equipping exam rooms with examination tables and the type of equipment that primary care practitioners expect to have easily accessible in the course of a physical examination.

- Research—Given the enormous rate of activity on the primary care/behavioral health interface, it is critical that services research be informed by, and help inform, these evolving models. Researchers must be willing to move from the more traditional "top down" models of intervention design to partnerships with administrators and community leaders to develop and evaluate these evolving models. In order to ensure timeliness and relevance, these evaluations will need to use innovative approaches beyond those used in traditional randomized trials, and include careful cost analyses to understand if, and how, these models can be sustained in real world settings.

5-Year Expected outcome for Provider and Patients:

Our five year goal is to reduce acute behavioral health readmissions by 50% through integrating psychiatric nurse practitioners into the primary care setting within THPG primary care model. This will allow for patients to have a home for both medical and behavioral care. THPG has 234 primary care physicians and at the five year mark we will have integrated 20% of the primary care offices as co-locations for primary and behavioral health care. We will also integrate a primary care nurse practitioner into our behavioral health outpatient satellites.

Starting Point/Baseline:

The population in Tarrant County from the 2011 census is 1,849, 815. One in four persons suffers from a diagnosable mental disorder, which would be 462,453 people in Tarrant County. Our inpatient discharges for 2011 were 2,433 with a readmission rate of 10.8%. The majority of these patients have a comorbid chronic medical issue. Most of these patients are receiving uncoordinated fragmented care. We have had discussions with providers and they recognize the need for this project to go forward. We have provided training to our staff on recognizing the comorbid patient and have put together a chronic disease booklet for mentally ill.

Rationale:

In the past decade, the number of practicing psychiatrists has grown from 39,494 to 40,904– an uptick of only 1,410, according to 2010 data from the American Medical Association's *Physician Characteristics and Distribution in the U.S.* An estimated 26% of Americans age 18 and older suffer from a diagnosable mental disorder in a given year. The estimated lifetime prevalence of any mental disorder among the U.S. population is 46%. The interconnections between chronic disease, injury, and mental illness are striking. The evidence is extensive for associations between mental illness and chronic diseases, such as cardiovascular disease, diabetes, obesity, asthma, arthritis, epilepsy, and cancer. The provision of behavioral health services leads to a decline in use of medical services. This phenomenon is commonly referred to as the cost-offset effect. In the presence of active behavioral health treatment, patients with behavioral and medical comorbidities reduced their overall medical costs by 17% and decreased their readmissions to inpatient facilities.

Project Components:

Our project contains all of the core components including:

- Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. Examples of selection criteria could include proximity/accessibility to target population, physical plant conducive to provider interaction; ability / willingness to integrate and share data electronically; receptivity to an integrated team approach.
- Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.

- Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.
- Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations.
- Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:
    - Regular consultative meetings between physical health and behavioral health practitioners;
    - Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners; and/or
    - Shared treatment plans co-developed by both physical health and behavioral health practitioners.
- Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.
- Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.
- Arrange for utilities and building services for these settings.
- Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individuals treated in these integrated service settings.
- 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.

Our milestones measure the increase in patients receiving behavioral health care and physical health care in one site for an integrated model of care. These milestones and metrics will measure how many patients are receiving care at our integrated site (rather than fragmented behavioral and physical health care). The first milestone P-2 will help us identify existing clinics where we can begin integration. The second milestone P-3 will help us implement a set of standards that we can use to show effective data sharing through the EHR and that we are ensuring the most physically and mentally chronic patients are referred to an integrated site. Milestone 1.8 will allow us to track how many chronic mentally ill patients are receiving care at the integrated site and Milestone 1-10 will show how many no shows we have and could possibly need more intensive case management to encourage integrated follow up appointments to prevent readmissions

Unique community need identification numbers the project addresses:

- CN.5 – Insufficient integration of mental health care in the primary care medical care system
- CN.1 – Lack of provider capacity
- CN.4 – Lack of access to mental health services

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

This project is a new initiative and we have not received any other federal funds for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

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

By the end of the Waiver our goal is to reduce readmissions by 50% by integrating behavioral health and primary care and utilizing a "one location" for chronic behavioral health and physical health issues. Emerging literature on co-located treatment and primary care has shown that patients have better outcomes, with the greatest improvement for those with poorer health. Diagnosis and treatment may significantly improve in co-located models. This reduces readmissions into the hospital. This is attributed to behavioural health clinicians taking an active role in teaching and coaching primary care providers.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**

Expand Chronic Care Management Models (136326908.2.1)

Patients with heart failure often also have diabetes. Diabetics, who also have heart failure, would be referred to the Chronic Care Management (Diabetes) Clinic for improving management of their diabetes.

Establish/Expand Patient Care Navigation Program (136326908.2.5)

Patient navigation program will assist with the identification of at-risk patient who might benefit from closer monitoring and support of the patient's disease management and refer them to heart failure chronic care program.

Related Category 4 Population-focused improvements: TBD

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Valuation:

- **Approach/Methodology:** For every behavioral health readmission avoided, $7,491 in cost is saved by the health care system. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale:** Behavioral health outcome improvement targets are dependent on the target population served (aging populations will have increased readmissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, readmission rates can only decrease) and also current processes in place that already prevent avoidable readmissions.
- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.
- **Individual benefits** were calculated using lost wages, caretaker expense and extension of life (if applicable).

136326908.2.3	*2.15.1*	*2.15.1 A-J*	*INTEGRATION OF BEHAVIORAL HEALTH AND PRIMARY CARE*
Texas Health Harris Methodist Hospital HEB/Springwood			*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.4*	*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]: Identify existing clinics or other community-based settings where integration could be supported.] Metric 1 [P-2.1[: Discussions/ interviews with community health care providers Baseline/Goal: Visits with 25 providers/ 10% being viable integration points Data Source: Information from persons interviewed Milestone 1 Estimated Incentive Payment $ 595,747	**Milestone 2** [P-3]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa Metric 1 [P-3.1]: Number and types of referrals that are made between providers at the location Baseline/Goal: 30% of comorbid patients will be referred between medical and behavioral health providers Data Source: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results Metric 2 [P-3.2] Number of referrals that are made outside of the location Data Source: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results Metric 3 [P-3.3]: Number of referrals which follow the established standards	**Milestone 3** [I-8]: Integrated services Metric 1 [I-8.1]: Percent of individuals receiving both physical and behavioral health care at the established locations Goal: 75% of the 30% of patients identified in Milestone 2 (Year 3) that are referred between providers Data Source: Project data; claims and encounter data; medical records Milestone 3 Estimated Incentive Payment: $ 608,363	**Milestone 4** [I-8]: Integrated services Metric 1 [I-8.1]: Percent of individuals receiving both physical and behavioral health care at the established locations Goal: 100% of the 30% of patients identified in Milestone 2 (Year 3) that are referred between providers Data Source: Project data; claims and encounter data; medical records Milestone 4 Estimated Incentive Payment: $245,613 **Milestone 5** [I-10]: No show appointments Metric 1 [I-10.1]: Decrease the no shows for behavioral and physical health Goal: no more than 5% of scheduled patients no show Data Source: Project data, clinical registry data; claims and encounter data Milestone 5 Estimated Incentive Payment: $ 245,613

	Data Source: Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results Milestone 2 Estimated Incentive Payment: $576,811		
Year 2 Estimated Milestone Bundle Amount: $595,747	Year 3 Estimated Milestone Bundle Amount: $576,811	Year 4 Estimated Milestone Bundle Amount: $608,363	Year 5 Estimated Milestone Bundle Amount: $491,225
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD $2,272,147			

Attachment 1: Project Summary Template to be completed for each Category 1 and 2

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)

Unique Project ID: 136326908.2.4

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Hurst Euless Bedford / 136326908

Provider: Texas Health Harris Methodist Hospital Hurst-Euless-Bedford has nearly 300 beds and more than 550 active physicians on its medical staff. THHEB provides emergency and acute inpatient care to the community. Nineteen percent of our patients are indigent, uninsured or covered by Medicaid.

Intervention: Goals for the project include improved management of patient health care needs resulting in a reduction of inappropriate ED utilization for non-emergent conditions and increased navigation of patients to appropriate health care resources, including establishing a PCP. This is an expansion of existing initiative.

Need of the project: There are an estimated 10,000 people in our hospital system that come for emergency services that are in the targeted population.

Target population: The target population is patients, primarily those patients without insurance or with government funded insurance, who present to the ED for care that could be provided at a lower level or those with frequent utilization of the ED routine healthcare. Estimated 38,101 patients will be served over course of waiver period. Target population is based on each separate THR entity's internal data for 2011 ED visits.

Expected patient benefits: The ED case manager will navigate patients to appropriate healthcare facilities or community programs refer to area resources or assist in establishing a medical home. The ED case manager will continue to follow the patient post discharge to provide necessary education, re-enforce discharge plans and monitor patient compliance with follow-up care to improve their health.

Category 1 or 2 expected patient benefits: Milestones selected include expansion of the ED health care navigation program to include hiring, training and providing ongoing education to RN case managers acting as navigators with the support of social workers and other health care team members. A process for tracking and reporting on the patients enrolled, interventions implemented would be developed. Tracking outcomes of the programs including PCP referrals for patients without a medical home and decrease in avoidable patient use of the ED would be monitored.

Category 3 outcomes: Our project goal is to implement programs that will improve the health of patients who are most at risk of receiving disconnected and fragmented care by improving appropriate use of the ED over the course of the project.

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)

Unique Project ID: 136326908.2.4
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Hurst Euless Bedford / 136326908

Project Description:

The Emergency Department (ED) care navigation team of clinical and support staff will provide the targeted patients with support for psychosocial and clinical issues. This includes education, coaching, and navigation through the health care system, introduction to pertinent resources and a medication assistance program. Encouragement and help to develop the necessary tools to manage their disease process is also a primary role. The ED RN case manager will work with a multidisciplinary health care team to assist disadvantaged patients without primary care access to:

- Navigate patients to obtain necessary community resources to meet identified patient needs.
- Facilitate finding and obtaining a primary care provider (PCP) or enroll in a nurse practitioner -run chronic disease management clinic to more effectively manage their disease on an ongoing basis.
- Intervene as necessary to provide education, monitor identified patients post discharge to encourage compliance with their follow-up plan, and provide ongoing care/support for their health care needs.
- Facilitate arrangements for care, as clinically appropriate, at a less resource intense level, such as an outpatient clinic or skilled nursing facility to avoid hospital admission and reduce risk of ongoing utilization of ED for non-emergent care needs.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to develop and implement an innovative system with clinical and support staff that will guide the targeted patient population into programs that will help them stay out of the hospital and lead more productive enjoyable lives. This would include developing an in hospital program that will help low income senior or disabled individuals of the mid-cities better self-manage their chronic issues. The navigator program is a mandatory part of helping the patient understand why getting to the right place at the right time is important, since these patients are almost always seen in the Emergency Department that is the most logical place to have such a system. This program will focus on patients who have been identified through researching our area to be at risk. This is the seniors, self-pay, frequent flyers chronically ill and the mentally ill. The goal is to see all of the above individuals placed in the program so that help can be obtained. Education and support from the navigator, teaching to utilize the system,

finding a physician and facilitating visits is a part of the duties that would be needed to facilitate all that needs to take place and is now impossible. Of the 63,000 patients seen each year, it is documented approximately 10,000 need significant assistance. The average readmissions rate in North Texas is 20.6%.

There are no resources in North Tarrant County or lower Denton County for these patients. They are seen in the ED, given instruction and information about the few resources that are available and then there is only minimal follow up. A trip to JPS Health Network is much too far as the majority have no transportation. The hospital navigator would have the ability to help the patient access what is available and then follow into the community-based clinic as it becomes a reality. Referrals to dietitians, pharmacists and other support professionals through the hospital network would also be part of the navigation program as well as the clinic.

This project meets the following Regional goals:

A major goal of North Texas is to provide improved access to ongoing preventive, primary and chronic care. This navigator project would contribute to the management of the hospital patients, alignment with the local agencies, providing primary care and chronic disease management. In reaching this hospital's part of the overall goal it is projected that ED visits that could be reduced 3%. Here we have been working on this for at least 2 years and have managed a 6% reduction with this help we feel our personal goal of 10% could be managed as the project comes together.

Challenges:

Higher than the national average of around 8%, 9.7% adults 18 years and older in Texas are diagnosed with diabetes (i.e., about 1.8 million adults). Among the elderly population (older than 65, the rate is 23%, and among adults between 45-64 years of age, the rate is 14%.[319] While chronic conditions are a growing concern for all U.S. populations, the uninsured and Medicaid beneficiaries with chronic conditions are at the greatest risk of unnecessary disease-related complications and avoidable hospitalizations. Those who are uninsured or without access to appropriate care have been widely reported in clinical research literature as having the greatest difficulty in managing chronic conditions due to lack of a medical home, minimal or no primary care access, limited or no access to medications necessary for disease management, and limited or no access to regular lab work.[320]

As a community hospital we have seen in the last 3 years our self-pay go from 10%to 16%. This has been a change in the demographics and large increase in unemployment. Our mission is to

[319] Stockton, M B, Lanctot, J Q, McClanahan, BS, Klesges, L M, Klesges RC, Kumanyika, S, and Sherrill-Mittleman, D. Self-preception and body image associations with body mass index among 8-10-year old African American girls. Journal of Pediatric Psychology 34, 10 (2009): 1144-1154.

[320] Caprio, S, Daneils, S R, Drewnowski, A, Kaufman, F R, Palinkas, L A, Rosenbloom, A, and Schwinner J B. Influence of race, ethnicity, and culture on childhood obesity: Implications for Prevention and Treatment. Diabetes Care 31, 11 (2008): 2211-2221.

care for our community and to provide for them as best we can. The lack of resources in our area is being addressed and the coordination between all areas of the proposal will do that.

5-Year Expected outcome for Provider and Patients:

Our five-year goal is to deliver chronic care management utilizing the ED navigator program. This will be measured utilizing the internal mechanisms in place for readmissions, frequent fliers, and chronic disease identification.

Starting Point/Baseline:

There are currently two case managers and one support person working on this project in our hospital. They have made a difference in the lives of patients they are seeing; this is an average of 45 people a week. They work on providing primary and preventive care. The goal is to increase the self-reliance of the client so they will be able to receive more appropriate care when the need reoccurs. This is less than 3% of the identified ED population. We have seen our percentage of self-pay go down the last three months to 10% so we are making a difference but it is all we can do with the resources we have. Baseline numbers are collected and utilized. As the clinics begin to occur in the Texas Health system our resources for patients will have increased and with a true ED navigator program we will be able to not only help the community but the hospital.

Rationale:

There are an estimated 10,000 people in our hospital systems that come for emergency services that are in the targeted population. With advances in technology and the increase in chronic illness a "make-over" in which primary care access is the basis for the model our plan will pursue. The ED navigator program will insure the patients can receive the needed coordination of care. Additionally, we have focused this project on a population disproportionately affected by the lack of primary care, economically disadvantaged and underserved adults living with a chronic disease.

Project Components:

1) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
2) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
3) Connect patients to primary and preventive care.
4) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
5) 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.

The rational for the above is the lack of resources and the identified need in the community.

Our milestone measures are based on the identified increase of patients in our community that are without resources. The metrics will measure all facets of the program. The priority is to begin in the hospital ED and help those that are presenting with an immediate need. The resources will grow as the navigation team grows and expands out into the community.

Unique community need identification numbers the project addresses:

- CN.10 – Overuse of emergency services
- CN.11 – Inefficient care coordination

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

The small program in the hospital's ED is working well it is just not big enough. The project proposed has many of the same elements, limited by finances. There is no federal funding.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

IT-9.2 Right Care, Right Setting – ED appropriate utilization (Stand-alone measure)

This project will reduce inappropriate ED visits for the following target condition – Congestive heart failure (CHF), diabetes, end-stage renal disease (ESRD), cardiovascular disease (CV)/hypertension, behavioral health (BH)/substance abuse, chronic obstructive pulmonary disease (COPD), asthma

This project provides navigation services so the patient gets the right care, in the right setting and in a timely fashion, avoiding unnecessary ED visits and avoidable hospital admissions. (See data discussed in Section 4.a). Many studies have demonstrated the effectiveness of case management/navigation program to improve management of patient health, reduce risk of avoidable readmissions and provide better primary care access. RN Navigators will assist patients in obtaining resources necessary to more effectively manage their chronic condition or maintain their health. Patients with effectively managed disease and access to a dedicated health care provider will be less likely to utilize the ED for non-emergent conditions and will manage their health through primary and non-emergency health care providers. The program also assists in avoiding inpatient hospitalizations by providing patients with more appropriate alternatives to receive care and coordinating the necessary services from the ED.

Relationship to Other Projects:

- **Related Category 1 and 2 projects**:

- This project is related to project 2.2 Expand Chronic Care Management Models. The ED case manager will utilize the chronic care clinics as a resource to refer patients needing assistance with management of their chronic condition.

- **Related Category 4 population-focused improvements:**
  - RD1: Potentially Preventable Admissions 1.Congestive Heart Failure Admission Rate; 2. Diabetes Admission Rate; 3. Behavioral Health and Substance Abuse Admission Rate; 4. Chronic Obstructive Pulmonary Disease Admission Rate; 5. Hypertension Admission Rate
  - RD-5 Emergency Department: 1. Admit decision time to ED departure time for admitted patients (NQF 0497)
  - The ED Case Management program will help navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care. Through the navigation of patients to available resources, patient admissions can be avoided increasing the availability of inpatient beds for those in need of hospitalization. Increased bed availability impacts ED patient throughout and improves time for ED patients to receive their inpatient bed.

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

- **Approach/Methodology**: For every ED visit avoided, $535 in cost is saved by the health care system. The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification**: ED visit outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with greater than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.
- **Community benefits** were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

136326908.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Harris Methodist Hurst Euless Bedford Hospital			*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.5*	*3.IT-9.2*	*IT-9.2 ED appropriate utilization (Stand-alone measure) Reduce Emergency Department frequent flyer visits, defined as greater than 3 visits per year*

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]: 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 (and hire the RN case managers to act as) navigators, develop procedures (including data collection mechanism) and establish continuing navigator education Metric 1 [P-2.3]: Frequency of contact with care navigators for high risk patients. Baseline/Goal: *170* encounters Data Source: Patient navigation program materials and database, EHR Milestone 1 Estimated Incentive Payment *(maximum amount):* $139,200	**Milestone 4** [P-8]: 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. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Attend 2 programs/year Data Source: Documentation of semiannual meetings including meeting agendas slides from	**Milestone 6** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: 50% of identified patients Data source: Administrative data on patient encounters and scheduling records from patient navigator program Milestone 6 Estimated Incentive Payment: $213,221 **Milestone 7**[I-8]: Reduction in ED use by identified ED frequent users receiving navigation services	**Milestone 8** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1[I-6.2]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: 60% of identified patients Data source: Administrative data on patient encounters and scheduling records from patient navigator program Milestone 8 Estimated Incentive Payment: $172,166 **Milestone 9** [I-8]: Reduction in ED use by identified ED frequent users receiving navigation services Metric 1 [I-8.1]: ED visits pre- and

136326908.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Harris Methodist Hurst Euless Bedford Hospital			*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.5*	*3.IT-9.2*	*IT-9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department frequent flyer visits, defined as greater than 3 visits per year*

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 2 [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 represents the liaison between primary, secondary, tertiary and quaternary health care.	presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment *(maximum amount):* $202,163 **Milestone 5** [P-3]: Provide care management/navigation services to targeted patients. <u>Metric 1</u> [P-3.1] Increase percent of targeted patients enrolled in the program Goal: 10% Data Source: Claims and EHR/registry Milestone 5 Estimated Incentive Payment: $202,163	<u>Metric 1</u> [I-8.1]: ED visits pre- and post-navigation services by individuals identified as ED frequent users. Goal: 9% reduction for the overall target patient population • Data Source: Claims and EHR/registry Milestone 7 Estimated Incentive Payment: $213,221	post-navigation services by individuals identified as ED frequent users. Goal: 13% reduction Data Source: Claims and EHR/registry Milestone 9 Estimated Incentive Payment: $172,166

136326908.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Harris Methodist Hurst Euless Bedford Hospital			*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.5*	*3.IT-9.2*	*IT-9.2 ED appropriate utilization (Stand-alone measure)* *Reduce Emergency Department frequent flyer visits, defined as greater than 3 visits per year*

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)**
Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided. Baseline/Goal: Data collection completed with at least one report produced Data Source: Provider developed database Milestone 2 Estimated Incentive Payment *(maximum amount):* $139,200 **Milestone 3** [P-8]: 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			

136326908.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Harris Methodist Hurst Euless Bedford Hospital			*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.5*	*3.IT-9.2*	*IT-9.2 ED appropriate utilization (Stand-alone measure) Reduce Emergency Department frequent flyer visits, defined as greater than 3 visits per year*

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)
can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1[P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Attend 2 programs/year Data Source: Documentation of semiannual meetings including meeting agendas slides from presentations, and/or meeting notes. Milestone 3 Estimated Incentive Payment *(maximum amount):* $139,200			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $417,599	Year 3 Estimated Milestone Bundle Amount: $404,326	Year 4 Estimated Milestone Bundle Amount: $426,442	Year 5 Estimated Milestone Bundle Amount: $344,332

136326908.2.4	*2.9.1*	*Project Components: 2.9.1 (a-e)*	*Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*
Texas Health Harris Methodist Hurst Euless Bedford Hospital			*136326908*
Related Category 3 Outcome Measure(s):	*136326908.3.5*	*3.IT-9.2*	*IT-9.2 ED appropriate utilization (Stand-alone measure) Reduce Emergency Department frequent flyer visits, defined as greater than 3 visits per year*
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $1,592,699**			

Project Option 2.1.1 – Enhance Medical Homes

Unique Project ID: 138910807.2.1 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807

Provider: Children's has two hospitals, one in Dallas with 487 licensed beds and one in Plano with 72 licensed beds. Children's has pediatric specialty outpatient services in Dallas, Plano and Grapevine (Region 10). Children's also has a system of primary care centers, MyChildren's, which focuses on providing primary care to children covered by Medicaid and CHIP. There is one MyChildren's office in Grapevine (Region 10). Annually, Children's has approximately 600,000 patient contacts. Children's has the largest market share for pediatrics in the DFW region with 51% of the market for inpatient discharges. Of that volume, 67% of the cases were either covered by a government payor (Medicaid and CHIP) or had no insurance (indigent/uninsured). Payor mix for MyChildren's: 75% Medicaid, 15% CHIP, 5% self-pay (uninsured) and 5% Commercial insurance.
Intervention: The purpose of this project is to transform the MyChildren's primary care office into an NCQA-certified medical home. It is a new initiative.
Need for the project: The need for this project is documented in the community needs assessment, specifically: CN. 1 Lack of provider capacity, CN. 10 Overuse of emergency department (ED) services, CN. 11 Need for more care coordination, CN. 12 Need for more culturally competent care to address unmet needs, CN. 13 Necessity of patient education programs, and CN. 14 Need for more education, resources and promotion of healthy lifestyles.
Target population: Children in RHP 10 covered by Medicaid and CHIP who will receive care in a medical home setting. Estimated number of patients to be served over course of waiver period: 31,000 patient visits. Provide primary care and preventive care services to children in the medical home setting to allow for better coordination care, improved health outcomes and improved satisfaction for children and their families.

Year	Patient Visits
DY3	9,400
DY4	10,300
DY5	11,300
Total	31,000

DY5 Patient Panel estimates: 6,700
Category 1 or 2: How do they tie into project's purpose? Process and improvement milestones were selected to support the successful implementation of the project and to support care delivery in a medical home environment.
Category 3 outcomes: OD-9 Preventive and Primary Care IT-9.2 ED appropriate utilization. (Stand-alone measure) Access to care delivered in a medical home environment should reduce both the use of the ED for inappropriate reasons as well as reduce overall use of the ED for patients receiving care in a medical home setting. Studies have shown a decrease of 25% or more in inappropriate use of the ED by patients enrolled in a medical home as well as a decrease in overall use of the ED patient receiving care in a medical home environment.

Project Option 2.1.1 – Enhance Medical Homes

Unique Project ID: 138910807.2.1 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807

Project Description:

- In Children's Medical Center (CMC) pediatric primary care center, MyChildren's, in Tarrant County, develop and implement a medical home team-based approach to care, transforming the existing fee-for-service delivery system from a reactive, fragmented approach to a proactive, comprehensive approach to improving the health of a population
- Expand staff roles to ensure that all staff practice at the top of their license; redesign processes in the CMC primary care center to effectively use technology and staff to take responsibility for the health of a defined population and improve cost, quality, health and satisfaction outcomes
- Implement the effective use of IT systems, including patient identification, risk adjustment/analysis/scoring, predictive modeling, data warehousing, gaps in care alert system, provider profiling, outcomes measurement and reporting system capable of aggregating data at all levels, including individual patient, chronic disease, pediatric physician panel, clinic and systemwide.
- Build, implement and spread a pediatric patient/family care coordination system for the Tarrant County CMC primary care center

Goals and Relationship to Regional Goals:

Project Goals:

The goal of the project is to build infrastructure to expand the CMC primary care medical home capability and perform extensive innovation and redesign to achieve the outcome of NCQA Primary Care Medical Home recognition. This five-year project will involve capacity to manage chronic diseases, increase screening for potentially treatable and preventable conditions, and contribute to reduction in avoidable ED care and avoidable admissions/readmissions.

The expansion of a pediatric medical home approach complements and leverages the expansion of CMC's primary care centers such that the incremental primary care centers will be able to achieve a higher level of comprehensive, coordinated care and better quality, cost, health and satisfaction outcomes. By spreading the medical home model to all our primary care centers in order to empanel thousands of patients comprehensively and systematically, we can make a measureable difference in the experience, results and costs of health care.

Expanded prevention, wellness and patient/family education programs also feeds into the expansion of medical homes and more organized care delivery, better prevention and wellness programs specific to immunizations and well-child care, better prevention and management of chronic conditions, integrated physical-behavioral health care and better utilization of health care

resources. Patients and families have better access to care, better access to behavior change programs, better access to social support networks and better access to health education, all of which is delivered in a patient/family-focused and culturally appropriate manner.

The medical home model increases opportunities to prevent disease and treat it early, where patients and families, upon patient discharge, can be scheduled for follow-up appointments at a medical home, thereby reducing the risk and consequences of worsening health conditions. Additionally, staff takes responsibility for proactively reaching out to high-risk patients, patients transitioning from one care setting to another and patients due for preventive services.

Year	Patient Visits
DY3	9,400
DY4	10,300
DY5	11,300
Total	31,000

DY5 Patient Panel estimates: 6,700

This project meets the following regional goals:
The project is related to the regional goals of increased access to medical homes, improved patient and family satisfaction with services and better coordination of care.

Challenges:
A major challenge will be the thoughtful and careful redesign of care delivery and communications processes resulting in a team approach to patient/family-centered care, requiring a formally structured, inclusive project management approach. This project will use proven process improvement methodologies to guide the redesign, as well as use lessons learned from providers who have successfully redesigned care delivery in their practices.

5-Year Expected Outcome for Provider and Patients:
Five-year expected outcomes include increased access to care, improved patient and family satisfaction, increased patient navigation and care coordination services for patients with chronic diseases, increased availability of information on healthy lifestyle choices and self-management and decreased low-complexity emergency department visits.

Starting Point/Baseline:
Baseline measurements will be established using DY1 data.

Rationale:
The project is data-driven and based on community needs and local data that demonstrate the project is addressing an area of poor performance (lack of coordination of care).

The demand for both primary and specialty care services exceeds that of available physicians in Tarrant County for children covered by Medicaid and CHIP, thus limiting health care access for many low-level management or specialized treatment for prevalent health conditions. Additionally, many individuals in North Texas suffer from chronic diseases that present earlier in life, are becoming more prevalent, and exhibit more severe complications. Finally, emergency departments are treating high volumes of patients with preventable conditions, or conditions that are suitable to be addressed in a primary care setting. Additionally, readmissions are higher than desired, particularly for those with severe chronic diseases or behavioral health.

The impact of the limited primary and specialty care is profound for children and families in the Region. With the current pediatric need being more than 80% of the current supply, in rural and urban areas the demand for primary care services is much higher than the current supply. In the North Texas Corridor, almost 40% of children were either uninsured or enrolled in Medicaid or CHIP in 2010, exacerbating the issue of availability of primary care access and treatment. Additionally, data indicate that many of the pediatric specialists are limited, creating a backlogged pipeline for those needing specialty services after seeking primary care.

As we seek to develop pediatric medical homes through National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) recognition, MyChildren's will have the opportunity to provide better care through improved prevention screenings and routine primary and chronic care. The majority of the MyChildren's primary care providers are still functioning in a more traditional fee-for-service approach. We want to make sure the pediatric medical home model is embedded within the care delivery model at MyChildren's so that all patients can receive the right care in the right place at the right time. This is a strategic priority for MyChildren's because by providing more patients with family-centered, culturally appropriate coordinated care services grounded in their primary care medical homes, children can stay healthier and families can take better care of their children, thereby reducing avoidable ED visits, specialty visits, admissions and readmissions. Children will be identified via the IT support systems and then receive this care in a proactive, planned manner so that they can receive evidence-based interventions across the care continuum. The staff will be complemented to include nutritionists, social workers, community health workers and therapists as part of the family-focused patient care teams. Services will include group visits, care management, chronic care management, telephone outreach and home health care. Heavy emphasis will be placed on a patient/family-focused approach that incorporates evidence-based clinical protocols, and is applied in a consistent and documented manner. Rigorous measurement of both processes of care and pediatric outcomes will ensure continuous improvement and sustainability over time.

MyChildren's will utilize the IT support systems to track and monitor prevention and wellness programs, with targeted improvements in key quality indicators, such as well-child visits, immunizations and potentially preventable acute care services. Currently, primary care capacity, resources, infrastructure and technology are severely limited. Our goal is to better treat the volume of patients who need preventive and wellness interventions in addition to chronic care

management. The IT support systems will promote tracking, trending timely intervention and also support patient/family education.

Project Components:
All the project components of 2.1 will be included in this project, as they are all relevant to the successful implementation of the project:

a. Utilize a gap analysis to assess and/or measure the primary care providers' readiness for National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) status
b. Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status
c. Conduct educational sessions for primary care physician offices, hospital board of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision
d. Conduct quality improvement for the project using methods such as rapid cycle improvement

All milestones and metrics are based on the relevancy to RPH 10's population, community needs, RHP priorities and the starting point for the project.

Unique community need identification numbers the project addresses:

- CN. 1 Lack of provider capacity
- CN. 10 Overuse of emergency department (ED) services
- CN. 11 Need for more care coordination
- CN. 12 Need for more culturally competent care to address unmet needs
- CN. 13 Necessity of patient education programs
- CN. 14 Need for more education, resources and promotion of healthy lifestyles

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents a new initiative to bring medical home practices into MyChildren's Primary Care Centers practices. Significant changes to practice, staffing, process and productivity will be reflected in the process of becoming qualified medical homes.

Related Category 3 Outcome Measures:
Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:
OD-9 Preventive and Primary Care IT-9.2 ED appropriate utilization. (Stand-alone measure)

Access to care delivered in a medical home environment should reduce both the use of the ED for inappropriate reasons as well as reduce overall use of the ED for patients receiving care in a medical home setting. Studies have shown a decrease of 25% or more in inappropriate use of

the ED by patients enrolled in a medical home as well as a decrease in overall use of the ED patient receiving care in a medical home environment

Relationship to Other Projects:

1.1 Expand Access to Pediatric Care

1.2 Expand Disease Management Services

1.3 Expand/Enhance Behavioral Health Care

Related Category 4 Population-focused improvements

RD-1 Potentially Preventable Admissions

RD-2 30-day readmissions

RD-3 Potentially Preventable Complications

RD-4 Patient-centered Health care

-RD-6 Initial Core Set of Health Care Quality Measures

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

This project was valued using a Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals 3
- Addresses Community Needs 2
- Project Scope 1
- Project Investment 2
- Value Weight of the Project 8

Each point of the scale was given a value of $187,500 based on expected savings, improved outcomes and improved satisfaction with the health care system over the life of the project and

beyond the life of the project as all patients are pediatric with expected savings to continue into adulthood. The overall project value was then divided between Category 1 and 3 based on HHSC-provided guidelines with Category 4 being allotted the maximum 15% in later years by reporting on Optional Domain 6.

References

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138910807.2.1	*2.1.1*	*2.1.1 A, B, C, D*	*ENHANCE/EXPAND MEDICAL HOMES*
Children's Medical Center			**138910807**
Related Category 3 Outcome Measure(s):	*138910807.3.4*	*IT-3.9.2*	*Preventive and Primary Care*

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]: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. Metric 1 [P-2.1]: Performing Provider policies on medical home Rationale/Evidence: Operationalizing the work as part of the "Policies and Procedures" for an organization will make the work the "norm" or expectation for the organization and its employees. Goal: Policies and systems in place by 9/30/13 Data Source: Performing Provider's "Policies and Procedures" documents **Milestone 1 Estimated Incentive Payment *(maximum amount):*** $159,375	**Milestone 3** [P-1]: Implement the medical home model in primary care clinics Metric 1 [P-1.1]: Increase number of primary care clinics using medical home model a. Numerator: Number of primary care clinics using medical home model b. Denominator: Total number of eligible primary care clinics Rationale/Evidence: NAPH found that nearly 40% of programs could offer either anecdotal or quantitative evidence of reduced ED usage—attributed to the redirection of primary care-seeking patients from the ED to a medical home.62 In addition to reductions in ED utilization, the medical home model has helped improve the delivery and quality of primary care and reduce costs. Goal: 100% of eligible clinics implemented with medical home model by 9/30/14, 1clinic	**Milestone 5** [I-18]: Obtain medical home recognition by a nationally recognized agency (e.g., NCQA, RAC, AAHC, etc.). The level of medical home recognition will depend on the practice baseline and accrediting agency. Metric 1 [I-18.1]: Medical home recognition/accreditation a. Numerator: number of sites or clinics receiving recognition/accreditation b. Denominator: total number of sites or clinics eligible for recognition/accreditation. Rationale/Evidence: It is important to validate the medical home service being provided by seeking and receiving recognition/accreditation. Some safety net sites that have attained NCQA accreditation "reported that they have become far more sophisticated as a result of the application effort and have invested in quality improvement efforts that might otherwise have gone unrealized".	**Milestone 8** [I-16]: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home Metric 1 [I-16.1]: Percent of primary care visits at medical home a. Numerator: Number of enrolled patients' primary care visits with medical home primary care provider/team b. Denominator: Total number of enrolled patients' primary care visits within the Performing Provider Rationale/Evidence: Patients know the professionals on their care team and establish trusting, ongoing relationships to reinforce continuity of care. Medical home model should enhance continuity. Goal: 50% of patients in panel, 3,350 patients Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider

138910807.2.1	*2.1.1*	*2.1.1 A, B, C, D*	*ENHANCE/EXPAND MEDICAL HOMES*
Children's Medical Center			**138910807**
Related Category 3 Outcome Measure(s):	*138910807.3.4*	*IT-3.9.2*	*Preventive and Primary Care*

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 2 [P-4]: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members.66 Metric 1 [P-4.1]: Expanded primary care team member roles; Rationale/Evidence: "Primary care physicians are expected to provide acute, chronic, and preventive care to their patients while building meaningful relationships with those patients, and managing multiple diagnoses according to a host of evidence-based guidelines. A research study estimates that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 patients plus an additional 10.6 hours to adequately manage this panel's chronic conditions.67 It is clear that primary care physicians in the 15-minute visit can no longer do what their patients expect and deserve."	Data source: Administrative data **Milestone 3 Estimated Incentive Payment *(maximum amount):*** $140,625 **Milestone 4** [P-7]: Track the assignment of patients to the designated care team Metric 1 [P-7.1]: Tracking medical home patients Rationale/Evidence: Review panel status (open/closed) and panel fill rates on a monthly basis for equity to be able to adjust to changing environment (e.g., patient preference, extended provider leave). Goal: Tracking report developed by 9/30/14 Data Source: Submission of tracking report. Can be tracked through the practice management system, EHR, or other documentation as designated by Performing Provider	Goal: 100% of eligible clinics receive medical home certification by 9/30/15, 1 clinic Data Source: Documentation of recognition/accreditation from nationally recognized agency (e.g., NCQA) **Milestone 5 Estimated Incentive Payment *(maximum amount):***$87,500 **Milestone 6** [I-12]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 [I-12.1]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the Performing Provider a. Numerator: Number of eligible patients assigned to a medical home b. Denominator: Total number of eligible patients Rationale/Evidence: Murray M, Davies M, Boushon B, Panel Size:	**Milestone 8 Estimated Incentive Payment *(maximum amount):*** $97,500 **Milestone 9** [I-17]: Medical home provides population health management by identifying and reaching out to patients who need to be brought in for preventive and ongoing care Metric 1 [I-17.1]: Reminders for patient preventive services a. Numerator: For select specific preventive service (e.g., pneumococcal vaccine for diabetics), the number of patients in the registry needing the preventive service and who have been contacted to come in for service b. Denominator: Total number of patients in the registry needing the preventive service Rationale/Evidence: Panel manager (or staff on care team) identifies patients who have process or outcome care gaps and contacts them to come in for services. This approach has been used

138910807.2.1	*2.1.1*	*2.1.1 A, B, C, D*	*ENHANCE/EXPAND MEDICAL HOMES*	
Children's Medical Center				**138910807**
Related Category 3 Outcome Measure(s):	*138910807.3.4*	*IT-3.9.2*	*Preventive and Primary Care*	
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)**
Goal: Staffing plan developed by 9/30/13 Data Source: Revised job descriptions **Milestone 2 Estimated Incentive Payment *(maximum amount):*** $159,375	**Milestone 4 Estimated Incentive Payment *(maximum amount):*** $140,625		How Many Patients Can One Doctor Manage? *Fam Pract Manag.* 2007 Apr;14(4):44-51 Goal: 50% of eligible patients in MyChildren's assigned a medical home by 9/30/15 Data Source: Practice, 3,000 patients Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider **Milestone 6 Estimated Incentive Payment *(maximum amount):*** $87,500 **Milestone 7: I-13.** New patients assigned to medical homes receive their first appointment in a timely manner **Metric 7: I-13.1.** Improve number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120	with good effect in state and federal health disparity collaborative. The care team assesses the patient's overall health and co-develops a health care plan with the patient, including health goals, ongoing management, and future visits. Goal: 50% of patients receive information regarding preventive services by 9/30/16, 3,350 patients Data Source: Registry, or other documentation as designated by Performing Provider **Milestone 9 Estimated Incentive Payment *(maximum amount):*** $97,500

138910807.2.1	*2.1.1*	*2.1.1 A, B, C, D*	*ENHANCE/EXPAND MEDICAL HOMES*	
Children's Medical Center				**138910807**
Related Category 3 Outcome Measure(s):	*138910807.3.4*	*IT-3.9.2*	*Preventive and Primary Care*	
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)**
			days a. Numerator: Number of new patients contacted within specified days b. Denominator: Total number of new patients c. Data Source: Practice management or scheduling systems, registry, EHR, or other documentation as designated by Performing Provider d. Rationale/Evidence: It is important to get new patients into the medical home in a timely manner. e. Goal: 50% of new patients in medical home models in MyChildren's receive first appointment within or before 60 to 120 days . Approximately 450 new patients annually **Milestone 7: I-13. Estimated Incentive Payment *(maximum amount):*** $87,500	

138910807.2.1	*2.1.1*	*2.1.1 A, B, C, D*	*ENHANCE/EXPAND MEDICAL HOMES*	
Children's Medical Center				**138910807**
Related Category 3 Outcome Measure(s):	*138910807.3.4*	*IT-3.9.2*	*Preventive and Primary Care*	
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)**	
Year 2 Estimated Milestone Bundle Amount: $318,750	**Year 3 Estimated Milestone Bundle Amount:** $281,250	**Year 4 Estimated Milestone Bundle Amount:** $262,500	**Year 5 Estimated Milestone Bundle Amount:** $195,000	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,057,500				

Project Option 2.7.6 – Promoting Physical and Mental Health Among At-risk, Underserved African-American Pre-teen Girls in Tarrant County

Unique Project ID: 138980111.2.1
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Providers: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: Deliver educational and activity-based programming to improve self-esteem and provide alternatives to risky behaviors for African American preteen girls would be expanded using existing youth serving organizations such as the A B Christian Learning Center, YMCA, and similar existing organizations. SPARK-based interventions include age-appropriate physical activity and self-management curriculum to promote physical activity as part of personal development and a healthy life style. In addition activities include nutrition education and demonstrations. Beyond the SPARK-based intervention, activities will focus on self-esteem and self-efficacy development through a series of small group sessions that focus on body awareness and self-respect, character development, appropriate response to peer and other pressures, an awareness of problematic habits that effect lifestyle, i.e., obesity, lack of physical fitness, poor eating habits, smoking, alcohol and drugs, and the development of strong mentoring relationships. This project is a new initiative that seeks to increase access for African American preteen girls to youth-serving organizations, social services, and medical services.
Need for the project: African American young women in Tarrant County have high levels of risk factors for poor birth outcomes as indicated by the infant mortality rate for African American women (12.7 infant deaths per 1000 live births in 2010), which is over twice that for other women in the county. Increased access to youth serving organizations, social services, and medical services should result in healthier births by healthier women, which should reduce the demand for NICU and services related to poor birth outcomes.
Target population: African American pre-teen girls who are at risk for poor birth outcomes. Estimated 40 patients will be served over course of waiver period.
Expected patient benefits: Targeting at-risk, underserved African American pre-teen girls will help to improve health knowledge and health behaviors in the near term, which will have long-term impact on the health access and health outcomes of these women and their families as they grow and mature.
Category 1 or 2 expected patient benefit:

i. 25 - pre-teen African American girls receiving intervention consistent with evidence-based model by DY4 and 40 by DY5
ii. Increase access to disease prevention programs by 10% over baseline by DY4 and 20% over baseline by DY5

Category 3 outcomes:

i. IT-10.1 – -Increase over baseline in quality of life score as measured by PedsQL of 2% by DY4 and 5% by DY5

Project Option 2.7.6 – Promoting Physical and Mental Health Among At-risk, Underserved African-American Pre-teen Girls in Tarrant County

Unique Project ID: 138980111.2.1
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:
Project Area: Implement Evidence-based Disease Prevention Programs
Project Intervention: Implement other evidence-based project to implement evidence-based disease prevention programs in an innovative manner.

Research has demonstrated an association of obesity, a major risk factor for subsequent disease and poor self-image, and self-perceptions, healthy diet, and physical activity behaviors. Self-efficacy has also been linked to lower drug use and reduced alcohol use in adolescents. (Stockton et al 2009)- Obesity is a risk factor for diseases such as diabetes, heart disease, hypertension, cancer, and respiratory and circulatory conditions which are costly to the healthcare system and lead to poor quality of life for individuals. Preteen African-American girls are at higher risk to be obese and as a result, tend to have higher healthcare costs.(Caprio et al 2008)- - This project will deliver educational and activity-based programming to improve self-esteem and provide alternatives to risky behaviors for African-American preteen girls employing evidence-based interventions based on SPARK's and GEMS' programming.(McKenzie et al 2009, Klesges et al 2010, Doswell et al, 1998)- - Project inventions will be delivered through youth serving organizations such as the A B Christian Learning Center and the YMCA that base their programming on these and related models. While the project intervention is a holistic approach in its focus on self-esteem and health awareness, it will seek to impact risk factors for specific diseases such as obesity through education and age-appropriate activities. SPARK-based interventions include age-appropriate physical activity and self-management curriculum to promote physical activity as part of personal development and a healthy life style. In addition activities include nutrition education and demonstrations. Beyond the SPARK-based intervention, activities will focus on self-esteem and self-efficacy development through a series of small group sessions that focus on body awareness and self-respect, character development, appropriate response to peer and other pressures, and the development of strong mentoring relationships.

Goals and Relationship to Regional Goals:

Project Goals:
The purpose of this project is to engage pre-teen girls in youth-serving organizations to improve their self-esteem and related health behaviors. The goals of this project are to 1) increase access to educational programming for pre-teen African-American girls that offers positive preconception health knowledge and 2) engage pre-teen African-American girls in behaviors that provide alternatives to risk behaviors that negatively impact their long term health.

This project meets the following Regional goals:
African-American young women in Tarrant County have high levels of risk factors for poor birth outcomes as indicated by the infant mortality rate for African-American women (12.7 infant deaths per 1,000 live births in 2010), which is over twice that for other women in the County. These women lack access to youth serving organizations, social services, and medical services. This project will increase their access to these services by developing necessary outreach infrastructure. Healthier births by healthier women should reduce the demand for NICU and services related to poor birth outcomes.

Challenges:
Recent research links stress in the African-American community to poor health outcomes.(Boutwell & Hwu 2009) This stress results from continued racial discrimination, economic circumstances, family and neighborhood situations, and other disparate social conditions and is compounded by biological predispositions. In addition, Michael Lu and his associates have demonstrated that a life course perspective is needed to address the high rates of infant mortality and other poor birth outcomes in the African-American community associated with this stress. (Boutwell & Hwu 2009) Life course factors are believed to influence pregnancy outcomes through not only the early life or fetal programing pathway, but also through a cumulative, wear and tear mechanism, known as weathering. For both the fetal programing and weathering pathway, (Boutwell & Hwu, 2009) stress is believed to be the underlying mechanistic factor to which the body responds. (Boutwell & Hwu 2009, Coleman) The implementation of life course perspective at the Northern Manhattan Perinatal Partnership reduced its infant mortality rate from 27.7 deaths per 1,000 live births in 1990 to 6.1 in 2008. The child development programs of many national youth serving organizations provide approaches for girls to learn to cope with the life stresses of their environment. To demonstrate the effectiveness of their programs, these organizations have conducted their own evaluations, expanded the capacity of its affiliates to evaluate their programming, and commissioned (Premier Quality Advisor, Coleman) independent evaluators to study program, training, and management effectiveness (Readmissions in North Texas, Premier Quality Advisor).

5-Year Expected Outcome for Provider and Patients:

This project seeks to increase the mental and physical health of African-American pre-teen girls in Tarrant County prior to first conception. The project will engage 40 or more girls in the program and increase their access to prevention programs. Specific project outcomes include:

- Development and implementation of the project plan
- Execution and documentation of the learning and diffusion strategy
- Execution and documentation of the evaluation process, tools, and analytics
- Identification of 40 African-American pre-teen girls to participate in the program
- Increased access to disease prevention programs by program participants
- 5% increase in the PedsQL score by DY5
- Implementation of age-appropriate evaluation techniques such as maintaining a food diary and measuring BMI

Starting Point/Baseline:
Focus group information indicated a lack of access for African-American youth to youth-serving organizations in the target area of Tarrant County. This is a new project that will serve 40 African-American pre-teen girls. Baseline rates for this project will be defined in DY2.

Rationale:
Extensive focus group analysis in this community has identified the need for services to build self-esteem among young women before they reach their teenage years. Recent research links stress in the African-American community to poor health outcomes (Boutwell & Hwu 2009). This stress results from continued racial discrimination, economic circumstances, family and neighborhood situations, and other disparate social conditions and is compounded by biological predispositions. In addition, Michael Lu and his associates have demonstrated that a life course perspective is needed to address the high rates of infant mortality and other poor birth outcomes in the African-American community associated with this stress (Coleman). Life course factors are believed to influence pregnancy outcomes through not only the early life or fetal programing pathway, but also through a cumulative, wear and tear mechanism, known as weathering. For both the fetal programing and weathering pathways, stress is believed to be the underlying mechanistic factor to which the body responds.(Coleman) The implementation of life course perspective at the Northern Manhattan Perinatal Partnership reduced its infant mortality rate from 27.7 deaths per 1,000 live births in 1990 to 6.1 in 2008. The child development programs of many national youth serving organizations provide approaches for girls to learn to cope with the life stresses of their environment. To demonstrate the effectiveness of their programs, these organizations have conducted their own evaluations, expanded the capacity of its affiliates to evaluate their programming, and commissioned independent evaluators to study program, training, and management effectiveness (Readmissions in North Texas, Premier Quality Advisors).

Project Components:

No required core components were listed. Core activities for this project include baseline data collection, hiring and training team members, project planning and implementation of a comprehensive intervention to address the needs of this high risk population, and project evaluation and analysis.

Texas spends over $2.2 billion per year in the Medicaid program for birth and delivery services. Half of the births in Texas are Medicaid births. Costs related to infant care are increasing and NICU utilization is growing. Over 60% of Medicaid program birth and delivery costs are for extremely premature babies (51.3%) or premature infants with problems (10.8%). Approximately $51,000 is spent for every premature infant. These statistics provide a compelling business case for improving preconception health of women in Tarrant County, especially African-American women.

The process milestones selected as the initial stages of this project intervention will be planned in conjunction with stakeholder organizations providing evidence-based youth services and the specific resources that will be needed to accomplish the project will be identified. This planning will also include the determination of timelines and the methods to document implementations. The outcome improvement target was selected to demonstrate the potential improvement in quality of life experienced by pre-teen African-American girls based on their participation in the intervention.

Quality Milestone P-7- was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

CN.12 – Need for more culturally competent care to address unmet needs (e.g.,, Latino-population need care, translators, translated materials

CN.13 – Necessity of patient education programs

CN.15 – Need for more education, resources and promotion of healthy lifestyles (free and safe places to exercise, health screenings, health education, healthy environments, etc.)

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

African-American youth in Tarrant County have high levels of risk factors for poor birth outcomes as indicated by the infant mortality rate for African-American women (12.7 infant deaths per 1,000 live births in 2010), which is over twice that for other women in the County. These women lack access to youth-serving organizations, social services, and medical services. This project will increase their access to these services by developing the necessary outreach infrastructure.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:
Outcome Measure 1: IT-10.1 Quality of life
Demonstrate improvement in quality of life scores, as measured by evidence-based and validated assessment tool (PedsQL), for the target population.
Improvement Target: 5% increase in the PedsQL score by the end of the Waiver period.
Rationale: The outcome improvement target was selected to demonstrate the potential improvement in quality of life experienced by pre-teen African-American girls based on their participation in the intervention. Meaningful child health outcome measurement must go beyond narrow morbidity and mortality measures to assess broader health concerns such as physical, emotional, social, and school functioning. The PedsQL is a complex measure that includes indicators of physical functioning, emotional functioning, social functioning, and school functioning. The measure also has the benefits of brevity (23 questions), time required (approximately five minutes) as well as established reliability, validity, sensitivity, and responsiveness to changes in overall health. (Varni et al. 2003.) The broad based intervention that is used by youth serving organizations may have different impacts on each factor, although a generally positive impact. Hence, in the absence of baseline data, the projected 5% increase indicates a general positive effect, while effects in each subarea may be greater or less. In addition, there are confounding factors such as age and family SES that may influence the effect.

Relationship to Other Projects:
138980111.2.4 Tarrant County - Perinatal Health Promotion Initiative. Both this project and the project proposed in this document employ a life course perspective and focus on the - health of women - at different stages of their physical and mental health development, especially populations experiencing health disparities. The proposed project focuses on the preteen years and the development of physical and emotional coping behaviors while the Tarrant County Health Promotion project focuses on addressing awareness, education and risk factor reduction for poor birth outcomes prior to pregnancy or interconception.

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

Implement Evidence-based Disease Prevention Programs - Implement other evidence-based project to implement evidence-based disease prevention programs – 2.7.6: Promoting Physical and Mental Health Among At-risk, Underserved African American Pre-teen Girls in Tarrant County

- 126675104.2.15 JPS Health Network-Journey to Life. The project is related to the proposed project in that it focuses on the life course of women who are pregnancy and need access to prenatal care. For women to have healthy births during their life course, four stages must be addressed: the preconception health of women from childhood on,

prenatal care, care during delivery, and post-natal care for mother and infant. These two projects address two of these stages.

- 130614405.2.3 Texas Health Arlington Memorial Prenatal Care. This project is related to the proposed project in that it also focuses on the life course of women prior to pregnancy. Specifically, the project focuses on prenatal care of pregnant women by adding access to care and using the CenteringPregnancy model. If preteens are physically and emotionally healthier based on the proposed project, their prenatal care, if available, will have a greater likelihood of reducing poor birth outcomes.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value was calculated on a single outcome, quality of life.

a. For quality of life, UNT Health Science Center defined the population that will be directly impacted by the project as Pre-teen African-American girls who are at risk for poor birth outcomes, which would be approximately 40 patients. We are anticipating that we will test the entire population, and are expecting to increase the quality of life scores for the project by 3%-.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $25,000 (as cited in the article, "Mapping the EQ-5D Index from the SF-12: US General Population Preference in a Nationally Representative Sample" in the journal, Medical Decision Making and "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's School of Public Health), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention. -This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.2.1	*2.7.6*	*N/A*	*Implement Evidence-based Disease Prevention Programs – Implement other evidence-based project to implement evidence-based disease prevention programs – 2.7.6: Promoting Physical and Mental Health Among At-risk, Underserved African -American Pre-teen Girls in Tarrant County*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.18*	*3.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-1]: Development of an innovative evidence-based project for targeted population (African-American pre-teen girls [with a focus on specific high-incidence diseases for this population, specifically obesity]). Metric 1 [P-1.1]**:** Document innovational strategy and plan Baseline/Goal: Strategy and plan developed Data Source: Program records Milestone 1 Estimated Incentive Payment *(maximum amount):* $164,628 **Milestone 2** [P-2]**:** Implement evidence-based innovational project for targeted population (African-American pre-teen girls). **Metric 1** [P-2.1]: Document implementation strategy and testing outcomes Baseline/Goal: Implementation	**Milestone 4** [P-3]: Execution of learning and diffusion strategy for testing, spread, and sustainability Metric 1 [P-3.1]**:** Document learning and diffusion strategic plan Baseline/Goal: Learning and diffusion strategic plan documented Data Source: Program records Milestone 4 Estimated Incentive Payment *(maximum amount):* $171,743 **Milestone 5** [P-4]: Execution of evaluation process for project innovation Metric 1 [P-4.1]: Document evaluation process, tools, and analytics Baseline/Goal: Evaluation process, tools, and analytics documented Data Source: Program records Milestone 5 Estimated Incentive	**Milestone 7** [I-5]: Identify 25 patients in defined population receiving innovative intervention consistent with evidence-based model (African-American pre-teen girls). Metric 1 [I-5.1]**:** Number of patients in defined population receiving innovative intervention consistent with evidence-based model Goal: 25 pre-teens in DY4 Data Source: Milestone 7 Estimated Incentive Payment: $183,725 **Milestone 8** [I-7]: Increase access to disease prevention programs using innovative project option Metric 1 [I-7.1]: Increase percentage of target population reached Goal: 10% increase over baseline. Data Source: Milestone 8 Estimated Incentive Payment: $183,725	**Milestone 10** [I-5]: Identify 40 patients in defined population receiving innovative intervention consistent with evidence-based model (African-American pre-teen girls) Metric 1 [I-5.1]: Number of patients in defined population receiving intervention consistent with evidence-based model Goal: 40 pre-teens in DY5 Data Source: Milestone 10 Estimated Incentive Payment: $177,512 **Milestone 11** [I-7]: Increase access to disease prevention programs using innovative project option Metric 1 [I-7.1]: Increase percentage of target population reached Goal: 20% increase over baseline Data Source: Milestone 11 Estimated Incentive

138980111.2.1	*2.7.6*	*N/A*	*Implement Evidence-based Disease Prevention Programs – Implement other evidence-based project to implement evidence-based disease prevention programs – 2.7.6: Promoting Physical and Mental Health Among At-risk, Underserved African -American Pre-teen Girls in Tarrant County*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.18*	*3.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)
strategy and testing outcomes documented, baseline established Data Source: Program records Milestone 2 Estimated Incentive Payment *(maximum amount):* $164,628 **Quality Milestone 3** [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. Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 3 Estimated Incentive Payment *(maximum amount):*	Payment *(maximum amount):* $171,743 **Quality Milestone 6** [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. Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 6 Estimated Incentive Payment *(maximum amount):* $171,743	**Quality Milestone 9** [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. Metric 1 (P-7-.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 9 Estimated Incentive Payment *(maximum amount):* $183,725	Payment: $177,512 **Quality Milestone 12** [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. Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 12 Estimated Incentive Payment *(maximum amount):* $177,512

138980111.2.1	*2.7.6*	*N/A*	*Implement Evidence-based Disease Prevention Programs – Implement other evidence-based project to implement evidence-based disease prevention programs – 2.7.6: Promoting Physical and Mental Health Among At-risk, Underserved African -American Pre-teen Girls in Tarrant County*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.18*	*3.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)**
$164,628			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $493,885	Year 3 Estimated Milestone Bundle Amount: $515,229	Year 4 Estimated Milestone Bundle Amount: $551,175	Year 5 Estimated Milestone Bundle Amount: $532,537
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $2,092,826			

Attachment 1
Project Summary Template to be completed for each Category 1 and 2 project
Project Option 2.8.1 – Improving Primary Care Clinical Processes to Reduce Hospitalization Risk

Unique Project ID: 138980111.2.2
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: Utilizing an integrated, multi-faceted educational model shown to result in reductions in preventable hospitalizations in communities around Texas, a series of educational interventions targeting primary care interprofessional and multidisciplinary teams will be used to provide training and education on process improvement related to the management of Bacterial Pneumonia, Chronic Obstructive Pulmonary Disease, Diabetes Long-term Complications, and Hypertension (High Blood Pressure. This is a new initiative.
Need of the project: This project meets regional goals of improving health of populations and reduction of costs by addressing processes that impact the issues of poorly managed conditions, suboptimal application of clinical guidelines and inadequate patient and provider community resources.
Target population: Patients of primary care workforce receiving training who have diagnosis of COPD, Adult Asthma and/or are at high risk for contracting bacterial pneumonia. It is estimated that 1,100 providers will be trained, and 110 providers/clinics will undertake process improvement methodologies, impacting approximately 700 patients in RHP 10.
Expected patient benefits: The project is important because the conditions targeted to be impacted by enhanced processes can be costly to CME when they result in hospitalization, as frequently occurs with poor management.
Category 1 or 2 expected patient benefits: This project seeks to conduct 15 trainings by DY3; have -10 providers/clinics undertake process improvement initiatives by DY3, 50 more by DY4, and 50 more by DY5; designate 100 process improvement champions by DY3 and see 5% of providers by DY4 and 10% of providers by DY5 trained to realize improved efficiencies.
Category 3 outcomes:

i. IT 2.5 Our goal is to improve COPD admission rates by 1% by DY4 and 3% by DY5 in patients of targeted population.
ii. IT 2.6 Our goal is to improve Adult Asthma admission rates by 1% by DY4 and 3% by DY5 in patients of targeted population.
iii. IT 2.10 Our goal is to improve flu and pneumonia admission rates by 1% by DY4 and 3% by DY5% in patients of targeted population.

Project Option 2.8.1 – Improving Primary Care Clinical Processes to Reduce Hospitalization Risk

Unique Project ID: 138980111.2.2
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:
Project Area: Apply Process Improvement Methodology to Improve Quality/Efficiency
Project Intervention: Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.

Utilizing an integrated, multifaceted educational model shown to result in reductions in preventable hospitalizations in communities around Texas, a series of educational interventions targeting primary care interprofessional and multidisciplinary teams will be used to provide training and education on process improvement related to the management of bacterial pneumonia, chronic obstructive pulmonary disease, diabetes long-term complications, and hypertension (high blood pressure). Education will target primary care clinics and providers in RHP 10 and demonstrate how improving clinical processes can result in patients who are better managed and can better self-manage, and reduce hospital admissions related to the targeted conditions. A series of live, face-to-face, live and on-demand online activities, printed material and individual coaching will facilitate process improvement.
Goals and Relationship to Regional Goals:

Project Goals:
The intent of this project is to realize a measured reduction in hospitalizations related to the four conditions targeted resulting from improved processes that lead to better care and patient management. Specific goals of this project are:

- 10% (110) of providers trained will realize improved efficiencies
- Costs related to admissions from the targeted conditions will be reduced throughout the RHP 10
- 15 Trainings will be conducted
- 110 providers/clinics will undertake process improvement methodologies
- 10% (110) of providers/clinics trained will realize improved efficiencies

This project meets the following Regional goals:
The Region's goals are to improve the experience of care, improve health of populations and reduce costs of health care. Many potentially preventable hospitalizations result from poorly managed conditions (clinical process inefficiencies), suboptimal application of clinical guidelines (clinical process inefficiencies) and inadequate patient and provider community resources. This project addresses each of these causes to reduce hospitalizations which cost the

community billions of dollars each year, decreases experience of care and decreases the health of the population through training and working with primary care physicians in best practices for improving primary care clinical processes.

Challenges:
Poor clinical management of chronic diseases is often a result of inadequate or absent clinical processes/methods, resulting in an escalation of adverse events from the disease. Clinical guidelines are slow to be translated into practice in primary care and meaningful practice assessments are insufficient.

5-Year Expected outcome for Provider and Patients:
The overall five-year goal of this project is to realize a reduction of admissions and health care costs related to diabetes short term complications, COPD, Hypertension and bacterial pneumonia through process improvement strategies, methodologies and culture, with a focus on clinical performance improvement. This project will reduce flu and pneumonia admission rates by 3% over baseline, reduce COPD admission rates by 3% over baseline and reduce adult asthma admission rates by 3% over baseline for patients of PCP providers receiving the intervention.

Starting Point/Baseline:
Between 2005 and 2010, potentially preventable hospitalizations (PPHs) accounted for $39.5 billion in Texas hospital charges. UNTHSC will employ a multidimensional, longitudinal educational model shown to contribute to fewer hospitalizations in Texas communities to reduce potentially-preventable hospitalizations related to bacterial pneumonia, chronic obstructive pulmonary disease, diabetes long-term complications, and hypertension (high blood pressure) throughout RHP-10. Health care cost savings due to reduced admissions (cost efficiencies), improved application of clinical guidelines (clinical efficiencies), and improved clinical processes (cost and clinical efficiencies) will be the expected outcomes. Human service delivery systems change relies in part on the identification and leveraging of unanticipated, complementary events. Reduction of hospitalizations can be attributed to educational interventions.

Rationale:
UNTHSC PACE has demonstrated its ability to use certified interdisciplinary continuing education and community partnerships to reduce potentially preventable hospitalizations (PPH) on a county-by-county and Regional basis in rural, semi-rural and metropolitan counties. Many PPHs result from poorly managed conditions (clinical process inefficiencies), suboptimal application of clinical guidelines (clinical process inefficiencies) and inadequate patient and provider community resources. This project addresses each of these causes to reduce hospitalizations which cost the community billions of dollars each year. Corresponding milestones: Specific workflows/processes/clinical areas targeted; Identify/target metric to

measure impact of processes. This project addresses the challenges by identifying processes in primary care clinics that result in less than optimal patient outcomes and, if improved, result in improved patient health, self-management and outcomes, leading to fewer hospitalizations in the targeted disease states. For example, clinical guidelines state that primary care should regularly perform spirometry for individuals over 55 with a history that includes risk factors for COPD. The majority of PC clinics do not regularly perform spirometry and, if they do, the test is of poor quality and results are often interpreted incorrectly. Improving these processes would result in increased assessment of patients so resources are not wasted on those without COPD and those with COPD can receive early intervention and slow the progression of the disease. Clinical processes have also been identified as barriers to smoking cessation ascertainment, patient education and immunization provision.

Project Components:

-. Core activities include:

A. Provide training and education to clinical staff on process improvement strategies, methodologies, and culture. Implementation of this activity will be accomplished through UNTHSC PACE's existing continuing education process, which relies of rigorous assessment, evidence-based educational design, program execution and assessment. Alignment with milestones 3, 5, 7, 11, and 15.

B. 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). The content development committee will define these measures and, at a minimum, UNTHSC PACE will incorporate ongoing data collection into a monthly dashboard to continually assess performance. Alignment with milestones 1 and 2.

C. Develop standard workflow process maps, staffing and care coordination models, protocols, and documentation to support continuous process improvement. These workflows will be based on best practices and evidence-based practices, adapted as teaching and learning aids and practice guides. Alignment with milestone 4

D. Evaluate the impact of the process improvement program and assess opportunities to expand, refine, or change processes based on the results of key performance indicators. Implementation will be accomplished through continuous data collection and comparison of data trends to baseline measures and benchmarks. Alignment with milestones 9, 10, 13 and 14.

E. Develop an employee suggestion system that allows for the identification of issues that impact work will not be an activity of this project due the inability to enforce the activity with the target population of this project – Primary Care Physicians in RHP 10.

F. Implement software to integrate workflows and provide real-time performance feedback will not be an activity of this project due to the inability to enforce the

activity with the target population of this project – Primary Care Physicians in RHP 10.

The milestones selected for this project will allow us to reach and/or measure the accomplishment of our 5-year expected outcome to improve coordination of care which will positively impact patient self-management through enhanced patient education and use of preventive measures. The milestones and metrics will demonstrate the effectiveness of improved processes in primary care practices. The demographic and geographic diversity of RHP 10 provides opportunity to make significant improvements in practices that will result in an improvement in self-management and a reduction in hospitalizations. Data for each milestone and metric demonstrate a need due to high rates of hospitalizations. Quality Milestone P-13 was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.11 – Need for more care coordination
- CN.13 – Necessity of patient education programs

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

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

Outcome Measure 1: IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5

Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD

Denominator: Population in Metro Area or county, age 18 years and older

Data Source: EMR, Claims

Target Improvement: 3% improvement in admission rate

Rationale: COPD is one of the highest causes of potentially preventable admissions in RHP 10, with 3,300 admissions in 2010 alone. COPD can be effectively managed in primary care when appropriate processes for screening, diagnosis and management/follow-up are combined with appropriate patient education material.

Outcome Measure 2: IT-2.6 Adult Asthma Admission Rate – PQI 15

Numerator: All discharges of age 18 years and older with a principal diagnosis code of asthma

Denominator: Population in Metro Area or county, age 18 years and older

Data Source: EMR, Claims

Target Improvement: 3% improvement in admission rate
Rationale: Asthma is one of the highest causes of potentially preventable admissions in RHP 10, with 1,558 admissions in 2010 alone. Asthma can be effectively managed in primary care when appropriate processes for screening, diagnosis and management/follow-up are combined with appropriate patient education material.

Outcome Measure 3: IT-2.10 Flu and Pneumonia Admission Rate
Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.
Denominator: Population in Metro Area or county, age 18 years and older
Data Source: EMR, Claims
Target Improvement: 3% improvement in admission rate
Rationale: Hospitalizations from bacterial pneumonia/influenza are a significant problem n RHP 10. In 2010, bacterial pneumonia alone resulted in 4,628 admissions. When appropriate immunization screening and patient education processes are applied, admissions for pneumonia/flu are reduced.

Relationship to Other Projects:
138980111.1.4 Increase Training of Primary Care Workforce – "Other" project option: Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement – 1.2.1: Training Primary Care Workforce in Evolving Healthcare Delivery Models. This project supports interventions in category 138980111.1.4 because many of the providers targeted in 138980111.1.4 will also receive targeted information during this project, reinforcing the intervention and supporting the outcomes measures for both projects.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
N/A for non-hospital providers.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value was calculated on three outcomes, which included (1) chronic obstructive pulmonary disease admissions rates, (2) adult asthma admission rates, and (3) flu and pneumonia admission rates.

a. For Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, UNT Health Science Center defined the population that will be directly impacted by the project as patients in RHP 10 who have been discharged with a principal diagnosis code for COPD and receive services from PCPs receiving intervention, which would be approximately 330 patients. We are anticipating a reduction of admission rates with a principal diagnosis code for COPD in the target population by 3%, equating to 10 lives positively impacted by this outcome.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it is determined that the valuation amount for each positive outcome realized would be $7,931 (TX Dept. of State Health Services data)

   For the selected outcome, an additional multiplier was applied to determine the benefit provided to the community, the resulting additional valuation amount is $4,759 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit provided to the individual, the resulting additional valuation amount is $3,172 for each positive outcome realized .

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For Adult Asthma Admission Rate –PQI 15, UNT Health Science Center defined the population that will be directly impacted by the project as patients in RHP 10 who have been discharged with a principal diagnosis code for adult asthma and receive services from PCPs receiving intervention, which would be approximately

156 patients. We are anticipating a reduction of admission rates with a principal diagnosis code for adult asthma in the target population by 3%, equating to 5 lives positively impacted by this outcome. -.

Utilizing - the pricing matrix developed by Regional providers to determine the value to the health care system, it was determined that the value amount for each positive outcome realized would be $6,285 (TX Dept. of State Health Services data).

For the selected outcome, an additional multiplier was applied to determine the benefit provided to the community, the resulting additional valuation amount is $3,771 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit provided to the individual, the resulting additional valuation amount is $2,514 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

c. For Flu and Pneumonia Admission Rate, UNT Health Science Center defined the population that will be directly impacted by the project as patients in RHP 10 who have been discharged with a principal diagnosis code for flu or pneumonia and receive services from PCPs receiving intervention, which would be approximately 463 patients. We are anticipating a reduction of admission rates with a principal diagnosis code for flu or pneumonia in the target population by 3%, equating to 14 lives positively impacted by this outcome.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $8,047 (TX Dept. of State Health Services data).

For the selected outcome, an additional multiplier was applied to determine the benefit provided to the community, the resulting additional valuation amount is $4,828 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit provided to the individual, the resulting additional valuation amount is $3,219 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.2.2	*2.8.1*	*2.8.1.A, 2.8.1.B, 2.8.1.C, 2.8.1.D, 2.8.1.E, 2.8.1.F*	*APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE QUALITY/EFFICIENCY – DESIGN, DEVELOP, AND IMPLEMENT A PROGRAM OF CONTINUOUS, RAPID PROCESS IMPROVEMENT THAT WILL ADDRESS ISSUES OF SAFETY, QUALITY, AND EFFICIENCY – 2.8.1- IMPROVING PRIMARY CARE CLINICAL PROCESSES TO REDUCE HOSPITALIZATION RISK*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*138980111.3.19* *138980111.3.20* *138980111.3.21*	*3.IT 2.5* *3.IT 2.6* *3.IT2.10*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5* *Adult Asthma Admission Rate – PQI 15* *Flu and pneumonia Admission 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]: 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 Baseline/Goal: Identification of workflows/processes to improve upon Data Source: Program Records Milestone 1 Estimated Incentive Payment *(maximum amount):* $72,339 **Milestone 2** [P-2]: Identify/target metric to measure impact of process improvement methodology and establish baseline Metric 1 [P-2.1]: Performing provider ID of impact metrics and baseline Baseline/Goal: Documentation of impact metrics Data Source: Programs Records	**Milestone 4** [P-3]: Compare and analyze clinical/quality data and identify at least one area for improvement Metric 1 [P-3.1]: Analysis and identification of target areas Baseline/Goal: Identify 3 area(s) for improvement Data Source: Program Records Milestone 4 Estimated Incentive Payment *(maximum amount):* $56,599 **Milestone 5** [P- 11]: Number of trainings conducted by designated trainee/process improvement champions Metric 1 [P-11.1]: Trained by the trainee/champion trainings. Baseline/Goal: 15 trainings conducted Data Source: Program Records	**Milestone 8** [I-15]: Increase the number of process improvement champions Metric 1 [15.1]: Number of designated quality champions. Number of trained and designated process improvement champions. Goal:50 more process improvement champions in RHP 10 undertaking process improvement in DY4 over DY3 Data Source: Program Records Milestone 8 Estimated Incentive Payment: $60,548 **Milestone 9** [I-13]: Progress toward target/goal Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal Goal: 1% of cases over baseline	**Milestone 12** [I-15]: Increase the number of process improvement champions Metric 1 [15.1]: Number of designated quality champions. Number of trained and designated process improvement champions. Goal:50 more process improvement champions in RHP 10 undertaking process improvement in DY5 over DY4 Data Source: Program Records Milestone 12 Estimated Incentive Payment: $58,500 **Milestone 13** [I-13]: Progress toward target/goal Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal Goal: 2-% of cases over baseline

138980111.2.2	*2.8.1*	*2.8.1.A, 2.8.1.B, 2.8.1.C, 2.8.1.D, 2.8.1.E, 2.8.1.F*	*APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE QUALITY/EFFICIENCY – DESIGN, DEVELOP, AND IMPLEMENT A PROGRAM OF CONTINUOUS, RAPID PROCESS IMPROVEMENT THAT WILL ADDRESS ISSUES OF SAFETY, QUALITY, AND EFFICIENCY – 2.8.1- IMPROVING PRIMARY CARE CLINICAL PROCESSES TO REDUCE HOSPITALIZATION RISK*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*138980111.3.19* *138980111.3.20* *138980111.3.21*	*3.IT 2.5* *3.IT 2.6* *3.IT2.10*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5* *Adult Asthma Admission Rate – PQI 15* *Flu and pneumonia Admission 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 2 Estimated Incentive Payment *(maximum amount):* $72,339 **Quality Milestone 3** [P-13]: 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. Metric 1 [P-13.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 3 Estimated Incentive Payment *(maximum amount):* $72,339	Milestone 5 Estimated Incentive Payment: $56,599 **Milestone 6** [I-15]: Increase the number of process improvement champions Metric 1 [15.1]: Number of designated quality champions. Number of trained and designated process improvement champions. Goal:100 process improvement champions in RHP 10 undertaking process improvement Data Source: Program Records Milestone 6 Estimated Incentive Payment: $56,599 **Quality Milestone 7** [P-13]: Participate in face-to-face learning at least twice per year with other	meet target Data Source: Program Records Milestone 9 Estimated Incentive Payment: $60,548 **Milestone 10** [I-14]: Measure efficiency and/or cost Metric 1 [I-14.1a]: Reduction of costs related to hospital admissions due to the four targeted conditions in RHP 10. Goal:1% total reduction in costs over baseline Data Source: North Texas Regional Extension Center and North Texas Accountable Health care Partnership Metric 2 [I-14.2]: Improved efficiency of educated/trained clinical and administrative staff managing the	meet target Data Source: Program Records Milestone 13 Estimated Incentive Payment: $58,500 **Milestone 14** [I-14]: Measure efficiency and/or cost Metric 1 [I-14.1a]: Reduction of costs related to hospital admissions due to the four targeted conditions in RHP-10. Goal:2% total reduction in costs Data Source: North Texas Regional Extension Center and North Texas Accountable Healthcare Partnership Metric 2 [I-14.2]: Improved efficiency of educated/trained clinical and administrative staff managing the four conditions.

138980111.2.2	*2.8.1*	*2.8.1.A, 2.8.1.B, 2.8.1.C, 2.8.1.D, 2.8.1.E, 2.8.1.F*	*APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE QUALITY/EFFICIENCY – DESIGN, DEVELOP, AND IMPLEMENT A PROGRAM OF CONTINUOUS, RAPID PROCESS IMPROVEMENT THAT WILL ADDRESS ISSUES OF SAFETY, QUALITY, AND EFFICIENCY – 2.8.1- IMPROVING PRIMARY CARE CLINICAL PROCESSES TO REDUCE HOSPITALIZATION RISK*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*138980111.3.19* *138980111.3.20* *138980111.3.21*	*3.IT 2.5* *3.IT 2.6* *3.IT2.10*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5* *Adult Asthma Admission Rate – PQI 15* *Flu and pneumonia Admission 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)**
	providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-13.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 7 Estimated Incentive Payment *(maximum amount):* $56,599	four conditions. Goal:5% total of providers trained will realize improved efficiencies Data Source: Program Records Milestone 10 Estimated Incentive Payment: $60,548 **Quality Milestone 11** [P-13]: 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. Metric 1 [P-13.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes	Goal:10% total of providers trained will realize improved efficiencies Data Source: Program Records Milestone 14 Estimated Incentive Payment: $58,500 **Quality Milestone 15** [P-13]: 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. Metric 1 [P-13.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes.

138980111.2.2	*2.8.1*	*2.8.1.A, 2.8.1.B, 2.8.1.C, 2.8.1.D, 2.8.1.E, 2.8.1.F*	*APPLY PROCESS IMPROVEMENT METHODOLOGY TO IMPROVE QUALITY/EFFICIENCY – DESIGN, DEVELOP, AND IMPLEMENT A PROGRAM OF CONTINUOUS, RAPID PROCESS IMPROVEMENT THAT WILL ADDRESS ISSUES OF SAFETY, QUALITY, AND EFFICIENCY – 2.8.1- IMPROVING PRIMARY CARE CLINICAL PROCESSES TO REDUCE HOSPITALIZATION RISK*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	*138980111.3.19* *138980111.3.20* *138980111.3.21*	*3.IT 2.5* *3.IT 2.6* *3.IT2.10*	*Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5* *Adult Asthma Admission Rate – PQI 15* *Flu and pneumonia Admission 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 11 Estimated Incentive Payment *(maximum amount):* $60,548	Milestone 15 Estimated Incentive Payment *(maximum amount):* $58,500
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $217,016	Year 3 Estimated Milestone Bundle Amount: $226,395	Year 4 Estimated Milestone Bundle Amount: $242,190	Year 5 Estimated Milestone Bundle Amount: $234,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $919,602			

Project Option 2.2.2 – Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School-Based Asthma Program

Unique Project ID: 138980111.2.3

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.

Intervention: Asthma 411 provides a school-based program for asthma management to improve the school's ability to help asthmatic students manage their asthma, reduce absenteeism from class due to asthma morbidity, increase use of a primary care provider, and improve asthma outcomes. This project is a new initiative to help asthmatic children manage their asthma through school-based clinics.

Need for the project: This project meets a number of regional goals, which are aligned with the goals of the waiver and CMS' triple aim. Specifically, this project will improve the health of asthmatic children which, in turn, improves the quality of life for members of their family and their community. In addition, through better management of their asthma, we will improve the health outcomes of this population, while lowering health care cost for the region due to decreased hospitalizations and ED use. In Tarrant County the only school district which has been found with a specific school based asthma program is the Keller ISD. The Keller ISD program is limited in scope and the health services director (Cindy Parsons, BSN, RN) has expressed an interest in participating as has the health services director (Michael Steinert, MA, LPC) of Fort Worth ISD, the largest district in Tarrant County.

Target population: K-12 students with asthma in the Fort Worth Independent School District. Estimated 6,000 patients to be served over the period of the waiver.

Expected patient benefits: It is estimated that approximately 83% of school age children with asthma at FWISD are eligible for Medicaid. Improved asthma management and linkage with a regular primary care provider and a medial home provided through this project will reduce asthma-related inpatient admissions, inappropriate ED visits, and decrease school absences due to asthma.

Category 1 or 2 expected patient benefits:

i. 10% (600 students) by DY4 and 20% (1,200 students) by DY5 of students (based on an estimated baseline of 6000) with asthma will have self-management goals (healthcare provider prepared asthma action plan
ii. 2% (12 students) increase over baseline by DY4 and 4% (24 students) by DY5 increase over baseline of identified K-12 students with asthma using school health services (based on an estimate of 600 students – 10% of 6000)

Category 3 outcomes:

i. IT-3.11 – 2% decrease by DY4 and 5% (estimated at 1 readmission) decrease by DY5 from baseline in the number of hospital readmissions
ii. IT-9.3 – 10% (estimated at 6) by DY4 and 20% (estimated at 12) by DY5 reduction from baseline in the number of ED visits from school due to asthma

Project Option 2.2.2 – Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School-Based Asthma Program

Unique Project ID: 138980111.2.3
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:
Asthma 411 provides a school-based program for asthma management to improve the school's ability to help asthmatic students manage their asthma, reduce absenteeism from class due to asthma morbidity, increase use of a primary care provider, and improve asthma outcomes. The Asthma 411 approach is based on the CDC's Strategies for Addressing Asthma within a Coordinated School Health Program. Asthma 411 is a care management model that provides tools, methods and strategies to support or redefine the existing health service and administrative structures and policies present in schools. Asthma 411 utilizes a consulting physician (which may be through linkage with a school-based clinic or other health services), the implementation of standing medication orders for respiratory distress, use of absenteeism data to identify high risk students, facilitates use of primary care practitioners and linkage with community resources. The goal is to reduce asthma morbidity in children on a population basis through a school-based program.

Goals and Relationship to Regional Goals:

Project Goals:

The project goal is to reduce asthma-related morbidity through implementation of a school-based asthma management program for children. The 5-year goals are listed in 2c.
Pediatric asthma is a serious chronic disease issue in Tarrant County. Fort Worth, Tarrant County and surrounding Region 10 counties have high asthma prevalence rates. Cook Children's 2008 Community-wide Children's Health Assessment and Planning Survey (CCHAPS 2009 Report) identified elevated asthma prevalence (~18.59%) in Tarrant County as a major concern. This childhood asthma rate is approximately double the national average of 9% and greater then Texas' average of 8.8%. Of Tarrant County children ages 0-14 years, approximately 75,500 have asthma. By age nine fully 25% of the County's children have been diagnosed with asthma, with a disproportion number of cases occurring among the county's African-American children. The county's Hispanic children also have elevated rates of asthma (19%), even though Hispanics traditionally have a lower rate of asthma than white non-Hispanics. Asthma was the primary diagnosis for 5% for all admits at the Cook Children's Hospital Medical Center in Fort Worth, with 36% of these as asthma as the primary diagnosis. Further, 27% of absences lasting three days or longer were due to asthma.

This project meets the following Regional goals:
This project meets a number of Regional goals, which are aligned with the goals of the Waiver and CMS' triple aim. Specifically, this project will improve the health of asthmatic children which, in turn, improves the quality of life for members of their family and their community. In addition, through better management of their asthma, we will improve the health outcomes of this population, while lowering health care cost for the Region due to decreased hospitalizations and ED use.

Challenges:
Pediatric asthma is a serious chronic disease issue in Tarrant County. Our target population is characterized by a high rate of ED visits and hospital admissions due to asthma, and low use of primary care physicians (PCPs) and care management through a medical home. It is also estimated that approximately 83% of school-age children with asthma at FWISD are eligible for Medicaid (FWISD Annual Report 2011-2012). Improved asthma management and linkage with a regular primary care provider and a medical home provided through this project will reduce asthma-related inpatient admissions.

Additionally, this population is limited in its usage of asthma action management plans (AAPs). This project will improve access to AAPs through school nurses implementing program procedures to increase PCP prepared AAPs submitted to school nurse, and the use of these plans to help improve asthma management, reduce morbidity and further decrease ED usage and hospital admissions. So far at least six school districts in the DFW area have indicated interest in participation.

There are 2 specific challenges. #1 concerns access to data. Most of the data necessary to determine baselines and follow-up of outcome success are not presently tracked or recorded (this includes absences or visits to school clinics due to asthma, ED or hospitalization if not from school, and readmission incidents). Mechanisms for collecting this information will need to be established. The two initial participating schools districts as well as JPS and CCH, the two major hospitals which serve the majority of this population and also have clinics associated with schools, have indicated interest in working to establish and implement mechanisms to track this information. In addition, the NorTex Primary Care Research Institute, a consortium of physicians which treat a large portion of the children with asthma, will be collaborating as well. #2 concerns consent for participation. In the prior implementation of this program in St. Louis, MO, it was required for participants to 'opt-out/non-consent' rather than 'opt-in/consent', which resulted in close to 100% participation. Interpretation of the Family Education and Privacy Act (FERPA) regulations now requires participants to opt-in, primarily in regards to data acquisition, which will entail additional recruitment efforts. Both school districts have indicated their willingness and effort to maximize recruitment. Additionally, a number of the implementation activities would become standard health services activities and will not require consent. For both of these primary challenges program implementation staff has been added to address the data collection and consent challenge. Although other implementation challenges of varying types exist, prior experience of implementing this program as well as the school districts interest in performing will help to minimize those issues. These other challenges include school staff resistance to change, technology compatibilities for data and information transfer, and arranging training, education and professional development programs at times when health services staff are available.

5-Year Expected Outcome for Provider and Patients:

This program will provide a school-based program for asthma management to improve students' ability to better manage their asthma, reduce student absenteeism due to asthma morbidity, and improve their asthma-specific health outcomes. Specifically, the program will:

- Reduce school absences due to asthma by 10% (Based on an estimated 12,000 absence days of students with asthma/year, this would reduce absences by 1,200 days annually by DY5).
- Reduce number of 911 calls/ED visits from school due to asthma by 20% (based on an estimated 60/year, this would reduce the number of 911 calls/ED visits from school by 12 annually by DY5).
- Increase the number of health care provider-prepared asthma action plans for individual students submitted to school by a minimum of 20% (based on an estimated 1200 asthma action plans, this would increase the number by 240 by DY5).
- 25% decrease in school clinic visits due to asthma symptoms (based on an estimated 600 clinic visits, this would reduce the number of clinic visits in school by 150 annually by DY5).
- Provide a school-based program for asthma management to improve the school's ability to address asthma-related issues, reduce absenteeism from class due to asthma morbidity, and improve asthma outcomes.

Starting Point/Baseline:
School districts are the project's primary providers of the Asthma 411 Program. The starting point is the students with asthma at the schools and the school-based health services personnel. The project will begin with establishing baseline data (i.e. number of children with asthma, prevalence of asthma action management plans, ED utilization and hospitalization rates related to asthma, etc.) and establishing project processes (such as how to integrate program into school health services). The expected project outcome is an integrated and sustainable program that results in decreased morbidity and absenteeism due to asthma.

Rationale:
Pediatric asthma prevalence in North Texas (and Texas as a whole) has a significant negative impact on school-based learning, resulting in increased student absenteeism and decreased productivity for working parents.

Project Components:

No core components are required. However, the core activities for the project include training of school health services staff to do the following: (1) identify and document children with asthma, (2) encourage development of health care provider action plans, (3) track asthma trigger events and outcomes, and (4) perform respiratory treatment for asthma attacks. School districts will also have a consulting physician available to write standing orders for albuterol treatments for students with asthma. We anticipate these core project activities will prevent ED visits and reduce school absences.

The project team selected milestones and metrics to achieve project improvement targets. Our project approach is based on similar proven school-based approaches used in the St. Louis Metropolitan area (Moonie, et al., 2006; Richmond, et al., 2006; Moonie, et al., 2008; Wilson, et al., 2008; Wilson, et al., 2009). The project is being implemented in Region 10 based on the high-prevalence of asthma in children as mentioned above. Quality Milestone P-16- was selected to promote collaborative learning around shared or similar project.

Unique community need identification numbers the project addresses:

- CN.10 – Overuse of emergency department (ED) services
- CN.13 – Necessity of patient education programs

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

This project is a new initiative to help asthmatic children manage their asthma through school-based clinics. In Tarrant County the only school district which has been found with a specific school-based asthma program is the Keller ISD. - The Keller ISD program is limited in scope and the health services director (Cindy Parsons, BSN, RN) has expressed an interest in participating as has Michael Steinert, MA, LPC, the health services director of Fort Worth ISD, the largest school district in Tarrant County. - This is a new initiative which is not receiving federal funds from other sources.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

a. **Outcome Measure 1:** IT-3.11 Pediatric Asthma 30-Day Readmission Rate (Age group defined as those attending grades K-12 in the participating school districts)
   Numerator: The number of readmissions for asthma among students in participating school districts within 30 days of discharge from the index asthma admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
   Denominator: The number of admissions among students in participating school districts with a principal diagnosis of asthma and with a complete claims history for the 12 months prior to the admission.
   Improvement target: By DY5, reduce the number of readmissions by 5% (estimated reduction of 1 readmit annually by DY5) from baseline.
   Rationale: The outcome improvement target to reduce readmission rates by 5% is determined as a conservative estimate based on a similar proven approach used in the St. Louis metropolitan area. Using data from Cook Children's Hospital for 2011 it is estimated there are up to 20 readmits annually due to asthma.

b. **Outcome Measure 2:** IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381
   Numerator: Numerator is all patients with asthma who have greater than or equal to one visit to the emergency department for asthma during the measurement period. (Percentage of students identified with asthma that have greater than or equal to one visit from the school to the emergency department for asthma during the measurement period).
   Denominator: Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. (All students in K-12 identified with asthma during the measurement period)
   Improvement target: By the end of DY5 reduce by 20% (Based on 60 ED visits from school annually, estimated reduction of 12 ED visits annually by DY5) from baseline the number of ED visits from school due to asthma.
   Rationale: The outcome improvement target of reduction of school-based ED visits

due to asthma by 20% is determined as a conservative estimate from reduction rates seen from the implementation in the St. Louis metropolitan area over a similar time period, where the reduction was ~35%.

Relationship to Other Projects:

a. **Describe the related Category 1 and 2 projects**
   N/A
b. **Describe the related Category 4 Population-focused improvements**
   N/A for non-hospital providers

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

Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School Based Asthma Program

- 126675104.2.16 JPS School-Based Chronic Care – JPS would be performing this program through their 19 school based clinics throughout Tarrant County. In discussions with Ms. Dowling at JPS, The Director of the School Based Health Centers, we have agreed to work out methods to better link/follow up visits by students to the clinics due to asthma (or other chronic conditions) at the schools participating in the Asthma 411 with the school nurses. This would improve recognition and management of those most at risk. Additionally, this would improve the ability to evaluate impact of the program through tracking of increases (ambulatory) or decreases (such as ED) in health care usage.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates – that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value was calculated on two outcomes, which included (1) pediatric asthma 30-day readmission rates and (2) pediatric/young adult asthma emergency department visits.

- For Pediatric Asthma 30-day Readmission Rates, UNT Health Science Center defined the population that will be directly impacted by the project as school age children (K-12) identified by school health services as having asthma in FWISD. We estimate that 20 school age children will be readmitted due to asthma-related illness. The percentage of the population expected to be positively impacted by the project is 5%, equating to 1 life positively impacted by this outcome.

  Utilizing - the pricing matrix developed by Region-10 providers to determine the value to the health care system , it was determined that the valuation amount for each positive outcome realized would be $7,491 (TX Dept. of State Health Services data).

  For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $2,996 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $4,495 for each positive outcome realized.

  The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

- For Pediatric/Young Adult Asthma Emergency Department Visits, UNT Health Science Center defined the population that will be directly impacted by the project as 138 school-age children (K-12) identified by school health services as having asthma in FWISD. The percentage of the population expected to be positively impacted by the project is 20%, equating to 28 lives positively impacted by this outcome.

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,200. -For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $480 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $720 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.2.3	*2.2.2*	*N/A*	*Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School- Based Asthma Program*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.22* *138980111.3.23*	*3.IT-3.11* *3.IT-9.3*	*Pediatric Asthma 30-Day Readmission Rate* *Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381*

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]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1]: Increase percent of staff trained Baseline/Goal: 50% of staff (nurses) trained (estimated as 60 staff). Data Source: Program records Milestone 1 Estimated Incentive Payment *(maximum amount):* $10,029 **Milestone 2** [P-11]: Develop and implement program to assist patient to better self-manage their chronic conditions (patient is K-12 student with asthma) Metric 1 [P-11.1]: The number of patients enrolled in a self-management program. Baseline/Goal: 25% of students identified with asthma will be enrolled in the program (based on	**Milestone 5** [P-2]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1]: Increase percent of staff trained Baseline/Goal: Additional 50% of remaining staff (nurses) trained (estimated as additional 30 staff). Data Source: Program records Milestone 5 Estimated Incentive Payment *(maximum amount):* $13,949 **Milestone 6** [P-11]: Develop and implement program to assist patient to better self-manage their chronic conditions (patient is K-12 student with asthma). Metric 1 [P-11.1]: The number of patients enrolled in a self-management program. Baseline/Goal: 50% (estimated as 3000 students) of students identified with asthma will be	**Milestone 8** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]**:** Patients with self-management goals (health care provider prepared asthma action plan) Goal: 10% of patients will have self-management goals (using baseline of 6000, estimated as 600) Data Source: School District Health Services Records Milestone 8 Estimated Incentive Payment: $14,923 **Milestone 9** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]**:** Additional patients receive care under the Chronic Care Model for a chronic disease or for MCC (asthma) Goal: Increase of 2% over prior year of identified K-12 students with asthma using school health	**Milestone 11** [I-18]: Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patients with self-management goals (health care provider prepared asthma action plan) Goal: Total of 20% of patients will have self-management goals (using baseline of 600, estimated as 1200) Data Source: School District Health Services Records Milestone 11 Estimated Incentive Payment: $14,418 **Milestone 12** [I-17]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]**:** Additional patients receive care under the Chronic Care Model for a chronic disease or for MCC (asthma) Goal: Increase of 2% over DY4 of identified K-12 students with asthma using school health services

138980111.2.3	*2.2.2*	*N/A*	*Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School- Based Asthma Program*	
University of North Texas Health Science Center (UNTHSC)				*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.22* *138980111.3.23*	*3.IT-3.11* *3.IT-9.3*	*Pediatric Asthma 30-Day Readmission Rate* *Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381*	
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)**
6000 possible students estimated to be 1500 students) Data Source: Program records Milestone 2 Estimated Incentive Payment *(maximum amount):* $10,029 **Milestone 3** [P-12]: Develop and implement plan for standing orders Metric 1 [P-12.1]: Documentation plan for standing orders Baseline/Goal: Physician is identified and standing orders for albuterol treatment for respiratory distress are in place Data Source: Program records Milestone 3 Estimated Incentive Payment *(maximum amount):* $10,029 **Quality Milestone 4** [P-16-]: 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.	enrolled in the program. Data Source: Program records Milestone 6 Estimated Incentive Payment *(maximum amount):* $13,949 **Quality Milestone 7** [P-16-]: 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. Metric 1 [P-16-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Payment *(maximum amount):* $13,949		services (Based on 600 in prior year, estimated at additional 12). Date Source: Program records Milestone 9 Estimated Incentive Payment: $14,923 **Quality Milestone 10** [P-16-]: 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. Metric 1 [P-16-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 10 Estimated Incentive Payment *(maximum amount):* $14,923	(Based on 612 in prior year, estimated at an additional 12.2). Date Source: Program records Milestone 12 Estimated Incentive Payment: $14,418 **Quality Milestone 13** [P-16-]: 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. Metric 1 [P-16-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 13 Estimated Incentive Payment *(maximum amount):* $14,418

138980111.2.3	*2.2.2*	*N/A*	*Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School- Based Asthma Program*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.22* *138980111.3.23*	*3.IT-3.11* *3.IT-9.3*	*Pediatric Asthma 30-Day Readmission Rate* *Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381*

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)**
Metric 1 [P-16-.1]**:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 4 Estimated Incentive Payment *(maximum amount):* $10,029			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $40,114	Year 3 Estimated Milestone Bundle Amount: $41,848	Year 4 Estimated Milestone Bundle Amount: $44,768	Year 5 Estimated Milestone Bundle Amount: $43,254
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $169,983			

Project Option 2.7.4 – Tarrant County -Perinatal Health Promotion Initiative
Unique Project ID: 138980111.2.4
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: This project addresses the health and well-being of women - of reproductive age in Tarrant County through an outreach and home visitation intervention- applied during the - interconception period. This project is a new initiative.
Need for the project: This project directly responds to a community priority – the reduction of infant mortality. Tarrant County has led the state in the highest rate of infant mortality for most of the past two decades. African American - women in Tarrant County have high levels of risk factors for poor birth outcomes as indicated by the infant mortality rate for African American women (16.6 infant deaths per 1000 live births in 2010), a rate which is over twice that of other women in the county. Women who experience an adverse birth outcome are at an increased risk of having a subsequent adverse outcome (Adams, et al 2000, Mercer et al., 1999, Surkan et al., 2004).
Target population: Low income - women in Tarrant County - with previous adverse birth outcomes (preterm birth, low birth weight infant, infant death, infant with neural tube defect and stillbirth).- Estimated population served throughout the waiver period is - 150 - women.
Expected patient benefits: This project will improve care coordination for women with a history of poor birth outcomes, - - - increase their access to medical and social services including family planning, - and provide needed patient education - - that will result in healthier lifestyles, improved infant health and reduced health care costs.
Category 1 or 2 expected patient benefits:

iii. 10% increase by DY4 and 20% (150 total) increase by DY5 over baseline of women in defined population who receive - interconception care intervention
iv. 10% increase by DY4 and 20% increase by DY5 in access to health programs and activities among program participants

Category 3 outcomes:

i. -IT-8.2 – 5% reduction by DY4 and 10% reduction by DY5 from baseline in low birth weight births among participants
ii. IT-8.9 – 60% of women by DY4 and 65% (98) of women by DY5 achieve a pregnancy interval of at least - 9 months

Project Option 2.7.4 – Tarrant County - Perinatal Health Promotion Initiative
Unique Project ID: 138980111.2.4
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:
Project Area: Implement Evidence-Based Disease Prevention Programs
Project Intervention: Implement innovative evidence-based strategies to reduce low birth weight and preterm births.

This project is a community-based -interconception intervention targeting - low-income - women of reproductive age in Tarrant County that have experienced a - previous adverse birth outcome.-. The intervention employs intensive case management and peer health worker outreach and coordination to deliver - services in the community setting (i.e., home visitation) - to women who have experienced a previous adverse birth outcome (i.e., low birth weight, infant death, preventable birth defect, stillbirth, etc.). The goal is to reduce the chances of a subsequent poor birth outcome. Care coordination, health teaching, advocacy, counseling, social support and community services collaboration are interventions included in this case management model. For this project key social and medical preconception services include health care coverage, primary care/medical home, family planning, nutrition counseling, mental health counseling, substance abuse treatment, smoking cessation, financial counseling/assistance, and housing.

Goals and Relationship to Regional Goals:

Project Goals:
The goals of this project are: increased awareness of the importance of positive preconception health behaviors - increased awareness of the importance of reproductive life planning, - and optimal pregnancy spacing, - increased access to care for high-risk women who have had a previous adverse birth outcome - increased receipt of relevant community services and ultimately increases in positive -interconception behaviors that should result in improvements in birth outcomes for women at risk of - a subsequent adverse birth outcome or unintended pregnancy.

This project meets the following Regional goals:
This project meets a number of Regional goals, which are aligned with the goals of the Waiver and CMS's triple aim. Improving birth outcomes and reducing the significant racial/ethnic disparities in birth outcomes are national, state and local priorities. Additionally, this project will provide needed patient education programs for - women that will result in healthier lifestyles and reduced health care costs. This project also directly responds to a community priority-the reduction of infant mortality. Tarrant County has led the state in the highest rate of infant mortality for most of the past two decades. (Tarrant County Public Health, 2010) African-American youth and adult women in Tarrant County have high levels of risk factors for poor birth outcomes as indicated by the infant mortality rate for African-American women (16.6 infant deaths per 1,000 live births in 2010), a rate which is over twice that of other women in the county. (Tarrant County Public Health, 2011).

Challenges:
Preconception health conditions, such as asthma, obesity, diabetes, hypertension and other chronic diseases have been shown to increase adverse outcomes.(Johnson, et al., 2006; Atrash,et al., 2006) ¯ Health behaviors that place women at risk for a poor birth outcome include a history of sexually transmitted infections, tobacco use, alcohol use, illegal drug use and short pregnancy intervals.¯ Women who experience an adverse birth outcome are at an increased risk of having a subsequent adverse outcome (Adams, et al 2000, Mercer et al., 1999, Surkan et al., 2004). The inter-pregnancy period is an opportune time, if not only time for many low-income women, to provide interventions for women who have had a previous adverse outcome, maternal health condition or behavior. However, most low-income women lack access to health services and related health promotion programs in between pregnancies. Unintended pregnancies are associated with greater risks for adverse birth outcomes, particularly when other high-risk variables are present and not managed, such as smoking, substance abuse, obesity, and other medical conditions such as diabetes and hypertension.¯ (Pulley, et al, 2002, Orr, et al, 2000). Research also shows that women with unwanted pregnancies are more likely to smoke, use alcohol, use illegal drugs, enter prenatal care in the last trimester and less likely to breastfeed.¯ (Pulley, et al, 2002, Orr, et al, 2000). These poor health conditions, behaviors and poor birth outcomes disproportionately affect low-income and minority women.

5-Year Expected outcome for Provider and Patients:
Increase in the number of low income women -of reproductive age in Tarrant County who receive - interconception health education - and preventive services-and reduction in risks indicated by a previous adverse outcome.-Over the period of the project the following metrics will be met: the development, implementation and evaluation of the evidence-based project; at least - 150 patients (-cumulative from DY3, DY4 and DY5) in defined population will receive intervention consistent with evidence-based model

Starting Point/Baseline:
This is a new project that will address the health and well-being of women - of reproductive age in Tarrant County through interventions applied during the interconception period. - This project will target- low-income women with previous adverse birth outcomes to reduce the possibility of subsequent poor birth outcomes such as preterm birth, low-birth weight, infant mortality, neural tube defects and stillbirths. - Baseline information on type of previous adverse outcomes will be collected from program participants during program enrollment and will be used to develop individualized service plans.

Rationale:
Texas spends over $2.2 billion per year in the Medicaid program for birth and delivery services. Half of the births in Texas are Medicaid births. Costs related to infant care are increasing and NICU utilization is growing. Over 60% of Medicaid program birth and delivery costs are for extremely premature babies (51.3%) or premature infants with problems (10.8%).

Approximately $63,124 is spent o-n the first year of life for every premature infant compared to $404.00 for a term infant.(Lakey, 2012) These statistics provide a compelling economic case for improving - the interconception health of women in Tarrant County, especially African-American women. Addressing risk factors for poor birth outcomes during the preconception (prior to pregnancy), and interconception (between pregnancies), is a recommended evidence-based approach to improving the health of women and infants.
The p-roposed - interconception intervention- corresponds to the CDC's recommendations to improve preconception health published in 2006. (Johnson, et al., 2006).
The interventions are based on evidence the CDC used to support their recommendations, evidence-based best practices (e.g., Magnolia Project, Grady Memorial Interpregnancy Care Program), information gathered from existing community assessments (e.g., Fort Worth Women's Health Assessment) and information that will be collected from potential program participants via focus groups and in-depth interviews as part of a currently funded study.

Project Components:
The project components (consumer awareness, access to preventive care and family planning and community services, outreach, education, - peer support and intensive case management services) were selected because they enhance the access and care delivery infrastructure by strengthening the link between the women, clinical health care providers and community health and social services. This approach addresses social health needs that contribute to poor clinical outcomes that can best be addressed in the context of community. Because the focus is primarily on non-pregnant women of childbearing age, - including social -contributors to poor outcomes, the proposed project will engage a wide group of health and social providers.

These milestones and metrics were selected based on their ability to accurately assess improvements in risk reduction that will improve birth outcomes in the target population. The milestones and metrics are based on best practices from evidence-based interventions. This project will fill a gap in the local community for programs and services that address interconception health. Quality Milestone P-7- was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN. 11 – Need for more care coordination
- CN. 13 – Necessity of patient education programs
- CN. 15 – Need for more education, resources and promotion of health lifestyles

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This is a new project for this institution that will fill a gap in the local community for programs and services that address -interconception health through consumer awareness, access to care and

community services, outreach, education, peer support and intensive case management services. There is currently no other federal funding being received for this project.

Related Category 3 Outcome Measures:

Outcome Measure 2: IT-8.2 Percentage of Low Birth-weight Births
Rationale: Low birth weight is considered one of the most important indicators of a newborn's chances of survival, with low birth weight being a major risk factor for perinatal and infant mortality. Low birth weight babies are more likely to have health and developmental problems including learning difficulties, hearing and visual impairments, and chronic respiratory problems such as asthma and chronic diseases later in life.

Outcome Measure 3: IT-8. 9 Other Outcome Improvement Target: Interpregnancy interval/birth spacing
Rationale: The improvement target is to achieve a pregnancy interval of at least - 9 months of a previous birth among 65% (98) of the women enrolled in the interconception intervention. Spacing of less than six months is highly predictive of a subsequent poor birth outcome and pregnancy intervals of 12-18 months are associated with high rates of uterine rupture, maternal morbidities, preterm birth, low birth weight, and small for gestational age infants.

-**Relationship to Other Projects:**
138980111. 2.1 Promoting Physical and Mental Health Among At-risk, Underserved African-American Pre-teen Girls in Tarrant County. These projects are related because they represent a continuum of services across the reproductive life course for at-risk girls and women in Tarrant County. The Promoting Physical and Mental Health Among At-risk, Underserved African-American Pre-teen Girls in Tarrant County focuses on self-esteem and decision-making in young girls- antecedents to positive preconception health behaviors, while the Perinatal-Health Promotion project focuses on women at risk for poor outcomes.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:
Implement Evidence-based Disease Prevention Programs - Implement innovative evidence-based strategies to reduce low birth weight and pre-term births - 2.7.4: Tarrant County - Perinatal Health Promotion Initiative

- 126675104.2.15 JPS Health Network-Journey to Life-This project will provide a source of high-quality and evidence-based prenatal care for pregnant women. Existing relationships between UNT Dept of Ob/Gyn and JPS will facilitate seamless referrals into early prenatal care and timely postpartum care.
- 130614405.2.3 Texas Health Arlington Memorial Prenatal Care

- 028817305.2.1 Tarrant County Public Health FIMR-The Perinatal - Health Promotion Initiative interventions will be guided by findings of the FIMR. This will ensure that interventions will reflect the birth outcome experiences of women in Tarrant County and respond to identified gaps in services, behaviors, etc.

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

a. Specifically, this project's value was calculated on two -outcomes, which included (1) - percentage of low birth-weight births, - and (2) Interpregnancy interval/birth spacing, -For Percentage of Low Birth-weight Births, UNT Health Science Center defined the population that will be directly impacted by the project as women with previous low weight births, which would be approximately 50 patients. The percentage of - improvement by the project is 10%, equating to 5 lives positively impacted by this outcome-.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $44,482. -For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $26,689 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $26,689 for each positive outcome realized.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For Other Outcome Improvement Target: Interpregnancy Interval/Birth Spacing , UNT Health Science Center defined the population that will be directly impacted by the project as women with previous adverse birth outcome, including infant mortality, which would be approximately 150 women. The improvement target is to achieve a pregnancy interval of at least - 9 months of a previous birth among 65% of the women enrolled in the interconception intervention, equating to 98 lives positively impacted. -.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $51,589 (as cited in the article, "Preterm Birth: Causes, Consequences, and Prevention, Chapter 12: Societal Costs of Preterm Birth" in the journal *National Academies Press*) due to the reduction in the cost for care of infants born preterm.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $30,953 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $30,953 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.2.4	*2.7.4*	*N/A*	*Implement Evidence-based Disease Prevention Programs – Implement innovative evidence-based strategies to reduce low birth weight and preterm birth – 2.7.4: Tarrant County - Perinatal Health Promotion Initiative*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.25* *138980111.3.26*	*3.IT-8.2* *3.IT-8.9*	*Percentage of Low Birth-weight Births (CHIPRA/NQF #1382)* *Other Outcome Improvement Target: Interpregnancy interval/birth spacing*

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 based on distilling the needs assessment and determining priority of interventions for the community Metric 1 [P-1.1]: Document innovational strategy and plan Baseline/Goal: Strategy and plan documented Data Source: Program records Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,573,263 **Milestone 2** [P-2]: Implement evidence-based innovational project for targeted population Metric 1 [P-2.1]: Document implementation strategy and testing outcomes Baseline/Goal: Implementation strategy and testing outcomes	**Milestone 4** [P-1]: Development of innovative evidence-based project- for targeted population based on distilling the needs assessment and determining priority of interventions for the community Metric 1 [P-1.1]: Document innovational strategy and plan Baseline/Goal: Strategy and plan documented Data Source: Program records Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,230,941 **Milestone 5** [P-2]: Implement evidence-based innovational project for targeted population Metric 1 [P-2.1]: Document implementation strategy and testing outcomes Baseline/Goal: Implementation strategy and testing outcomes	**Milestone 8** [I-5-]: Identify at least 50 patients in defined population receiving innovative intervention consistent with evidence-based model Metric 1 [I-5-.1]: - Number of women in defined population who receive interconception consistent with evidence-based model Goal: -50 women Data Source: Program records Milestone 8 Estimated Incentive Payment *(maximum amount):* $1,755,761 **Milestone 9** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [I-8.1]: Increase percentage of target population reached Goal: 10% increase in access to health programs and activities among participants over DY3	**Milestone 11** [I-5-]: Identify at least 54 patients in defined population receiving intervention consistent with evidence-based model Metric 1 [I-5-.1]: Percent increase over baseline - women in defined population who receive interconception consistent with evidence-based model Goal: - 54 women Data Source: Program records Milestone 11 Estimated Incentive Payment *(maximum amount):* $1,696,388 **Milestone 12** [I-8-]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [I-8-.1]: Increase percentage of target population reached Goal: 20% increase in access to health programs and activities

138980111.2.4	*2.7.4*	*N/A*	*Implement Evidence-based Disease Prevention Programs – Implement innovative evidence-based strategies to reduce low birth weight and preterm birth – 2.7.4: Tarrant County - Perinatal Health Promotion Initiative*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.25* *138980111.3.26*	*3.IT-8.2* *3.IT-8.9*	*Percentage of Low Birth-weight Births (CHIPRA/NQF #1382)* *Other Outcome Improvement Target: Interpregnancy interval/birth spacing*

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)
documented Data Source: Program records Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,573,263 **Quality Milestone 3** [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. Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,573,262	documented Data Source: Program records Milestone 5 Estimated Incentive Payment *(maximum amount):* $1,230,941 **Milestone 6** [I-6]: Identify at least 46 patients in defined population receiving innovative intervention consistent with evidence-based model Metric 1 [I-6.1]: Number of -women in defined population who receive interconception intervention consistent with evidence-based model Goal - - 46 in DY3 Data Source: Program records Milestone 6 Estimated Incentive Payment *(maximum amount):* $1,230,941 **Quality Milestone 7** [P-7-]: Participate in face-to-face learning at	baseline. Data Source: Program records Milestone 9 Estimated Incentive Payment *(maximum amount):* $1,755,761 **Quality Milestone 10** [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. Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 10 Estimated Incentive Payment *(maximum amount):*	among participants over DY3 baseline. Data Source: Program records Milestone 12 Estimated Incentive Payment *(maximum amount):* $1,696,388 **Quality Milestone 13** [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. Metric1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 13 Estimated Incentive

138980111.2.4	*2.7.4*	*N/A*	*Implement Evidence-based Disease Prevention Programs – Implement innovative evidence-based strategies to reduce low birth weight and preterm birth – 2.7.4: Tarrant County - Perinatal Health Promotion Initiative*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.25* *138980111.3.26*	*3.IT-8.2* *3.IT-8.9*	*Percentage of Low Birth-weight Births (CHIPRA/NQF #1382)* *Other Outcome Improvement Target: Interpregnancy interval/birth spacing*

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)
	least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 7 Estimated Incentive Payment *(maximum amount):* $1,230,942	$1,755,762	Payment *(maximum amount):* $1,696,387
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,719,788	Year 3 Estimated Milestone Bundle Amount: $4,923,765	Year 4 Estimated Milestone Bundle Amount: $5,267,284	Year 5 Estimated Milestone Bundle Amount: $5,089,163

138980111.2.4	*2.7.4*	*N/A*	*Implement Evidence-based Disease Prevention Programs – Implement innovative evidence-based strategies to reduce low birth weight and preterm birth – 2.7.4: Tarrant County - Perinatal Health Promotion Initiative*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.25* *138980111.3.26*	*3.IT-8.2* *3.IT-8.9*	*Percentage of Low Birth-weight Births (CHIPRA/NQF #1382)* *Other Outcome Improvement Target: Interpregnancy interval/birth spacing*
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $20,000,000			

Project Option 2.12.2 – Discharge Planning and Care Coordination for Medicaid-eligible elders

Unique Project ID: 138980111.2.5
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: This project will implement an enhanced transition of care program for discharged Medicaid eligible elders of Tarrant County that includes a transition of care coordinator and in home medical care team. The team will facilitate an enhanced discharge plan, coordinate care, and provide evaluation and treatment. This model will provide collaboration between clinical and administrative representatives from a number of health care providers. This is a new initiative for UNTHSC that utilizes an enhanced discharge planning process to improve the health of discharged patients and reduce hospital re-admission rates and does not overlap with projects 1389800111.1.2, 138980111.1.3, or 138980111.1.6 though it can provide services to patients from those program who are hospitalized and transition them from the hospital back to those programs.
Need for the project: This project will contribute to achieving the region goal of improved access to chronic care services by focusing on a key population, low-income seniors, which the community needs assessment has found to be the population experiencing the highest growth rate, as well as the costliest. Additionally, the enhanced discharge plan will reduce hospital re-admissions, which is a very costly health burden to RHP 10 and CMS.
Target population: Medicaid eligible elders discharged from hospitals in Tarrant County are the targeted population. It is estimated that 750 Medicaid eligible elders will be served by this project.
Expected patient benefits: Medicaid elders suffer from multiple chronic conditions and are at high risk for hospital admissions followed by re-admissions, which is a financial drain on the medical care system. This project will improve the health of those served, better manage the chronic conditions and reduce health expenditures.
Category 1 or 2 expected patient benefits: This project seeks to serve 750 patients, implement standard care transition processes, identify and report on conditions, socioeconomic factors or other characteristics resulting in highest rates of re-admissions for 15% (113) of discharged targeted patients by DY4 and 25% (188) by DY5 - and increase percent of targeted patients in case management registry by 20% (15) by DY4 and 40% (300) by DY5.
Category 3 outcomes:

v. IT 3.1 Our goal is to reduce readmission rates by 5% (8 readmissions prevented) over baseline by DY4 and 10% (15 readmissions prevented) over baseline by DY5.
vi. IT 10.1 Our goal is to improve Quality of Life scores by 5% over baseline by DY4 and 10% over baseline by DY5.

vii. IT 4.5- Our goal is to reduce the number of falls by 5% (13 falls prevented) over baseline by DY4 and 10% (23 falls prevented) over baseline by DY5.

Project Option 2.12.2 – Discharge Planning and Care Coordination for Medicaid-eligible elders

Unique Project ID: 138980111.2.5
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:
Project Area: Implement/Expand Care Transitions Programs
Project Intervention: Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population: Implement a discharge planning program and postdischarge support program to prevent rehospitalizations in Medicaid-eligible elders

This project proposes a delivery model which will include an in home medical care team that coordinates care and provides evaluation and treatment with existent home health care services and will be implemented for discharged Medicaid-eligible community dwelling Tarrant County older adults. This model will provide collaboration between clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers and home care providers. Each discharged older adult will have a plan of care developed that includes discharge phone calls and visits by some of the members or the in home medical care team consisting of a PA/NP, Medical Assistant, Social Worker Care Coordinator and PT under the supervision of a geriatrician within the first 72 hours from discharge. The PA/NP and Medical Assistant will receive the discharge plans from the hospital and have full access to the hospital records in order to provide medication reconciliation with home medication lists, evaluate the patients' clinical, cognitive, and functional status and provide patient and family health education. The Social Worker Care Coordinator will collaborate with the Hospital Discharge Planner and identify the psychosocial and financial needs of the patient and provide assistance with referrals to appropriate aging network provider agencies. The PA/NP under the supervision of the geriatrician will develop and individualized plan of care and provide appropriate in home visits with the home health care program weekly until the patient has reestablished his or her baseline health status and is ready to return to his or her primary care practitioner. The PT will be responsible for evaluating/assessing home safety and needs of discharged patients and formulating treatment plans in a home care environment. Individual level of fall risk will be assessed with necessary interventions provided to further reduce risk of hospitalization. Evidence-based strategies and clinical protocols will be utilized that will support the seamless care transitions and reduce the preventable 30-day rehospitalizations. As mentioned, once successful transition back to home and stability is accomplished, the older adult will return to the prior primary care practitioner. Coordination will occur with the primary care practitioner regarding the post hospital needs of the vulnerable elder and detailed plan of post hospital care.

Goals and Relationship to Regional Goals:

Project Goals:
The purpose of performing this project is to decrease the multiple causes of rehospitalization for Medicaid-eligible older adults which, in turn, will provide a substantial cost savings to the health care system and to implement a successful discharge planning and postdischarge support program. The five-year goals of this project are to reduce rehospitalizations among Medicaid-eligible elders living in the community in Tarrant County by implementing the following: (1) implement and enhance the discharge planning process and services, (2) increase access to care coordination post hospital discharge and (3) provide an interprofessional in home care team to evaluate and manage the vulnerable older adult in their homes post hospitalization.

This project meets the following Regional goals:
A major goal of the Region is to provide improved access to chronic care services. This project would contribute to achieving that goal by focusing on a key population, low-income seniors, which the Community Needs Assessment has found to be the population experiencing the highest growth rate, as well as the costliest.

Challenges:
The rates of rehospitalizations are higher in the two weeks following discharge for older chronically ill adults. The cause of rehospitalizations has been linked to poor information transfer between the hospital and the patient and family members and the primary care offices, lack of consistent medication reconciliation, lack of in home care and services and need for closer disease management for patients with exacerbations of chronic disease processes or new diagnosis. Especially for the older adults who return home, the convalescence period represents an increased potential for falls due to their deconditioned state, combination of medical factors, and the sometimes overwhelming task of coping with the transition of care. The transition for these older adults back home may be marked by inaccurate medication lists that may cause adverse drug reactions, lack of attention to the medical condition that prompted the hospitalization because of inability to get in to see the primary care physician in a timely manner, lack of understanding about the discharge instructions from the hospital, lack of in home services or equipment that are necessary to remain independent in the home to name a few. This project aims to decrease the multiple causes of rehospitalization for Medicaid-eligible older adults which, in turn, will provide a substantial cost savings to the health care system and to implement a successful discharge planning and postdischarge support program.

5-Year Expected outcome for Provider and Patients:
At the end of the Waiver period this project expects to demonstrate an enhanced discharge planning process, an increased access to care coordination post hospital discharge and decreased rehospitalizations for this Medicaid-eligible population of older adults. The 5-year outcomes of

this project are to: 1) reduce all-cause 30-day readmission rates by 10% (15 readmissions prevented) over baseline for patients receiving intervention, 2) improve quality of life scores (SF-36) by 10% over baseline for patients receiving intervention, and 3) decrease the number of falls by 10% (23 falls prevented) over baseline for patients receiving intervention. These goals will be achieved through hiring of new providers and staff and deployment of an enhanced discharge planning process and in home care coordination model for Medicaid-eligible community dwelling elders of Tarrant County.

Starting Point/Baseline:
This project is designed to provide transitions services to hospitalized elders receiving services from hospitals who have affiliations with UNTHSC Division of Geriatrics. Baseline data will be collected in DY3 for the Medicaid-eligible older adults in Tarrant County regarding: 1) rehospitalization rate, 2) quality of life scores, and 3) number of falls and injuries possibly related to these falls.

Rationale:
The proposed expanded care transitions project that includes geriatrician oversight of a team comprised of a PA/NP, Medical Assistant, Physical Therapist and Social Service Coordinator to provide the assessments and the services for discharged older patients will decrease the rehospitalization rates of this vulnerable population, and therefore, save Medicare hospitalization costs. This project will also provide enhancement of the discharge planning process for the Medicaid-eligible elder population.

Project Components:
The proposed expanded care transitions project that includes geriatrician oversight of a team comprised of a PA/NP, Medical Assistant, Physical Therapist and Social Service Coordinator to provide the assessments and the services for discharged older patients will decrease the rehospitalization rates of this vulnerable population, and therefore, save Medicare hospitalization costs. This project will also provide enhancement of the discharge planning process for the Medicaid-eligible elder population.

Project Components:
There are no required core project components for this project area. Core activities of this project will include discharge checklists, hand off communication plans with receiving providers, patient and family education initiatives including patient self-management skills and “teach-back”, postdischarge.

By achieving our milestones of developing and implementing best practices for effectively communicating with patients and families and implementing standard care transition processes, we will accomplish our goals of reducing rehospitalization, improving quality of life scores and

decreasing the number of falls for Medicaid-eligible receiving the intervention. Quality Milestone P-12- was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.11 – Need for more care coordination
- CN.9 – Need for increased geriatric, long-term, and home care resources

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

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

Outcome Measure 1: IT 3.1 All-cause 30-day readmission rate – NQF 1789: 1 All-cause 30-day readmission rate for Medicaid-eligible elders 65 and above who are hospitalized at local partners of the UNTHSC Division of Geriatrics. Improvement goal is 5% (8 readmissions prevented) reduction in all-cause hospitalization rate over baseline in DY4 and a 10% (15 readmissions prevented) reduction in all-cause readmission rate over baseline in DY5.

Rationale: Approximately 20% of Medicaid-eligible elders are readmitted to hospitals within 30 days of discharge, which is a significant financial drain. Through implementation of our discharge planning and care coordination model, we will reduce 30-day readmission rates thereby providing a substantial cost savings.

Outcome Measure 2: IT 10.1 Quality of Life – Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool, for the target population.

Rationale: QOL is related to a range of diseases as well as health status, which in turn can be utilized to guide interventions (CDC). Higher QOL is related to improved utilization of medical services and reduced overall health costs. Through implementation of this discharge planning and care coordination model, we will significantly improve quality of life, which will have substantial positive impacts on other areas of health thereby offering significant cost savings.

Outcome Measure 3: IT 4.5 Patient Fall Rate – NQF 0141 -Rationale: Falls among the elderly is a significant health care issue. Every 18 seconds an older adult is treated in an ED for falls, which is the leading cause of hospital admissions for trauma among the elderly. Approximately one third of older adults fall each year in the U.S. The project will have targeted fall prevention education provided to patients. Preventing future falls will have a significant impact in reducing hospital 30-day readmissions among this targeted population.

Relationship to Other Projects:
138-980111.1.3 Expand Primary Care Capacity – Expand Existing Primary Care Capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid-eligible Elders. The current project will support and reinforce the Expanding Geriatric Primary Care and Consultative Services project as it will provide evidence-based transitions of care to all hospitalized Medicaid-eligible patients seen by the UNTHSC Geriatrics Clinic. Therefore, these projects will work in tandem serving hospitalized Medicaid-eligible elders.
138-980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics -1.1.3: Community-Based Primary Care for the Elderly. Many hospitalized poor elderly do not have regular access to geriatric primary care (or other primary care services). Therefore, the Community-Based Primary Care for the Elderly will provide a referral mechanism for hospitalized elders being discharged from the hospitals. The transitions-care teams will work with patients regarding discharge plans and provide a seamless transition to the Community-Based program for follow-up primary care services. Together, these programs will provide optimal evidence-based care that will reduce further hospitalizations.
This project serves hospitalized patients, which are not provided discharge services by projects 138980111.1.3, 138980111.1.2, and 138980111.1.6. The goals of this project will be examined independently of all other projects.

N/A for non-hospital providers

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates - that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value is calculated on three outcomes, which include (1) patient fall rate-, (2) quality of life/functional status – quality of life, (3) 30-day readmission rates.

a. For Patient Fall Rate -, UNT Health Science Center defined the population that will be directly impacted by the project as elderly patients who are eligible for coverage by Medicaid, which we have estimated to be approximately 750. It is anticipated 30% of these patients (225) will be experience a fall. The percentage of improvement is expected to be 10% (23 falls prevented) -.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $17,500 (as cited in the article "Cost of Falls Among Older Adults" by the CDC) -.

   For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $14,000 for each positive outcome realized

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For Quality of Life-, UNT Health Science Center defined the population that will be directly impacted by the project as Elderly patients who are eligible for coverage by Medicaid, which we have estimated to be 750 individuals. We are anticipating that we will test the entire population, and are expecting to increase the quality of life scores for the project by 10%-.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,755 (as cited in the aricle "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal Arch Gen Psychiatry, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention -. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect",

due to the positive impact the project would have on the population beyond those directly involved by the project.

c. For 30-Day Readmission Rates, UNT Health Science Center defined the population that will be directly impacted by the project as elderly patients who are eligible for coverage by Medicaid and receive care from UNTHSC Division of Geriatrics physicians – which was 750 patients in FY 2011. It is anticipated that 20% of these patients (150) will be readmitted within 30 days of discharge. Our goal is to reduce hospitalization rates by 10% (15 readmissions prevented) -.

   Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,491 (TX Dept. of State Health Services data).-.

   For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $5,993 for each positive outcome realized.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved with the project.

   Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.2.5	***2.12.2***	***N/A***	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAM – IMPLEMENT ONE OR MORE PILOT INTERVENTION(S) IN CARE TRANSITIONS TARGETING ONE OR MORE PATIENT CARE UNITS OR A DEFINED PATIENT POPULATION – 2.12.2: DISCHARGE PLANNING AND CARE COORDINATION FOR MEDICAID ELIGIBLE ELDERS*
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)			138980111
Related Category 3 Outcome Measure(s):	138980111.3.28 138980111.3.29 138980111.3.45	*3.IT 3.1* *3.IT 10.1* *3.IT 4.5*	*ALL-CAUSE 30-DAY READMISSION RATE – NQF 1789* *QUALITY OF LIFE* *PATIENT FALL 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]: Develop or implement best practices or evidence-based protocols for effectively communicating with patients and families during and postdischarge to improve adherence to discharge and follow up care instructions Metric 1 [P-1.1]: Care Transitions protocols Baseline/Goal: Protocols will be developed for discharged Medicaid- eligible elders/Documentation Completed Data Source: Program Records Milestone 1 Estimated Incentive Payment *(maximum amount):* $613,612 **Milestone 2** [P-7]: Develop a staffing and implementation plan to accomplish the goals/objectives of the care	**Milestone 4** [P-2]: Implement standard care transition processes Metric 1 [P-2.1]: Care transitions policies and procedures Baseline/Goal: Policies and procedures will be developed and applied to 10% (75) of hospital discharges of Medicaid eligible elders Data Source: Program Records Milestone 4 Estimated Incentive Payment *(maximum amount): $640,130* **Milestone 5** [P-5]: Using a validated risk assessment tool, create a patient identification system Metric 1 [P-5.1]: Patient stratification system Baseline/Goal: System will be developed for 25% (188) of	**Milestone 7** [I-10]: Identify the top chronic conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors or other patient characteristics resulting in highest rates of readmissions Goal: Identification and report for 15% (113) of discharged Medicaid eligible elders Data Source: Program Records, EMR Milestone 7 Estimated Incentive Payment: $410,874 **Milestone 8** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the	**Milestone 12** [I-10]: Identify the top chronic conditions and other patient characteristics or socioeconomic factors that are common causes of avoidable readmissions Metric 1 [I-10.1]: Identification and report of those conditions, socioeconomic factors or other patient characteristics resulting in highest rates of readmissions Goal: Identification and report for 25% (188) of discharged Medicaid eligible elders Data Source: Program Records, EMR Milestone 12 Estimated Incentive Payment: $396,980 **Milestone 13** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the

138980111.2.5	***2.12.2***	***N/A***	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAM – IMPLEMENT ONE OR MORE PILOT INTERVENTION(S) IN CARE TRANSITIONS TARGETING ONE OR MORE PATIENT CARE UNITS OR A DEFINED PATIENT POPULATION – 2.12.2: DISCHARGE PLANNING AND CARE COORDINATION FOR MEDICAID ELIGIBLE ELDERS*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)				138980111
Related Category 3 Outcome Measure(s):	138980111.3.28 138980111.3.29 138980111.3.45	*3.IT 3.1* *3.IT 10.1* *3.IT 4.5*	*ALL-CAUSE 30-DAY READMISSION RATE – NQF 1789* *QUALITY OF LIFE* *PATIENT FALL 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)**
transitions program Metric 1 [P-7.1]: Documentation of the staffing plan Baseline/Goal: Documentation Completed. Data Source: Program Records Milestone 2 Estimated Incentive Payment: $613,612 **Quality Milestone 3** [P-12-]: 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. Metric 1 [P-12-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting	discharged Medicaid eligible elders/Documentation Completed Data Source: Program Records Milestone 5 Estimated Incentive Payment: $*640,130* **Quality Milestone 6** [P-12-]: 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. Metric 1[P-12-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 6 Estimated Incentive		approved clinical protocols and care transitions policies Metric 1 [I-11.1]: Number over time of target population (Medicaid-eligible elders discharged from the hospital) receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Baseline/Goal: 400 patients receiving the interventions Data Source: Program Records, EMR Milestone 8 Estimated Incentive Payment: $410,874 **Milestone 9** [I-13]: Increase the number or percent of patients in the case management related registry Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case-management-related registry.	approved clinical protocols and care transitions policies Metric 1 [I-11.1]: Number over time of target population (Medicaid eligible elders discharged from the hospital) receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Goal: 750 patients - receiving the interventions Data Source: Program Records, EMR Milestone 13 Estimated Incentive Payment: $396,980 **Milestone 14** [I-13]: Increase the number or percent of patients in the case management related registry Metric 1 [I-13.1]: Increase in the number or percentage of patients in the case management related registry.

138980111.2.5	***2.12.2***	***N/A***	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAM – IMPLEMENT ONE OR MORE PILOT INTERVENTION(S) IN CARE TRANSITIONS TARGETING ONE OR MORE PATIENT CARE UNITS OR A DEFINED PATIENT POPULATION – 2.12.2: DISCHARGE PLANNING AND CARE COORDINATION FOR MEDICAID ELIGIBLE ELDERS*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)				138980111
Related Category 3 Outcome Measure(s):	138980111.3.28 138980111.3.29 138980111.3.45	*3.IT 3.1* *3.IT 10.1* *3.IT 4.5*	*ALL-CAUSE 30-DAY READMISSION RATE – NQF 1789* *QUALITY OF LIFE* *PATIENT FALL 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)**
notes Milestone 3 Estimated Incentive Payment *(maximum amount):* $613,612	Payment *(maximum amount):* *$640,130*		These patients will be targeted from those discharged from hospitals and followed by the Care Coordination team Goal: Target is increase of Medicaid eligible elders by 20% (150). Data Source: Program Records, EMR Milestone 9 Estimated Incentive Payment: $410,874 **Milestone 10** [I-14]: Implement standard care transition processes for the Medicaid eligible elder population Metrics 1 [I-14.1]: Measure adherence to processes. Goal: 15% (113) of Medicaid-eligible elders who are discharged from hospitals will be adherent to the processes developed for the care transitions program	These patients will be targeted from those discharged from hospitals and followed by the Care Coordination team Goal: Target is increase of Medicaid eligible elders by 40% (300). Data Source: Program Records, EMR Milestone 14 Estimated Incentive Payment: $396,980 **Milestone 15** [I-14]: Implement standard care transition processes for the Medicaid eligible elder population Metrics 1 [I-14.1]: Measure adherence to processes. Goal: 40% (300) of Medicaid eligible elders who are discharged from hospitals will be adherent to the processes developed for the care transitions program

138980111.2.5	***2.12.2***	***N/A***	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAM – IMPLEMENT ONE OR MORE PILOT INTERVENTION(S) IN CARE TRANSITIONS TARGETING ONE OR MORE PATIENT CARE UNITS OR A DEFINED PATIENT POPULATION – 2.12.2: DISCHARGE PLANNING AND CARE COORDINATION FOR MEDICAID ELIGIBLE ELDERS*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)				138980111
Related Category 3 Outcome Measure(s):	138980111.3.28 138980111.3.29 138980111.3.45	*3.IT 3.1* *3.IT 10.1* *3.IT 4.5*	*ALL-CAUSE 30-DAY READMISSION RATE – NQF 1789* *QUALITY OF LIFE* *PATIENT FALL 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)**
			Data Source: Program Records, EMR Milestone 10 Estimated Incentive Payment: $410,874 **Quality Milestone 11** [P-12-]: 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. Metric 1 [P-12-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 11 Estimated Incentive Payment *(maximum amount):* $683,532	Data Source: Program Records, EMR Milestone 15 Estimated Incentive Payment: $396,980 **Quality Milestone 16** [P-12-]: 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. Metric 1 [P-12-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 16 Estimated Incentive Payment *(maximum amount):*

138980111.2.5	***2.12.2***	***N/A***	*IMPLEMENT/EXPAND CARE TRANSITIONS PROGRAM – IMPLEMENT ONE OR MORE PILOT INTERVENTION(S) IN CARE TRANSITIONS TARGETING ONE OR MORE PATIENT CARE UNITS OR A DEFINED PATIENT POPULATION – 2.12.2: DISCHARGE PLANNING AND CARE COORDINATION FOR MEDICAID ELIGIBLE ELDERS*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER (UNTHSC)				138980111
Related Category 3 Outcome Measure(s):	138980111.3.28 138980111.3.29 138980111.3.45	*3.IT 3.1* *3.IT 10.1* *3.IT 4.5*	*ALL-CAUSE 30-DAY READMISSION RATE – NQF 1789* *QUALITY OF LIFE* *PATIENT FALL 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)**
				$396,980
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,840,835	Year 3 Estimated Milestone Bundle Amount: $1,920,391		Year 4 Estimated Milestone Bundle Amount: $2,054,372	Year 5 Estimated Milestone Bundle Amount: $1,984,901
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $7,800,499				

Project Option 2.13.1 – Health Navigation and Incentives for Dual Diagnosis Patients

Unique Project ID: 138980111.2.6
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Provider: UNT Health is the Faculty Group Practice at the University of North Texas Health Science Center comprised of over 220 physicians and other healthcare professionals practicing in 29 locations throughout Fort Worth and Tarrant County. In 2012, UNT Health recorded 553,820 patient encounters of which, approximately 93,471 or 17% were covered by Medicaid. The total gross patient charges recorded for unsponsored charity care provided in 2012 were $82,268,290.
Intervention: A technology-enhanced navigation program for high-risk dual diagnosis patients will be developed, implemented, and evaluated. - The project will draw on prior research on brief patient navigation systems that utilize motivational interviewing and wellness incentives to specifically target the relationship between substance abuse and mental health in this high-risk population. This project is a new initiative.
Need for the project: The primary goals are to reduce alcohol and drug use indicators (use, problems, severity), to reduce depression symptomatology (as measured by the PHQ-9), and to improve quality of life (as measured by the Q-LES-Q) among a group of previously homeless individuals residing in the Ft. Worth Permanent Supportive Housing (PSH) programs, who meet criteria for a co-occurring disorder. This project supports the regional goals of increasing access to mental health services, and improving coordination of care for more vulnerable individuals.
Target population: Dually-diagnosed patients enrolled in - Ft. Worth permanent supportive housing (PSH) programs. Residents in PSH programs have typically demonstrated a history of chronic homelessness, which includes a disabling health, mental health or substance abuse condition. Estimated 300 patients.
Expected patient benefits: Reduce alcohol/drug use, reduce depression symptoms, and improve quality of life of dually-diagnosed diagnosis patients residing in the Fort Worth PSH programs by increasing access to mental health services, raising individual motivation to change, and improving coordination of care for more vulnerable individuals. We expect to reduce alcohol and drug use indicators by at least 5% each in Years 4 and 5, for a total of 10% reduction. We expect to remit depression symptoms by at least 5% each in Years 4 and 5, for a total of 10% remission among patients who report moderate to severe depression. We expect to increase quality of life scores by at least 5% each in Years 4 and 5, for a total of 10% improvement. Finally, as a result of decreased drug and alcohol use, we expect to reduce admits to the criminal justice system by 2.5% each in Years 4 and 5, for a total of 5% reduction. Most outcomes refer to a reduction in mean scores for the group; for depression remission, the total number of people impacted will depend on enrolled participants' baseline scores on the PHQ-9.
Category 1 or 2 expected patient benefits:

viii. 2.5% decrease over baseline by DY4 and 5% decrease over baseline by DY5 in preventable admissions and readmissions into Criminal Justice System
ix. Reduce alcohol/drug use and problems by at least 5% over baseline by DY4 and 10% over baseline by DY5

Category 3 outcomes:

i. IT-1.9 – Remission of depression symptoms for 5% of patients by DY4 and 10% of patients by DY5 as evidenced by a reduction of PHQ-9 scores greater than 9 (i.e., at least moderate depression) to less than 5 (i.e., minimal or no depression) -. The total number of people impacted will depend on baseline scores of enrolled participants on the PHQ-9.
ii. IT-10.1 – 5% increase from baseline by DY4 and 10% increase from baseline by DY5 in quality of life scores as measured by the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q)

Project Option 2.13.1 – Health Navigation and Incentives for Dual Diagnosis Patients

Unique Project ID: 138980111.2.6
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Project Description:
Project Area: Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting
Project Intervention: Design, implement, and evaluate research-supported and evidence-based interventions tailored toward individuals in the target population.
A technology-enhanced navigation program for high-risk dual diagnosis patients will be developed, implemented, and evaluated. - The project will draw on prior research on brief patient navigation systems that utilize motivational interviewing and wellness incentives to specifically target the relationship between substance abuse and mental health in this high-risk population (Olsen & Nesbitt, 2010; Lundahl & Burke, 2009). The project team has extensive experience designing and implementing motivational interviewing interventions for similar populations (Neff, et al., in press; Pengchit et al., 2011; Walters, et al., 2007).

Our subject population will include 300 previously homeless individuals residing in - Ft. Worth Permanent Supportive Housing (PSH) programs. PSH programs combine housing rental vouchers with limited case management services around basic needs. Residents in PSH programs have typically demonstrated a history of chronic homelessness, which includes a disabling health, mental health or substance abuse condition. Targeting PSH residents will allow us to reduce attrition and to pilot test our health intervention to best determine efficacy and effectiveness. In addition, we will have the added benefit of providing data integrity and fidelity through the use of PSH case manager confirmation of substance use slips and/or relapses.

Goals and Relationship to Regional Goals:

Project Goals:
Reduce alcohol/drug use and problems by at least 10% over 2 years; reduce depression scores by 10% over 2 years; improve quality of life scores by 10% over 2 years; reduce criminal justice admits by 5% over 2 years.

This project meets the following Regional goals:
Our primary goals are to reduce alcohol and drug use indicators (use, problems, severity), to reduce depression symptomatology (as measured by the PHQ-9), and to improve quality of life (as measured by the Q-LES-Q) among a group of previously homeless individuals residing in -Ft. Worth PSH programs, who meet criteria for a co-occurring disorder. Recruiting from this pool

will allow us to test our health intervention on a well-defined and accessible population before it is disseminated to the larger group of dual diagnosis Medicaid patients in Tarrant County. This project supports the Regional goals of increasing access to mental health services, and improving coordination of care for more vulnerable individuals.

Challenges:
More than 5 million Americans have a co-occurring mood and substance use disorder, also called dual diagnosis (Center for Substance Abuse Treatment, 2007; Kessler et al., 2005). Roughly 30% of people diagnosed with any mental illness abuse alcohol or drugs, and about 50% of those with severe mental illnesses have substance abuse problems. People with co-occurring disorders have a much greater likelihood of violence, medication noncompliance, and treatment failures, than people with only substance abuse or mental illness. As a consequence, people with dual diagnosis are more likely to have acute medical crises that propel them into the hospital emergency center. For instance, in sample of dual diagnosis Medicaid-eligible patients in Tarrant County, 60% had chronic medical illnesses that required regular doctor visits (Nejtek et al., 2011). Finally, people with co-occurring disorders are much more likely to be homeless or jailed. In Tarrant County, an estimated 2,123 people meet the official definition of homeless (Tarrant County Homeless Coalition, 2012). The most recent analysis of this data showed that about 55% of the sheltered homeless population is considered trimorbid, which includes the DSM-IV criteria for co-occurring psychiatric and substance use disorders, as well as at least one chronic health condition. The demographics of this population are 63% male and 37% female with an age -range of 24-68 years. The vast majority are either African-American (52%) or White (46%) (Spence-Almaguer, et al., 2012). This project will address the syndemic problems of substance abuse and mental health in this high-risk population, with a targeted intervention that utilizes motivational interviewing, an evidence-based counseling style (Miller & Rollnick, 2012), and wellness incentives. Navigators will meet with patients in the community 1-2 times per month to help identify health and wellness needs, while providing them with referral to medical or mental health resources. Patients will have access to a wellness account of up to $1000 per year to purchase navigator-approved supplies and services related to their health goals. A computer tracking system will assist the health navigator in tracking patient goals and conducting the interview. Our goals over 2 years are to reduce alcohol/drug use and problems by at least 10%; remit depression by 10%; improve quality of life scores by 10%; and reduce criminal justice admissions by 5%.

5-Year Expected outcome for Provider and Patients:
Reduce alcohol/drug use, reduce depression symptoms, and improve quality of life of dually-diagnosed diagnosis patients residing in the Ft. Worth PSH programs. Our goals are to reduce alcohol/drug use and problems by at least 10%, improve quality of life by 10%, and to reduce depression symptomatology by 10% over 2 years. Most outcomes refer to a reduction in mean scores; for depression remission, the total number of people impacted will depend on baseline

scores of enrolled participants on the PHQ-9.

Starting Point/Baseline:
The first aim is to conduct a baseline needs assessment and establish a database linking providers who serve dual diagnosis patients in Tarrant County. The second aim is to develop and implement a behavioral intervention to reduce alcohol/drug use, reduce depression symptomatology, and improve quality of life in a group of dually-diagnosed patients residing in the Ft. Worth PSH programs. Substance abuse and depression frequently co-occur. Recent data from the PSH programs showed that 20% thought they had a problem with drugs or alcohol in the past 2 weeks (the screening question asked only about problem perception, not actual severity, which is likely much higher). The majority of patients demonstrated some level of dissatisfaction with their physical health (60.5%) and mood (59.9%), which when added to income (75.7%) comprise the three most problematic areas in the quality of life assessment. Between one-third and one-half of PSH residents reported regular frequency of depression and related symptoms such as: stopping enjoying things they used to enjoy (36.4%), difficulty concentrating, having racing thoughts or feeling out of control (37.8%) and having periods of intense unease or anxiety (48%). Overall, 35% reported dissatisfaction with their general happiness and more than one-quarter reported medication management problems during the prior two weeks.

Rationale:
People with co-occurring disorders have a much greater likelihood of violence, medication noncompliance, and treatment failures, than people with only substance abuse or mental illness. As a result, they are more likely to be homeless and to present in hospital or criminal justice settings.

Project Components:
The project contains all of the core components, including:

e. Assess size, characteristics and needs of target population(s)
f. Review the literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes
g. Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes
h. Design models which include an appropriate range of community-based services and residential support
i. Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

Substance use, depression, and quality of life are major indicators of mental health functioning, and appropriate for patients with a co-occurring mental health and substance abuse diagnosis.

Our pilot data suggest that the improvement milestones of reducing alcohol and drug use and problems by at least 10%, improving quality of life by 10%, and reducing depression symptomatology by 10% over 2 years are justified based on past work with similar community populations. Quality Milestone P-3 was selected to promote collaborative learning around shared or similar projects.

Unique community need identification numbers the project addresses:

- CN.4 – Lack of access to mental health services
- CN.5 – Insufficient integration of mental health care in the primary care medical care system
- CN.11 – Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.
Related Category 3 Outcome Measures:
Outcome Measures and Reasons/rationale for selecting the outcome measures:

Outcome Measure 1: IT-1.9: Depression management: Depression Remission at 12 Months (NQF #0710)
Reduction in depression symptomatology as measured by the PHQ-9.
Improvement Target: By DY5, 10% of patients who report moderate to severe depression will have a significant reduction in depression symptomatology, as evidenced by a reduction of PHQ-9 scores greater than 9 (i.e., at least moderate depression) to less than 5 (i.e., - or no depression). The total number of people impacted will depend on baseline scores of enrolled participants on the PHQ-9.

Rationale: The improvement milestone of remitting depression symptomatology for at - least 10% of patients is justified based on published research with similar community populations (Baker et al., 2012; Westera et al., 2011).
Outcome Measure 2: IT-10.1 Quality of Life
Demonstrate improvement in quality of life (QOL) as measured by evidence-based and validated assessment tool for the target population.
Improvement Target: By DY5, 10% increase in quality of life scores for the target population as measured by the Quality of Life Enjoyment and - Satisfaction Questionnaire (Q-LES-Q).
Rationale: The improvement milestone of improving quality of life by - at least 10% is justified based on published research with similar community populations (Lundahl & Burke, 2009).

Relationship to Other Projects:
Our project does not relate to any other UNTHSC projects.

N/A for non-hospital providers

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

Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population – 2.13.1: Health Navigation and Incentives for Dual Diagnosis Patients

- 126675104.2.3 This project will be closely coordinated with the JPS "Care Connections for the Homeless" project. Our project specifically targets supportive housing tenants who have co-occurring mental health and substance abuse problems. This subgroup of people transitioning out of homelessness has special needs that may benefit from our more intensive navigator project, which specifically targets those with substance abuse and mental health problems. Staff of this project will regularly meet with JPS and actively cross-refer patients for the unique services delivered by the "Care Connections for the Homeless" and vice versa.

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Specifically, this project's value is calculated on two outcomes, which include (1) depression management and (2) Quality of Life.

a. For Depression Management: Depression Remission at Twelve Months, UNT Health Science Center defined the population that will be directly impacted by the project as 300 dually-diagnosed patients enrolled in the Ft. Worth permanent supportive housing (PSH) program. We are expecting to decrease depression symptomatology for at least 10% of patients, equating to 30 lives positively impacted by this outcome. - -.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,759.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

b. For Quality of Life, UNT Health Science Center defined the population that will be directly impacted by the project as 300 dually-diagnosed patients enrolled in the Ft. Worth permanent supportive housing (PSH) program. We are anticipating that we will test the entire population, and are expecting to increase quality of life scores by 10%.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $16,750 (as cited in the article, "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention. - This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's

payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.2.6	*2.13.1*	*2.13.1.(A-E)*	*Provide an Intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population – 2.13.1: Health Navigation and Incentives for Dual Diagnosis Patients*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.32* *138980111.3.31*	*3.IT-1.9* *3.IT-10.1*	*Depression management: Depression Remission at Twelve Months (NQF #0710)* *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-1]: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources (Component A: Assess size, characteristics and needs of target population(s); Component B: Review the literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes). Metric 1 [P-1.1]: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization. Baseline/Goal: Needs assessment completed Data Source: Program records and literature review	**Milestone 3 [P-2]:** Design community-based specialized interventions for target population (Component C: Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes; Component D: Design models which include an appropriate range of community-based services and residential support). -Metric 1 [P-2.1]: Project plans which are based on evidence/experience and which address the project goals Baseline/Goal: - Completed project implementation and evaluation plan Data Source: Program records Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,308,107 **Quality Milestone 4**- [P-7-**]:**	**Milestone 5** [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: 300 enrolled Data Source: Program records Milestone 5 Estimated Incentive Payment *(maximum amount): $559,748* **Milestone 6** [P-4]: Evaluate and continuously improve interventions. (Component E: Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.) Metric 1 [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles	**Milestone 10**- [I-1]: Criminal Justice Admissions/Readmissions. (Component E: Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.) Metric 1 [I-1.1]: Decrease in preventable admissions and readmissions into Criminal Justice System Goal: 5% decrease over baseline in preventable admissions and readmissions into Criminal Justice System Data Source: Local and state criminal justice databases Milestone 10- Estimated Incentive Payment: $901,366 **Milestone 11**- [I-5]: Functional status. (Component E: Assess the impact of

138980111.2.6	*2.13.1*	*2.13.1.(A-E)*	*Provide an Intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population – 2.13.1: Health Navigation and Incentives for Dual Diagnosis Patients*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.32* *138980111.3.31*	*3.IT-1.9* *3.IT-10.1*	*Depression management: Depression Remission at Twelve Months (NQF #0710)* *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 Estimated Incentive Payment *(maximum amount):* $1,253,916 **Quality Milestone 2** [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. (Component A: Assess size, characteristics and needs of target population(s); Component B: Review the literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes). Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas,	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. (Component B: Review the literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes). Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,308,107	Baseline/Goal: Complete evaluation plan, and document continuous improvement cycles. Data Source: Program records and evaluation reports Milestone 6 Estimated Incentive Payment *(maximum amount): $559,748* **Milestone 7- [I-1]:** Criminal Justice Admissions/Readmissions. (Component E: Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.) Metric1 [I-1.1]: Decrease in preventable admissions and readmissions into Criminal Justice System Goal: 2.5% decrease over baseline in preventable admissions and readmissions into Criminal Justice	interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.) Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments Goal: Reduce alcohol/drug use and problems by at least 10% over baseline. Data Source: Alcohol/drug use (Timeline Followback, with cheek swab verification), alcohol/drug consequences (Inventory of Drug Use Consequences), dependence symptoms (DSM IV) Milestone 11- Estimated Incentive Payment: $901,366

138980111.2.6	*2.13.1*	*2.13.1.(A-E)*	*Provide an Intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population – 2.13.1: Health Navigation and Incentives for Dual Diagnosis Patients*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.32* *138980111.3.31*	*3.IT-1.9* *3.IT-10.1*	*Depression management: Depression Remission at Twelve Months (NQF #0710)* *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)
slides from presentations, meeting notes, and review of literature Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,253,916		System Data Source: Local and state criminal justice databases Milestone 7- Estimated Incentive Payment: -$559,748 **Milestone 8- [I-5]:** Functional status. (Component E: Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.) Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments. Goal: Reduce alcohol/drug use and problems by at least 5% over baseline. Data Source: Alcohol/drug use	**Quality Milestone 12-** [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. (Component B: Review the literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes; Component E: Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.) Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas,

138980111.2.6	*2.13.1*	*2.13.1.(A-E)*	*Provide an Intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population – 2.13.1: Health Navigation and Incentives for Dual Diagnosis Patients*
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.32* *138980111.3.31*	*3.IT-1.9* *3.IT-10.1*	*Depression management: Depression Remission at Twelve Months (NQF #0710)* *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)
		(Timeline Followback, with cheek swab verification), alcohol/drug consequences (Inventory of Drug Use Consequences), dependence symptoms (DSM IV) Milestone 8- Estimated Incentive Payment: -$559,748 **Quality Milestone 9**- [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. (Component B: Review the literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes; Component E: Assess the impact of interventions based on standardized quantitative measures and qualitative	slides from presentations, meeting notes Milestone 12- Estimated Incentive Payment *(maximum amount):* $901,366

138980111.2.6	*2.13.1*	*2.13.1.(A-E)*	*Provide an Intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population – 2.13.1: Health Navigation and Incentives for Dual Diagnosis Patients*	
University of North Texas Health Science Center (UNTHSC)				*138980111*
Related Category 3 Outcome Measure(s):	*138980111.3.32* *138980111.3.31*	*3.IT-1.9* *3.IT-10.1*	*Depression management: Depression Remission at Twelve Months (NQF #0710)* *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)**
			analysis relevant to the target population.) Metric 1 [P-7-.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: Participation in semi-annual meetings Data Source: Meeting agendas, slides from presentations, meeting notes Milestone 9- Estimated Incentive Payment *(maximum amount):* $559,749	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,507,833	Year 3 Estimated Milestone Bundle Amount: $2,616,215		Year 4 Estimated Milestone Bundle Amount: $2,798,741	Year 5 Estimated Milestone Bundle Amount: $2,704,098
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $10,626,887				

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program
Unique Project ID: 186221101.2.1
Performing Provider Name/TPI: Methodist Mansfield Medical Center / 186221101
Provider: Methodist Mansfield Medical Center is a 168-bed facility in southeast Tarrant County serving a 403 square mile area and a population of approximately 387,000. Methodist Mansfield Medical Center provides a full range of acute care services to broad range of patients with all types of injuries and diseases across the continuum of care. Other than transplants, all other medical specialties are represented at this facility. In the last year, nearly twenty-nine percent of Methodist Mansfield's patients were Medicaid eligible or uninsured representing $78 million in charges for those services.
Intervention: To provide patient navigation services in the ED to patients who are at high risk of disconnecting from institutionalized health care services or are identified as not having a primary care physician and/or medical home to address their needs. This project will identify frequent ED users and use navigators as part of a preventable ED reduction program. This project will connect patients to primary and preventive care and increase access to care management and/or chronic care management which should improve unnecessary ED utilization as well as the health condition of those most at risk for costly chronic conditions. This project is a new initiative because the hospital does not provide patient navigation services in the ED currently and has not received any other federal funding for it.
Need for the project: A major goal of the region is to reduce the unnecessary utilization in the Emergency Departments of the DFW hospitals. This project will contribute to that goal by providing patient navigation resources that would identify patients that are eligible to receive care in a more appropriate setting. This project will impact a specific portion of the population in the region as well as provide a knowledge base that could be applied to other regional hospitals.
Target population: The target population is frequent users of the emergency department, defined as six or more visits per year, estimated to be 7.3% of total ED visits, or 3,700 patients per year. Approximately 43% of our ED patients are either Medicaid eligible or uninsured so we expect about 43% of the patients helped by the program to be Medicaid eligible or uninsured.
Category 1 or 2 expected patient benefits: I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Improvement Target: Baseline will be established in DY3 which is expected to be 3,705 targeted patients identified as frequent users of ED services. The project seeks to refer at least 50% of this target population or 1,835 to a more appropriate primary care setting for follow up care in DY4 and 70% of the original baseline referred to primary care in DY5. I-8 Reduction in ED use by identified ED frequent users receiving navigation. Improvement Target: Baseline will be established in DY3 which is expected to be 1,835. The project seeks to realize a 2.5% reduction over baseline expected in DY4 and an additional improvement of 2.5% of the prior year in DY5.
Category 3 outcomes: IT-9.2 Appropriate ED Utilization. Improvement Target: Baseline will be established in DY3 which is expected to be 1,835. Decrease utilization of ED patients from baseline by 2.5% in DY4 and an additional reduction of 2.5% over prior year in DY5. IT-3.1 All cause 30 day readmission rate. Improvement Target: Baseline will be established in DY3 which is expected to be 252 readmissions. Decrease readmissions to the hospital from baseline targeted population by 2.5% in DY4 and an additional reduction of 2.5% over prior year in DY5. These improvement milestones and outcomes support the project's objective to reduce utilization of high cost

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program

Unique Project ID: 186221101.2.1
Performing Provider Name/TPI: Methodist Mansfield Medical Center / 186221101

Project Description:
This project will provide patient navigation services in the emergency department to targeted patients who are at high risk of disconnecting from institutionalized health care services or are identified as not having a primary care physician and/or medical home to address their needs. This project will identify frequent ED users and use navigators as part of a preventable ED reduction program. This project will increase the number of people trained and deployed for innovative health services such as social workers. This project will connect patients to primary and preventive care and increase access to care management and/or chronic care management. This project should improve the utilization of unnecessary ED utilization as well as improve the health condition of those most at risk for costly chronic conditions.

This project will apply to the following ZIP codes in the hospital service area that fall within Region 10: 76001, 76002, 76016, 76017, 76018, 76060 and 76063. Hospital and market data indicates that approximately 40% of ED outpatient visits and 30% of inpatients with diabetes are Medicaid and uninsured patients. In the northern portion of the hospital service area 31% of the population is Hispanic and represents the fastest growing population segment. Region 10 and Tarrant County data indicate that the 26% of non-elderly individuals who are without health insurance exceeds the nearly 19% nationally of non-elderly individuals are without health insurance. These rates increase for individuals with lower incomes. Minority and low-income individuals without insurance generally lack a regular source of medical care, and suffer from medical conditions that are either preventable or easily treated in the outpatient setting.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of this project is to utilize community health workers, case managers or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of care services. Patient Navigators will ensure that patients receive timely, coordinated and site appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the ED to site-appropriate locations. Implementing this project

will identify health care workers, case managers or other types of health professionals needed to engage with patients in a culturally and linguistically appropriate manner that will be essential to guiding the patients through the integrated health care delivery systems.

This project meets the following Regional goals:
A major goal of the Region is to reduce the unnecessary utilization in the Emergency Departments of the Region 10 hospitals. This project will contribute to that goal by providing patient navigation resources that would identify patients who are eligible to receive care in a more appropriate setting. This project will impact a specific portion of the population in the Region as well as provide a knowledge base that could be applied to other Regional hospitals.

Challenges:
Emergency Departments have become a vital source of care for those without insurance who generally lack a source of primary care, since they are required to evaluate and treat patients regardless of the ability to provide payment. Consequently, although care delivered through the ED is frequently for non-urgent problems, it is substantially more costly than care delivered in a more appropriate setting. Region 10 and Tarrant County data indicate that the 26% of non-elderly individuals who are without health insurance exceeds the nearly 19% nationally of non-elderly individuals are without health insurance. These rates increase for individuals with lower incomes. Minority and low-income individuals without insurance generally lack a regular source of medical care, and suffer from medical conditions that are either preventable or easily treated in the outpatient setting. Consequently, the uninsured are four times more likely than the insured to forgo or postpone needed preventive care. The ED has become a societal solution for those with chronic conditions and/or lacking access to primary care. The patient navigation project will be focused on overcoming these societal challenges. Additional challenges will include the acquisition of professional resources that have a background and training to provide social services and navigation care services, as well as overcoming the reliance on personal accountability of the patient to follow up with a provider in a more appropriate care setting.

5-Year Expected outcome for Provider and Patients:
The expected outcomes for the patient navigation project are to:

- Identify frequent ED users and use of navigators as part of preventable ED reduction program.
- Train- health care navigators in cultural competency.
- Deploy- innovative health care personnel such as case managers/workers, community health workers and other types of health professionals as patient navigators.
- Connect- patients to primary and preventive care.
- Increas- access to care management and/or chronic care management, including education in chronic disease self-management.
- Decreas- of inappropriate ED utilizations.

Starting Point/Baseline:
Currently the baseline is zero. During DY2 frequent ED users will be identified based on a needs assessment to identify the patient population for which the program will be targeted. Patient navigation and care management will be provided to these patients. DY3 will serve as the baseline period for the project. Based on the number of patients served by the project, the number of providers trained to support the program will be identified and implemented.

Rationale:
Emergency Department utilization in Region 10 exceeds national utilization rates resulting in higher costs for providing care to the Region. The Community Health Needs Assessment points to a lack of accessing primary care sites and the inability to redirect patients to a more appropriate care setting. The patient navigator project will provide resources to help patients and their families better locate and navigate appropriate care locations.

Project Components:
The following core project components were selected because each component is designed to provide and improve navigation services to targeted patients who are at high risk of disconnect from institutionalized health care:

- Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
- Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators
- Connect patients to primary and preventive care
- Increase access to care management and/or chronic care management, including education in chronic disease self-management
- Conduct quality improvement for project using methods such as rapid cycle improvement.

Our milestones measure the reduction in the number of patients who frequently use the ED; 1) we are increasing the number of patients identified as frequent users of the ED, 2) increasing the number of patient navigators available to provide services to those patients, and 3) increasing the number of patients referred to more appropriate care settings. As a result of these efforts, there will be a reduction in the number of ED visits by those enrolled in the program by 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Unique community need identification numbers the project addresses:

- CN.1
- CN.2

- CN.8
- CN.10
- CN.11
- CN.13

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative because the hospital does not provide patient navigation services in the ED currently and has not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/ Rationale for Selecting the Outcome Measures:
There are two Related Category 3 Outcome Measures for this project:

The first is Outcome Measure "Right Care, Right Setting" (OD-9) and IT-9.2 ED Utilization. Specifically there will be a reduction in all ED visits if the patient navigation program is effective. By identifying frequent users of the ED and providing navigation services, these patients will be exposed to alternative care locations that would be more effective for managing their non-urgent health conditions and health need. The IT-9.2 measures is the most appropriate indicator to assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost.

The second is Outcome Measure "Potentially Preventable Re-admissions – 30 Day Readmission Rates" and IT-3.1 All-cause 30-day readmission rate. The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the lack of chronic disease management and lack of access to appropriate sites of care. The patient navigator program will re-direct patients from the ED to a more appropriate care setting, where management of chronic conditions will be better suited. A reduction in frequent ED users and access to better care site for chronic conditions will lead to a reduction in readmission rates for those enrolled in the program.

Relationship to Other Projects:
This project will support, reinforce and enable the following Category 4, Reporting Domains through the project design and intervention for appropriate targeted patients:

RD-1(Preventable Admissions).1-CHF Admission Rate
RD-1(Preventable Admissions).2-Diabetes Admission Rate
RD-1(Preventable Admissions).4-COPD/Asthma Admission Rate
RD-1(Preventable Admissions).5-Hypertension Admission Rate
RD-2 (Preventable 30-day Readmissions).1-CHF Readmission Rate

RD-2 (Preventable 30-day Readmissions).2-Diabetes Readmission Rate
RD-2 (Preventable 30-day Readmissions).4-COPD/Asthma Readmission Rate
RD-2 (Preventable 30-day Readmissions).5-Hypertentsion Readmission Rate

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

This project will participate in the Region's learning collaborative activities. (See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.)

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Methodist Mansfield Medical Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

Methodist Mansfield Medical Center defined the population that will be patients who frequent the ED. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project

186221101.2.1	2.9.1	*2.9.1 A-E*	ESTABLISH A PATIENT CARE NAVIGATION PROGRAM	
Methodist Mansfield Medical Center				*186221101*
Related Category 3 Outcome Measure(s):	**186221101.3.1** **186221101.3.2**	*IT-9.2* *IT-3.1*	*ED Appropriate Utilization* *All-cause thirty day readmission*	
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]: 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 navigation education. Metric 1 [P-2.1]: Number of people trained as patient navigator Baseline = 0/Goal = 1 Data Source: Administrative Records Milestone 1 Estimated Incentive Payment *(maximum amount):* $223,074 **Milestone 2** [P-3]: Provide care management/ navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline = 0 /Goal: Start program to see first patient by 9/30/2013 Data Source: Administrative Records	**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 navigation education. Metric 1 [P-2.1] Number of people trained as patient navigator Baseline = 1/Goal = 2 Data Source: Administrative Records Milestone 3 Estimated Incentive Payment *(maximum amount):* $152,101 **Milestone 4** [P-3]: Provide care management/ navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline = 1 /Goal: 1,853 Data Source: Administrative Records Milestone 4 Estimated Incentive		**Milestone 5** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Metric 1 [I-6.3]: Percent of patients without a primary care provider who are referred to a primary care provider in the ED. Baseline/Goal: 1,853/50% Data Source: Administrative Records Milestone 5 Estimated Incentive Payment *(maximum amount):* $244,069 **Milestone 6** [I-8.1]: Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1 [I-8.1]: ED visits pre- and postnavigation services by individuals identified as ED frequent users Baseline/Goal: 1,853 / 2.5% Data Source: Administrative Records Milestone 6 Estimated Incentive Payment *(maximum amount):* $244,069	**Milestone 7** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services. Metric 1 [I-6.3]: Percent of patients without a primary care provider who are referred to a primary care provider in the ED. Baseline/Goal: 50%/70% Data Source: Administrative Records Milestone 10 Estimated Incentive Payment *(maximum amount):* $201,622 **Milestone 8** [I-8.1]: Reduction in ED use by identified ED frequent users receiving navigation services. Metric 1 [I-8.1] ED visits pre- and post-navigation services by individuals identified as ED frequent users Baseline/Goal: 2.5% / 2.5% Data Source: Administrative Records Milestone 8 Estimated Incentive Payment *(maximum amount):*

186221101.2.1	**2.9.1**	***2.9.1 A-E***	**ESTABLISH A PATIENT CARE NAVIGATION PROGRAM**	
Methodist Mansfield Medical Center				*186221101*
Related Category 3 Outcome Measure(s):	**186221101.3.1** **186221101.3.2**	*IT-9.2* *IT-3.1*	*ED Appropriate Utilization* *All-cause thirty day readmission*	
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 2 Estimated Incentive Payment *(maximum amount):* $223,074	Payment *(maximum amount):* $152,101 **Milestone 5** [P-8]: Participate in face to face learning at least twice a year with other providers in the RHP to promote collaboration learning <u>Metric 1</u> [P-8.1]: Participate in semi-annual face to face meetings organized by the RHP Baseline = 0 /Goal: 2 Data Source: Administrative Records Milestone 5 Estimated Incentive Payment *(maximum amount):* $152,101			$201,623
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $446,148	Year 3 Estimated Milestone Bundle Amount: $456,303		Year 4 Estimated Milestone Bundle Amount: $488,138	Year 5 Estimated Milestone Bundle Amount: $403,245
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,793,834				

Project Option 2.2.2 – Expand Chronic Care Management Models
Unique Project ID: 186221101.2.2
Performing Provider Name/TPI: Methodist Mansfield Medical Center / 186221101
Provider: Methodist Mansfield Medical Center is a 168-bed facility in southeast Tarrant County serving a 403 square mile area and a population of approximately 387,000. Methodist Mansfield Medical Center provides a full range of acute care services to broad range of patients with all types of injuries and diseases across the continuum of care. Other than transplants, all other medical specialties are represented at this facility. In the last year, nearly twenty-nine percent of Methodist Mansfield's patients were Medicaid eligible or uninsured representing $78 million in charges for those services.
Intervention: The primary purpose of this project is to develop and implement a chronic disease management intervention geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. This project is a new initiative because the hospital does not have standing orders for diabetes protocols, does not offer dedicated diabetes education on self-management and has not received any other federal funding for it.
Need for the project: Promoting effective change in provider settings to support evidence-based clinical and quality improvement across a wide variety of health care settings will make a significant improvement to the self-management of chronic conditions such as diabetes. CDC data indicates that almost half of all Americans, more than 145 million, live with a chronic condition. In the hospital market more than 10% of the population has been diagnosed with diabetes and the number is growing. More than half of individuals with a chronic condition have multiple conditions. **Target population:** The target population is our ED patients that have either a principal or secondary diagnosis of diabetes and need education on managing diabetes and have high risk needs associated with diabetes based on clinical protocols of HbA1c >9.0%, , at least one ED visit in the past 12 months and/or have not received diabetes education within the past five years. Our annual ED visits are approximately 45,000.Those diagnosed with diabetes as the primary or secondary diagnosis is 2,988. Approximately 29% of our patients are either Medicaid eligible or uninsured so we expect about 29% of the patients enrolled in the program to be Medicaid eligible or uninsured.
Category 1 or 2 expected patient benefits: I-17: Apply the chronic care model to targeted chronic diseases which are prevalent locally such as Diabetes. Of our target population, we expect 30% to be eligible or in need of diabetes care model. Our baseline is zero as this is a new program at the hospital.. In DY3 the goal is to begin providing care through the new program with 10 new patients receiving care under the chronic care management program by 9/30/14, increasing that number to 1000 in DY4 with an additional improvement of 5% over DY4 in DY5. I-18: Improve the percentage of diabetic inpatients with self-management goals. The baseline is zero as this is a new program at the hospital.. The project seeks to improve number of diabetic ED patients with self-management goals from 0 to 5% of the target population (those identified above as eligible for the chronic care management program), or 50 patients in DY4 and an additional 5% or 100 patients in DY5.
Category 3 outcomes: IT-1.11 Diabetes care: Blood pressure control (<140/80mm Hg). Improvement Target: While the baseline is zero as this is a new program at the hospital, it is expected that 25% of the 1000 eligible expected to be in the program or 250 patients will have controlled blood pressure.. Therefore, in DY4, the goal is to increase the number of target

patients in the program with controlled blood pressure by 1.5% and an additional improvement in DY5 of 1.5% over DY4.
IT-1.10 Diabetes care: HbA1c poor control (>9.0%). Improvement Target: While the baseline is zero as this is a new program at the hospital, it is expected that 65% of the target population or 650 patients will have uncontrolled A1c levels. Therefore, in DY4, the goal is to decrease the number of target patients in the program with uncontrolled A1c levels by 1.5% with an additional decrease of 1.5% over DY4 in DY5.
IT-3.3 Diabetes 30 day readmission rate. Improvement Target: The target population in DY4 for this program is expected to be 1000 patients. Historically the diabetes readmission rate is 6.8%. Therefore, we expect the diabetes 30-day readmission rate among this target population to be 6.8% or 68 patients. In DY4, the goal is to decrease diabetes 30-day readmissions to the hospital from this target population by 10% with an addional 10% reduction over DY4 in DY5.

Project Option 2.2.2 – Expand Chronic Care Management Models

Unique Project ID: 186221101.2.2
Performing Provider Name/TPI: Methodist Mansfield Medical Center / 186221101

Project Description:
This project will apply evidence-based care management models for ED patients identified as having high-risk health care needs associated with diabetes. The project will develop chronic disease management education, protocols and self-management criteria for patients through a multidisciplinary process. These protocols, once developed will be implemented in the hospital through new outpatient and inpatient education services, through the network of primary care physicians and made available to community clinics supporting diabetic patients. Historically, patients who do not effectively manage their diabetes tend to develop chronic diabetes complications, comorbidities and lead to higher utilization and costs related to health care services. This program will be implemented to help those who need education on managing diabetes and providing monitoring services where they are being treated. Patients will be identified by partnering with primary care physicians, community clinics and inpatient nurse/care managers. Patients identified as having high risk needs associated with diabetes will be based on clinical protocols of A1C>9, at least one ED visit in the past 12 months and/or have not received diabetes education within the past five years.

This project will apply to the following ZIP codes in the hospital service area that fall within Region 10: 76001, 76002, 76016, 76017, 76018, 76060 and 76063. Hospital and market data indicates that approximately 40% of ED outpatient visits and 30% of inpatients with diabetes are Medicaid and uninsured patients. In the northern portion of the hospital service area 31% of the population is Hispanic and represents the fastest growing population segment.

Goals and Relationship to Regional Goals:

Project Goals:
The goal of this project is to develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization. The purpose for implementing a chronic disease management program for diabetes is based on hospital and community data. Diabetes-related diagnoses account for the third highest patient segment for readmissions to the hospital. Diabetes management is also one of the top five community health needs with over 10% of the Tarrant county population having been diagnosed with diabetes. The development and implementation of chronic disease management interventions for diabetes will lower costs and improve outcomes for the diabetic patients and community health status.

This project meets the following Regional goals:
A major goal of the Region is to improve the rate of chronic disease self-management and education. This project will contribute to that goal by providing patient education resources based on clinical management protocols.

Challenges:
Hospital and market data indicates that approximately 40% of ED outpatient visits and 30% of inpatients with diabetes are Medicaid and uninsured patients. In the northern portion of the hospital service area 31% of the population is Hispanic and represents the fastest growing population segment. Hispanics are 1.5 times as likely to develop diabetes as non-Hispanic populations according to the CDC. Effective communication and creativity in reaching this community demographic has been identified as a challenge for this project. Additional challenges include the need to create a registry to track patients; we will be reliant on others responding to our requests for information as well as the patient's desire and ability to better manage their disease; and also the challenge of bringing a diverse independent medical staff together to develop this pathway.

5-Year Expected outcome for Provider and Patients:
The five year expected outcomes for the patient navigation project are to have:

- Formed multidisciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar
- Developed a comprehensive diabetes care management program
- Developed and implemented plan for standing orders for diabetes patients
- Trained staff in the Chronic Care Model, including essential components of a delivery system that supports high-quality clinical and chronic diabetes management, and on the standing orders for diabetes patients
- Developed and implemented OP Diabetes Education Clinic and IP Educator program to assist patients to better self-manage their chronic diabetes
- Improved number of patients with self-management goals
- Improved number of patients being treated under the Chronic Care Model and/or Standing Orders for Diabetes

Starting Point/Baseline:
Diabetes-related diagnoses account for the third highest patient segment for readmissions to the hospital. Diabetes management is also one of the top five community health needs with over 10% of the Tarrant county population having been diagnosed with diabetes. The hospital currently does not offer outpatient diabetes education clinic services or inpatient diabetes education; therefore, our current baseline is zero. During DY2 and DY3 as the chronic health management program and clinical protocols for standing orders are developed, the target

populations will begin to be identified. Historically, the ED has seen approximately 3,000 patients that also have a principal or secondary diagnosis of diabetes. We expect to target 30% of those with the program; 25% (or 250) are expected to have controlled blood pressure and 65% (or 650) uncontrolled A1c levels > 9.0%.

Rationale:

Promoting effective change in provider settings to support evidence-based clinical and quality improvement across a wide variety of health care settings will make a significant improvement to the self-management of chronic conditions such as diabetes. CDC data indicates that almost half of all Americans, more than 145 million, live with a chronic condition. In the hospital market more than 10% of the population has been diagnosed with diabetes and the number is growing. More than half of individuals with a chronic condition have multiple conditions. The challenge in the community due to the lack of proper self-management of chronic conditions is higher rates of illness, higher utilization of high cost services and lower quality of life.

Project Components:

The following core project components were selected because each component is designed to apply evidence-based care management model to patients identified as having high-risk health care needs related to diabetes:

- Formalize multidisciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model
- Develop a comprehensive care management program
- Develop and implement a plan for standing orders
- Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease management
- Develop and implement an OP Diabetes Education Service and Inpatient Educator Program to assist patients to better self-manage their chronic conditions
- Application of chronic care management model to diabetes
- Improve the percentage of patients with self-management goals

An integral part of this project is to provide patient education and self-management support. We will incorporate learnings from the hospital's current medical home and ACO initiatives to improve patient provider communication techniques and coordination with community resources.

We will conduct ongoing quality improvement efforts for the project. The hospital's quality committee of the board meets regularly to assess ongoing programs at the facility and will be used to evaluate the success and improvement opportunities of the chronic care management project as well.

Currently we use the Plan Do Check Act version of quality improvement for all of our programs at the hospital. We incorporate this process into any new program we do so that we embark with proper planning and have the systems in place to identify improvement opportunities throughout all stages of implementation.

Our process milestones measure the development of chronic care management program for diabetes, training and education of care givers in multiple care sites, development of standing orders for diabetic patients and the development of a new Outpatient Diabetes Education service and new Inpatient Educator program. The Improvement milestones measure the number of individuals who will be targeted for the education and self-management protocols, as well as the increased number of patients with self-management goals. The specific improvement targets for the number of patients provided services for education and the number of patients with self-management goals will be determined during DY2.

Unique community need identification numbers the project addresses:

- CN.13 –Necessity of patient education programs
- CN.15 –Need for more information to promote healthy lifestyles
- CN.11 –Need for more care coordination

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative because the hospital does not have standing orders for diabetes protocols, does not offer dedicated diabetes education on self-management and has not received any other federal funding for it.

Related Category 3 Outcome Measures:
IT-1.10 Diabetes Care: HbA1c poor control
IT-1.11 Diabetes Care: Blood Pressure control
IT-3.3 Diabetes 30-Day Readmission Rate

Outcome Measures and Reasons/ Rationale for Selecting the Outcome Measures:
There are three Related Category 3 Outcome Measures for this project. The first two fall within Outcome Measure "Primary Care and Chronic Disease Management" (OD-1). Specifically the two Improvement Targets are IT-1.10 (Diabetes Care: HbA1c poor control (>9.0%)) and IT-1.11 (Diabetes Control: Blood pressure control (<140/80mm Hg)). This project will identify patients in the ED who are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in

the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes.

The third Related Category 3 Outcome Measure falls within the Outcome Measure "Potentially Preventable Readmissions – 30-Day Readmission Rates" and IT-3.3 Diabetes 30-day readmission rate. This project will identify ED patients who have poor diabetes control and ultimately at high risk for readmission to the hospital. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market. Better preparing patients for self-management, education and ongoing support for diabetes care will ultimately lead to reduced diabetic readmissions from this target population.

Relationship to Other Projects:

This project will support, reinforce and enable the following Category 4, Reporting Domains through the project design and intervention for appropriate targeted patients:

RD-1(Preventable Admissions).2-Diabetes Admission Rate
RD-2 (Preventable 30-day Readmissions).2-Diabetes Readmission Rate
RD-4 (Patient-centered Health Care).2-Medication Management

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Methodist Mansfield Medical Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

Methodist Mansfield Medical Center defined the population that will be high risk diabetic patients. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project

186221101.2.2	***2.2.2***		***EXPAND CHRONIC CARE MANAGEMENT MODELS FOR DIABETES***	
Methodist Mansfield Medical Center				*186221101*
Related Category 3 Outcome Measure(s):	***186221101.3.3*** ***186221101.3.4*** ***186221101.3.5***	*IT-1.11* *IT-1.10* *IT-3.3*	*Diabetes Care: Blood Pressure control* *Diabetes Care: HbA1c poor control* *Diabetes 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-4]: Formalize multidisciplinary teams, pursuant to the chronic care model defined by Wagner Chronic Care Model. Metric 1 [P-4.1]: Increase the number of multidisciplinary teams Baseline/Goal: 0/1 Data Source: Provider Milestone 1 Estimated Incentive Payment *(maximum amount):* $90,769 **Milestone 2** [P-3]: Develop a comprehensive care management program Metric 1 [P-3.1]: Documentation of care management program Baseline/Goal: 0/care management document Data Source: Administrative records Milestone 2 Estimated Incentive Payment *(maximum amount):* $90,769	**Milestone 3** [P-12]: Develop and implement plan for standing orders Metric 1 [P-12.1]: Documentation of plan for standing orders Baseline/Goal:0/care management document Data Source: Administrative records Milestone 3 Estimated Incentive Payment *(maximum amount):* $61,890 **Milestone 4** [P-2]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care Metric 1 [P-2.1]: Increase percent of staff trained Baseline/Goal: 0%/5% Data Source: Administrative records Milestone 4 Estimated Incentive Payment *(maximum amount):* $61,891 **Milestone 5** [P-11]: Develop and implement program to assist patient to better self-manage their chronic conditions Metric 1 [P-11.1]: Increase the number of patients enrolled in a self-		**Milestone 6** [I-17]: Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally, such as diabetes Metric 1 [I-17.1]: Percent of diabetic ED patients receiving care under the Chronic Care model Baseline/Goal: 10 /1000 Data Source: Administrative records Milestone 6 Estimated Incentive Payment *(maximum amount):* $99,312 **Milestone 7** [I-18]: Improve the percentage of diabetic inpatients with self-management goals Metric 1 [I-18.1]: Diabetic ED patients with self-management goals Baseline/Goal: 0/50 Data Source: Administrative records Milestone 7 Estimated Incentive Payment *(maximum amount):* $99,312	**Milestone 8** [I-17]: Apply the Chronic Care Model to targeted chronic diseases which are prevalent locally, such as diabetes Metric 1 [I-17.1]: Percent of diabetic ED patients receiving care under the Chronic Care model Baseline/Goal: 1000 / increase of 5% over DY4 Data Source: Administrative records Milestone 8 Estimated Incentive Payment *(maximum amount):* $82,041 **Milestone 9** [I-18]: Improve the percentage of diabetic inpatients with self-management goals Metric 1 [I-18.1]: Diabetic ED patients with self-management goals Baseline/Goal: 50 / 100 Data Source: Administrative records Milestone 9 Estimated Incentive Payment *(maximum amount):* $82,040

186221101.2.2	***2.2.2***		***EXPAND CHRONIC CARE MANAGEMENT MODELS FOR DIABETES***	
Methodist Mansfield Medical Center				*186221101*
Related Category 3 Outcome Measure(s):	***186221101.3.3*** ***186221101.3.4*** ***186221101.3.5***	*IT-1.11* *IT-1.10* *IT-3.3*	*Diabetes Care: Blood Pressure control* *Diabetes Care: HbA1c poor control* *Diabetes 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)**
	management program Baseline/Goal: 0 / 10 by 9/30/2014 Data Source: Administrative records Milestone 5 Estimated Incentive Payment *(maximum amount):* $61,890			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $181,538	Year 3 Estimated Milestone Bundle Amount: $185,671		Year 4 Estimated Milestone Bundle Amount: $198,624	Year 5 Estimated Milestone Bundle Amount: $164,081
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $729,914				

Attachment 1

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.1.1 – Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards (WCCA PCMH).

Unique Project ID: 206106101.2.1 (Pass 2)
Performing Provider Name/TPI: Wise Clinical Care Associates/206106101

Provider: There are five providers working in three primary care clinics located in cities in Wise County… Bridgeport, Boyd, and Decatur. Patients come from a wide area which includes Wise, Montage, Jack, Parker, and portions of Tarrant County. The WCCA providers are one of the only providers in Wise County accepting Medicaid for primary care. Approximately 20% of the total patient base is Medicaid with some providers as high as 45% payor mix of Medicaid.
Intervention: Our project will involve changing the care delivery model of three primary care clinics within WCCA into patient centered medical homes. The intervention emphasizes adding personnel, training, and education. This is a new intervention to redesign our care model to focus on patient-centered care.
Need for the project: This project is designed to fulfill the community need, CN.11Need for more care coordination. The clinics will work in coordination with various hospitals, MHMR, and children's hospitals.
Collaboration: This project is a collaboration between Wise Regional Health System and Wise Clinical Care Associates, although WCCA will be the Performing Provider. Within the base of primary care physicians referring patients to Wise Regional Health System, none are currently following the patient centered medical home model. Since WCCA would be the first, this project is transformative. Other physicians will be looking to WCCA and watching its ability to be successful with this care model. It is also transformative in that it provides education to local physicians on PCMH. This is a collaborative project for a couple of reasons. First, the coordination of care will have to come from the clinic side as well as the physician side. The offices of WCCA will communicate with case management in Wise Regional Health System to make sure their patients have a medical home from which they can receive care. The second reason it is collaborative is because the valuation per patient empaneled in a PCMH is closely tied to savings on the inpatient side. Implemented correctly, much of the savings to the health system come from reduced ED use and admissions into the acute care setting. This result helps the hospital systems begin to respond to changes in reimbursement and care delivery.
Target population: All WCCA patients, with an emphasis on those with diabetes. We anticipate close to 6,000 patients to be served through the medical home model with over 72,000 visits over 5 years. The number of patients per year will be as follows DY1 4606, DY2 5527, DY3 5530, DY4 5546, and DY5 5559. This projection includes a 20% attrition rate and a conservative estimate of 935 new patients each year. The total number of unique patients served over the 5 years is estimated to be 8,330. This number is greater than the number above because it includes the patients who will be served but attrition out. The 6,000 number referenced about does not include the attrition patients.

Expected patient benefits: In Wise County there are a limited number of resources available for Medicaid and uninsured patients. As a Medicaid provider we can increase our capacity to through PCMH.

Category 1 or 2 expected patient benefits: The metrics and milestones chosen are sequential and logical steps to establish the project goal, hire appropriate support staff, operate as a medical home and gain recognition by NCQA.

Category 3 outcomes: The first Category 3 measure selected is IT-1.10 Diabetes care: HbA1c poor control, with the implementation of the Patient Centered Medical Home, registries will be developed to capture and track patients based on diagnoses of chronic conditions, namely diabetes. This measure will provide insight to the effectiveness of our plan. Secondly, IT-6.1 Percent improvement over baseline of patient satisfaction scores - (2) how well their doctors communicate, will be used as a measure to determine that the implementation of this project is in fact improving the providers' ability to effectively communicate through-out the patient care process and ultimately improving the patients' overall satisfaction.

Project Option 2.1.1 – Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards (WCCA PCMH).

Unique Project ID: 206106101.2.1 (Pass 2)
Performing Provider Name/TPI: Wise Clinical Care Associates/206106101

Project Description:
Our project will involve changing the care delivery model of three primary care clinics within Wise Clinical Care Associates (WCCA) into patient centered medical homes. WCCA is a non-profit healthcare organization. It has an all physician board of four members. The intervention chosen will emphasize the training and education that is essential to make the necessary changes towards patient centered care. We will focus these efforts on care coordination and supporting our primary care physicians in health accountability for our target population. We will hire or put in place at least two additional staff members and restructure existing staff members to accommodate a more coordinated model. Team members will not only each have a responsibility in managing the care of each patient, they will also use existing technology to help in this process. WCCA uses eClinical Works as its EMR. We will use the chronic disease management capabilities of this technology. Specifically, we will utilize our diabetes registry more fully through this process. We will have a person responsible for the administrative requirements of PCMH and one person responsible for the clinical requirements of PCMH. Our focus will be on diabetes care, but we will provide coordinated care to all empaneled patients. Staff members will be trained in the NCQA PCMH requirements and additional emphasis will be given to diabetes and patient satisfaction. We will make the necessary changes to adopt the requirements needed to operate as a PCMH and, by the end of the Waiver period, attain accreditation as a PCMH by NCQA. We will measure and improve HbA1c poor control and patient satisfaction by the end of the Waiver. We will also review weekly data to see how new ideas, solutions, practices, or tools can be implemented to achieve goals of the project. The number of patients impacted per year will be as follows DY1 4606, DY2 5527, DY3 5530, DY4 5546, and DY5 5559. This projection includes a 20% attrition rate and a conservative estimate of 935 new patients each year. The total number of unique patients served over the 5 years is estimated to be 8,330. This number is greater than the number above because it includes the patients who will be served but attrition out. The 6,000 number referenced about does not include the attrition patients.

Goals and Relationship to Regional Goals:

Project Goals:
The project goals are to reorganize our primary care clinics into care teams to support a more proactive care model to our patients. Our goal of implementing the medical home model is for all stakeholders in this care model to enjoy the proven outcomes which similar models have achieved across the country. We expect to increase quality, patient satisfaction, and reduce overall health related costs by coordinating care with and around our patients. Our goal is to train our staff on the primary care model and gain recognition as a PCMH through NCQA.

This project meets the following regional goals:
This project addresses a common gap found throughout the region, lack of care coordination. Our regional goals are to strive for the triple aim of healthcare and the PCMH model has shown to be one of the most effective ways of reducing costs, improving quality, and increasing patient satisfaction.

Challenges:
Our primary care providers feel they are unable to make a difference in patient driven measures, such as HbA1ccontrol, with the current delivery model. By adopting the PCMH model, they will have support from other team members who can provide support in the health accountability of patients. Besides reorganizing our current staff into care teams who work at the top of their licenses, we will need to hire or put into place at least two additional staff members to implement the PCMH model. We will provide training to leadership and clinical support personnel on the patient centered medical home model and patient satisfaction. This additional support staff will provide a greater amount of health education for our patients.

5-Year Expected outcome for Provider and Patients:
The 5-year expected outcome is that we would reduce the percent of patients with poor HbA1c control from the current 35.94% to below 20%. We hope to increase the current percentage of diabetic patients listed in our diabetes registry from our current 32% to 75%. We will also have an increase in our overall patient satisfaction scores over baseline, specifically the perception of how well our doctors communicate.

Starting Point/Baseline:
We currently have two primary care physicians, two part time nurse practitioners, one full time nurse practitioner, three medical assistants, and three office support staff working in three locations spread 14 miles apart. From August 31, 2011 to September 30, 2012, the five providers had encounters from 4,606 patients. This number will serve as the target number of patients for empanelment in DY3. In DY4 we expect to lose 20% of those empaneled patients to attrition, but we expect to gain approximately 935 patients each year following. This would put the number of empaneled patients at 4,620 in DY4 and 4,631 in DY5. Also from August 31, 2011 to September 30, 2012 for the same patient population, we had 32% of diabetic patients registered in the registry. We wish to increase this number to 75% while at the same time reducing the number of patients poor HbA1c (>9) control from 35.94% to below 20%. We also measure patient satisfaction, including how well the provider communicates with patients, through patient satisfaction surveys. Our current frequency is too low to provide statistical relevancy. While measuring our patient satisfaction we will also increase our utilization rates for our survey.

Rationale:
The PCMH model has been one of the changes to the delivery system of care that has shown multiple and consistent results for improvement. The care delivery system in Wise County is still fractured and silo'ed. It has been the desire of Wise Clinical Care Associates to provide the best quality care to the residents of Wise County, and this means coordinated care. As a new delivery mode, this project option was chosen for PCMH implementation because of the need for education to local providers as well as the physicians implementing PCMH.

Project Components:
We will do all core project components for this project. We believe it not only benefits our own organization but also the physicians in our area to provide education and awareness of the medical home model. Our core components will be met in the following ways:

a) Utilize a gap analysis to assess and/or measure hospital-affiliated and/or PCPs' NCQA PCMH readiness. –NCQA offers a Gap Analysis tool. This toll will be used throughout the PCMH readiness process in not only DY1, but also while getting ready to gain accreditation. The tool is a question and answer set of questions on our readiness.
b) Conduct feasibility studies to determine necessary steps to achieve NCQA PCMH status. – The Gap Analysis tool will be used to see what questions were answered with a "no". This assessment will be used to determine the feasibility of achieving the additional requirements for NCQA PCMH accreditation.
c) Conduct educational sessions for primary care physician practice offices, hospital boards of directors, medical staff and senior leadership on the elements of PCMH, its rationale and vision. – The Board meetings for WCCA will include ongoing education for PCMH. We will also provide education for the hospital Board, and opportunities to local physicians. These sessions will be documented.
d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. – Our clinical PCMH coordinator, our administrative analyst, the clinic operations manager, and our physicians will conduct regular meetings in identifying lessons learned and key challenges during implementation and in the years following. The lessons learned and the findings will be documented.

The metrics and milestones chosen and the years of implementation in the plan are sequential and logical steps to operate as a medical home and gain recognition by NCQA. The process milestones are more focused on preparation and education for the staff, which includes 2 physicians, 3 nurse practitioners and 12 staff members, involved in nursing and front office responsibilities, in DY2 and DY3. The milestone of implementing the PCMH model in DY3 is

aggressive in the timeline of change adoption, but is feasible with prior education and training. In DY2 and 3 two additional staff members will be hired, one will be responsible for the administrative requirements of PCMH and the other responsible for the clinical requirements of PCMH. Two improvement milestones were chosen to reflect the desire to increase new patient adoption into the medical home and gain recognition as a PCMH.

Unique community need identification numbers the project addresses:
CN.11 Need for more care coordination.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

Outcome Measures and Reasons/rationale for selecting the outcome measures:

Outcome Measure #1: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059
Several outcomes could have been chosen for the PCMH model. Hospital admissions, readmissions, and ED use have all shown to have been lowered through adoption of the PCMH model. We chose diabetes care for two reasons.

1) Diabetes is an important disease to try to affect for both the region and Wise County because of its cost to the healthcare system and its projected increase in prevalence. Wise County CHNA has shown that approximately 9% of residents have diabetes. The PCMH model has shown a reduction in the HbA1c poor control by bringing awareness and education to the patients. (Grundy, Paul; Grumback, Kevin, Outcomes of Implementing Patient Centered Medical Homes:A Review of the Evidence from Prospective Evaluation Studies in the United States.UpdatedNovember 2010.) Available at "www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf". Another example of the effect on HbA1c levels in patients of PCMH of a similar size to the population we propose was shown by Westminster Medical Clinic ."From Jan. 31, 2010 to Jan. 31, 2011, the percentage of active patients whose most recent HbA1c level was over 9 dropped from 27 percent to 14 percent." Available at "http://www.setma.com/InTheNews/diabetes_guide_2011.pdf"
2) We wanted to use an outcome that is directly tied to the population in which the care is provided. This data comes from clinic EMR and is descriptive of the patients who will receive care from the PCMH.

Outcome Measure #2: IT-6.1 Percent improvement over baseline of patient satisfaction scores - (2) how well their doctors communicate; (**Standalone measure**)

Communication will be emphasized throughout the process of changing to the PCMH. This measure was chosen to track and evaluate physician communication from the patients' perspectives. More team members will be having health related conversations with patients. We want to be sure the patients maintain a positive perception of the amount of communication they are receiving from their physicians. We use a company called Survey Vitals to deliver the CG-CAHPS approved survey. We will need to assess our survey to make sure it is meeting NCQA standards for PCMH as well. Several areas are measured through the survey, but we chose this measure in particular because it reflects an area that is important to our physicians and patients. An example of where the PCMH implementation has shown an increase in patient satisfaction, and in particular the quality of interaction between physician and patients, was exhibited by Group Health Cooperative in Seattle, WA when they piloted the PCMH model. "http://www.pcpcc.net/files/benefits_of_implementing_the_primary_care_pcmh.pdf"

Relationship to Other Projects:

2.12.1 Expand Care Transitions Programs

Care transition is dependent upon care after inpatient stays. Likewise, care coordination through a PCMH will rely on communication from local hospitals. Both have shown a reduction on admissions and readmissions. Although both are unique, both projects benefit through increased communication between patient, clinic, and hospital.

The PCMH model has a wide impact since all patients associated with category 4 measures are in contact with primary care. This project will have the greatest impact on the following domains: RD-1.2, RD-1.8, RD-2.2, RD-2.7, RD-4.1, and RD-4.2

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

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Instead of valuing each outcome for our PCMH individually, we used our RHP 10 method of providing a value per empaneled patient at the end of the waiver and multiplying that times 5 years to reflect the value of the project as a whole. We used values determined by Baylor Health System of $2,366 in savings for empaneled patients in their first year and $1,186 per patient in subsequent years. We assumed a 20% attrition rate. We also added 935 patients per year based on historical numbers. Using this valuation model we counted 4606 new empaneled patients in

the first year for a year one value of $10,897,796. The second year had 3,685 existing patients and 935 new patients for a second year value of $6,582,382. Third year used 3,696 existing patients and 935 new patients for a value of $6,595,476. Fourth year has 3,705 existing patients and 935 new patients for a value of $6,605,951. The fifth year assumes 3,712 existing patients and 935 new patients for a value of $6,614,331. The total value of this project based on this valuation model is $37,295,937. Although using this method gave us the value for this project, we are only able to get funding valuation of $20,235,621 to apply across categories 1, 2, 3, and 4. We get this by combining the DSRIP allocation of $16,428,516 from WCCA and $3,897,105 from WRHS.

We took our overall value for project 2.1.1 and applied it proportionately across all categories with weighting per year reflecting the weighting change each category. We then allocated the amount for Category 1 for each DY equally on attainment of metrics.

206106101.2.1	2.1.1	2.1.1A 2.1.1B 2.1.1C 2.1.1D	ENHANCE/EXPAND MEDICAL HOMES-DEVELOP, IMPLEMENT, AND EVALUATE, ACTION PLANS TO ENHANCE/ELIMINATE GAPS IN THE DEVELOPMENT OF VARIOUS ASPECTS OF PCMH STANDARDS.
Wise Clinical Care Associates			206106101
Related Category 3 Outcome Measure(s):	206106101.3.1 206106101.3.2	IT-1.10 IT-6.1	Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 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-9]: Train medical home personnel on PCMH change concepts. Metric 1 [P-9.1]: Number of medical home personnel trained Baseline/Goal: 100% of staff currently 5 providers and 12 staff members, to have PCMH initial training by 9/30/2013 Data Source: HR Records Milestone 1 Estimated Incentive Payment: $1,425,857 **Milestone 2** [P-5]: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Empanelment should be based on the following principles: Assign all patients to a provider panel and confirm assignments with providers and patients; review and update panel assignments on a regular basis; Assess practice supply and demand, and balance patient load accordingly; Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need. Metric 1 [P-5.1]: Determine Panel size	**Milestone 4** [P-4]: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members. Metric 1 [P-4.1]: Expanded Primary care team member roles; Baseline/Goal: Define roles for every member, currently 5 providers and 12 staff members Data Source: Job Description Documentation Metric 2 [P-4.2]: Schedule of training and educational opportunities for providers and staff on expanded roles Baseline/Goal: Build on training provided in DY2 Data Source: HR Documentation, New Job Descriptions Milestone 4 Estimated Incentive Payment: $1,487,659 **Milestone 5** [P-11]: Identify current utilization rates of preventive services and implement a system to improve rates among targeted population (must	**Milestone 7** [I-13]: New patients assigned to medical homes receive their first appointment in a timely manner Metric 1 [I-13.1]: Improve number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120days Goal: 70% Data Source: eClinical Works, Documentation of PCMH Assignment Milestone 7 Estimated Incentive Payment: $2,391,104 **Milestone 8** [P-13]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. Metric 1 [P-13.1]: Number of new ideas, practices, tools, or solutions tested by each provider. Baseline/Goal: Ideas shared by staff each quarter Data Source: Brief description of the idea, practice, tool or solution tested by each provider. Milestone 8 Estimated Incentive Payment: $2,391,105	**Milestone 9** [I-13]: New patients assigned to medical homes receive their first appointment in a timely manner Metric 1 [I-13.1]: Improve number or percent of new patients assigned to medical homes that are contacted for their first patient visit within 60-120days Goal: 85% Data Source: eClinical Works, Documentation of PCMH Assignment Milestone 9 Estimated Incentive Payment: $1,540,164 **Milestone 10** [I-18]: Obtain medical home recognition by a nationally recognized agency (e.g., NCQA, URAC, AAAHC, etc.). The level of medical home recognition will depend on the practice baseline and accrediting agency. Metric 1 [I-18.1]:Medical home recognition/accreditation Goal: Attain PCMH NCQA Accreditation. Level TBD Data Source: Documentation from NCQA

206106101.2.1	***2.1.1***	***2.1.1A*** ***2.1.1B*** ***2.1.1C*** ***2.1.1D***	***ENHANCE/EXPAND MEDICAL HOMES-DEVELOP, IMPLEMENT, AND EVALUATE, ACTION PLANS TO ENHANCE/ELIMINATE GAPS IN THE DEVELOPMENT OF VARIOUS ASPECTS OF PCMH STANDARDS.***
Wise Clinical Care Associates			*206106101*
Related Category 3 Outcome Measure(s):	*206106101.3.1* *206106101.3.2*	*IT-1.10* *IT-6.1*	Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 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)**
Baseline/Goal: Panel Size Determined Data Source: Documentation, EMR Milestone 2 Estimated Incentive Payment*:* $1,425,857 **Milestone 3** [P-6]: Establish criteria for medical home assignment Metric 1 [P-6.1]: Medical home assignment criteria Baseline/Goal: Criteria Determined and Documented Data Source: Documentation, EMR Milestone 3 Estimated Incentive Payment*:* $1,425,858	select at least one metric): Metric 1 [P-11.1]: Implement a patient registry that captures preventive services utilization. Baseline/Goal: Baseline based on DY1 was 41.47% of diabetic patients in registry. Goal for DY3 will be 50% Data Source: EMR Registry Reports Milestone 5 Estimated Incentive Payment*:* $1,487,659 **Milestone 6** [P-1]: Implement the medical home model in primary care clinics Metric 1 [P-1.1]: Increase number of primary care clinics using medical home model Baseline/Goal: Increase from 0 to 2 Data Source: Records showing progress on PCMH adoption Milestone 6 Estimated Incentive Payment: $1,487,661		Milestone 10 Estimated Incentive Payment: $1,540,164 **Milestone 11** [P-13]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. Metric 1 [P-13.1]: Number of new ideas, practices, tools, or solutions tested by each provider. Baseline/Goal: Ideas shared by staff each quarter Data Source: Brief description of the idea, practice, tool or solution tested by each provider. Milestone 11 Estimated Incentive Payment: $1,540,164
Year 2 Estimated Milestone Bundle Amount: $4,277,572	Year 3 Estimated Milestone Bundle Amount: $4,462,979	Year 4 Estimated Milestone Bundle Amount: $4,782,209	Year 5 Estimated Milestone Bundle Amount: $4,620,492

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$18,143,252

Project Summary Template to be completed for each Category 1 and 2 project

Project Option 2.4.1 – Implement processes to measure and improve patient experience – becoming a facility with the culture of always

Unique Project ID: 216719901.2.1 (Pass 2)
Performing Provider Name/TPI: Glen Rose Medical Center/216719901

Provider: GRMC is a rural 16 bed hospital in Glen Rose, Texas serving a population of 7584 in 2011 with a 23% growth in Seniors (65 and over). GRMC is the county hospital in Somervell County for all indigent care as well as being the only facility in Somervell County.
Intervention: To improve patient satisfaction, quality of care and reduce cost by increasing our HCAHPS scores. This is a new initiative.
Need for the project: Improving patient satisfaction has shown patients become more engaged and make healthier lifestyle choices.
Target population: All patients of GRMC (community residents). Estimated number of patients to be served over course of waiver period: 1800.
Category 1 or 2 expected patient benefits: An improvement of HCAHPS scores "Stay at home healthcare" Satisfaction will spread in the community, but the scores will be of benefit to publish "our story". Example: This is what your neighbors have to say about your hometown hospital. Each milestone chosen will lead us along the path to a total hospital personnel buy in of a "culture of always."
Category 3 outcomes: Percent improvement over baseline of patient satisfaction. This outcome should result in improved health outcome of patients and reduced cost.

Project Option 2.4.1 – Implement processes to measure and improve patient experience – becoming a facility with the culture of always

Unique Project ID: 216719901.2.1 (Pass 2)
Performing Provider Name/TPI: Glen Rose Medical Center/216719901

Project Description:
We propose gathering baseline HCAHPS scores and improving them with the realization that improving our scores will improve quality and clinical outcomes. Glen Rose Medical Center will, once the baseline is assessed, develop a process to incorporate patient satisfaction into every employee's everyday function. We propose to increase patient experience by 25% in the areas where patients are unsatisfied by becoming a facility where the culture of always is an everyday affair.

Goals and Relationship to Regional Goals:

Project Goals:
Focusing on what patients want in their care is the cornerstone of improving clinical outcomes, compliance and quality. Satisfied patients are more inclined to listen and follow any education provided to them during their hospitalization. Systems that have done this have seen a reduction in malpractice risk and improvements in market share as well as physician satisfaction. By using the HCAHPS scores we can locate our weaknesses and create processes to improve those areas, thus making our patients feel taken care of and cared about.

This project meets the following regional goals:
The main goal of the region is the triple aim of improving patient experiences, reducing the cost and improving the health of our patients. Improving our patients' experience will impact the health of our patients and keep them involved in their health care.

Challenges:
Currently our HCAHPS scores are the lowest they have been in two years. An organizational improvement must be made to ensure satisfied patients. HCAHPS is an apples-to-apples comparison, and the results are tied to quality and clinical outcomes. Since quality of care is what all health care organizations strive for and will ultimately be what they are judged on when value-based purchasing begins in 2013, an improvement in our scores is a win for all. An improvement of HCAHPS will help drive our facility to a culture of always where quality care is not an exception but the norm.

5-Year Expected Outcome for Provider and Patients:

At the end of the five-year period, GRMC will increase our HCAHPS scores by 25% overall and will display our organization's performance both internally and externally.

Starting Point/Baseline:
GRMC is a small, 16-bed rural hospital that averages 1,000 acute care patients, 765 surgeries, 1,285 outpatient scopes, and 7,000 ER visits in a year, as well as thousands of patients receiving outpatient MRIs, X-rays, lab testing and physical and occupational therapy. Being a small hospital, all employees are critical to our patients' impression of our facility. All staff has the power to encourage greater patient care, which will ultimately lead to improved health outcomes and a better experience for our patients. GRMC will establish its baseline in DY2.

Rationale:
This project addresses the need to improve patient experience, thereby improving health and lowering cost.

Project Components:
By being a small facility, all employees and patients are critical. With a lower patientvolume, even a small number of unsatisfied patients impact HCAHPS scores greatly. The New England Journal of Medicine found that quality of care was significantly better in hospitals that performed better on HCAHPS. The data also supports that the patient experience is linked to great clinical care, reduced medical error and the advanced performance outcomes.[321] Currently, a few of our poor HCAHPS scores are "nurse listens carefully to you" – 77%, "staff describes side effect" – 47%, as well as "area around room quiet at night" – 68%. We struggle with these results and realize that we must hardwire the culture of always into our management and employees.
When patients feel cared for and cared about they are more apt to listen to the caregivers' instructions and guidelines, and follow the plan that will enable them to stay healthier and live better while decreasing the cost of inappropriate admissions/readmissions. We currently use Press Ganey as our survey vendor, so the core component D has already been established.
We will use all core components:
a) Organizational integration and prioritization of patient experience
b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience
c) Implementing processes to improve patients' experience in getting through to the clinical practice
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

[321] Strosahl and Sobel 1996

We have gathered HCAHPS scores for a number of years, and have continually struggled with the scores but have never taken a systematic, hospital wide approach. Some departments realize the importance more than others but by appointing one executive to drive the process we will create a cultural change which will give ALL employees the ability to make a difference in our patients lives. With the selected milestones and metrics, we will integrate the patient experience into each employee and managers training allowing it to become hardwired into the entire employee population, and not just in a few areas. The entire organization must walk the walk to achieve lasting impact and improved satisfaction, lower costs, and better patient health. This cannot be just a management concern, but must be a concern of all GRMC employees.

Unique community need identification numbers the project addresses:

CN. 11- Need for more care coordination

CN. 13- Necessity of patient education programs

CN. 15- Need for more education, resources and promotion of healthy lifestyles

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

This project is a new initiative and we have not received any other federal funding for it.

Related Category 3 Outcome Measures:

a) **Outcome Measure #1:** IT-6.1 Percent improvement over baseline of patient satisfaction cores

Outcome Measures and Reasons/Rationale for Selecting the Outcome Measures:

"Analyzing patient safety measures can alert hospitals to communication breakdowns that lead to lapses in care.322 Increasing patient satisfaction can thus significantly impact the quality of care and patient safety."[323] The New England Journal of Medicine article on patients' perception of hospital care in the United States found that patients' satisfaction with care was associated with the quality of clinical care in the hospitals. With this in mind, we plan to increase our HCAHPS scores by 25%.

Relationship to Other Projects:

This project is directly related to our Category 1 project (216719901.1.1) Expand Primary Care Capacity) of increasing primary care clinic hours. With the expansion of clinic hours we will be able to have a follow-up appointment already scheduled, which will ensure our patients leave satisfied and in control of their care.

This project is related to Patient-centered health care, patient satisfaction (216719901.4.1)

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

[322] Koyanagi 2004
[323] HCUP

(See Appendix G for a discussion of the Region's two proposed learning collaboratives along with a list of participating provider projects for each.) Though this project does not fit into the two learning collaboratives, over time the Region anticipates time the region anticipates that new learning collaboratives may develop as a result of providers' desire to share their experiences and learn from other DSRIP projects.

Project Valuation:

Glen Rose Medical Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Glen Rose Medical Center defined the population that will be directly impacted by the project as all patients seen within our facility, whether inpatient or outpatient. The percentage of the population expected to be positively impacted by the project is 25%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when people are positively impacted, their inclination is to listen more intently to instructions and education given to them, leading them to practice healthier habits and lifestyles which in turn decreases sick days and decreases cost of care.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person is positively impacted, the burden on society is lessened through healthier habits and lifestyles. The ability to serve as role models to children and/or coworkers is increased.

216719901.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	Implement processes to measure and improve patient experience.
Glen Rose Medical Center			*216719901*
Related Category 3 Outcome Measure(s):	*216719901.3.2*	*IT –6.1*	*Patient Satisfaction – 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]: Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance Metric 1 [P-1.1]: Documentation of an executive assigned responsibility experience performance Baseline/Goal: 1 executive accountable Data Source: Org chart or job description Milestone 1 Estimated Incentive Payment *(maximum amount):* $10,520 **Milestone 2** [P-7]: Assess the organizational baseline for measuring patient/family and/or employee experience and utilizing results in quality improvement Metric 1 [P-7.1]: Submission of an assessment that includes answering questions such as: What are as of the organization have regular measures (e.g., inpatient vs. clinics vs. EDs); What methods are used to obtain experience data (e.g., mailed surveys vs. phone); What are the scores/findings for the organization as a whole; What are the scores/findings	**Milestone 3**[P-4]: Integrate patient experience into employee training Metric 1[P-4.1]**:** Percent of new employees who received patient experience training as part of their new employee orientation Baseline/Goal: Goal 100% of employees hired between 10/1/13 to 9/30/14 Data Source: New Hire packet Milestone 3 Estimated Incentive Payment: $ 11,517 **Milestone 4**[P-5]: Integrate patient and/or employee experience into management performance measures. Metric 1[P-5.1]: Documentation of specific patient and/or employee experience objectives into management work plan and measures of performance, such as internal quality controls or performance dashboard. Goal: 100% management reviews Data Source: Employee review form Milestone 4 Estimated Incentive Payment: $11,517 **Milestone 5**[P-6]: Include specific	**Milestone 6**[I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families Metric 1[I-16.1]: Number of organization-wide displays (can be physical or virtual about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work Goal: 2 a year Data Source: Display board Milestone 6 Estimated Incentive Payment: $18,511 **Milestone 7**[I-19]: Make patient and/or employee experience data available externally (e.g., via a dashboard on the external website) and provide updates to the general public on the efforts the organization	**Milestone 8**[I-18]: Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families Metric 1[I-16.1]: Number of organization-wide displays (can be physical or virtual about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work Goal: 4 a year Data Source: Display board Milestone 8 Estimated Incentive Payment: $15,860 **Milestone 9**[I-19]: Make patient and/or employee experience data available externally (e.g., via a dashboard on the external website) and provide updates to the general public on the efforts the organization is undertaking to improve the

216719901.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	Implement processes to measure and improve patient experience.
Glen Rose Medical Center			*216719901*
Related Category 3 Outcome Measure(s):	*216719901.3.2*	*IT –6.1*	*Patient Satisfaction – 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)**
by service line, location, and patient demographics?; What are the response rates by service line, location, and patient demographics?; and/or How are data stored, analyzed, fed back to the sharp end and used in quality improvement? Baseline/Goal: Develop Baseline Data Source: Survey's Milestone 2 Estimated Incentive Payment: $10,519 **Milestone 3** [P-8]: Develop new methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data Metric 1 [P-8.1]: This will vary from Performing Provider to Performing Provider, based on the gaps identified in the assessment (previous bullet) and the assignment of improvement priorities by organization's leaders. Examples include: Develop a new patient experience survey tool or revise and improve the current ones; Translate and/or simplify written surveys to make them more user-friendly to LEP and low-literacy populations; Implement phone	patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them. Metric 1 [P-1]: % employees who have specific patient and/or employee experience objectives in their job description and/or work plan Goal: 100% of job descriptions will have pt and/or employee specific objectives listed Data Source: Job descriptions Milestone 5 Estimated Incentive Payment: $11,517	is undertaking to improve the experience of its patients and their families Metric 1[I-19.1]: Number of external communications aimed at the general public's understanding of the organization's results and improvement efforts in the area of patient and/or employee experience. Goal: One a year Data Source: External Website Milestone 7 Estimated Incentive Payment: $18,511	experience of its patients and their families Metric 1[I-19.1]: Number of external communications aimed at the general public's understanding of the organization's results and improvement efforts in the area of patient and/or employee experience. Goal: Quarterly Data Source: External Website Milestone 9 Estimated Incentive Payment: $15,860

216719901.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	Implement processes to measure and improve patient experience.
Glen Rose Medical Center			*216719901*
Related Category 3 Outcome Measure(s):	*216719901.3.2*	*IT –6.1*	*Patient Satisfaction – 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)**
surveys and/or focus groups as alternative methodologies to written surveys; Conduct care experience flow mapping;110 implement a survey of employee experience111; Roll out a pilot of real-time electronic methodology for capturing patients' feedback during the process of care;112 and/or implement another innovative method for obtaining patient and/or employee experience information a. Documentation of inquiry materials b. Data Source: Depends upon methodology selected c. Rationale/Evidence: Written mail-in surveys are most commonly used in obtaining patient experience information, yet this methodology often yields small numbers of responses given the socio-economic circumstances of certain patient populations. Therefore, it is important to test other methodologies that may be more applicable and convenient for the Performing Provider's patient populations. Baseline/Goal: Old Survey tool is baseline and new Goal to completely redo survey tool or revise as indicated by the assessment.			

216719901.2.1	***2.4.1***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	Implement processes to measure and improve patient experience.	
Glen Rose Medical Center				*216719901*
Related Category 3 Outcome Measure(s):	*216719901.3.2*	*IT –6.1*	*Patient Satisfaction – 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)**
Data Source: New or Revised survey tool Milestone 3 Estimated Incentive Payment: $10,519				
Year 2 Estimated Milestone Bundle Amount: ***(add incentive payments amounts from each milestone):*** **$31,558**	**Year 3 Estimated Milestone Bundle Amount: $34,552**		**Year 4 Estimated Milestone Bundle Amount: $37,022**	**Year 5 Estimated Milestone Bundle Amount: $31,720**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $134,852				

Category 3: Quality Improvement

Title of Outcome Measure (Improvement Target): IT-6.1- Percent Improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 020950401.3.1
Performing Provider Name/TPI: Medical Center of Arlington / 020950401

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
In DY2 we will establish baseline data to measure for patient satisfaction scores. The target for the outcome measure is 10% improvement in scores over baseline in DY4 and 20% in DY5. In DY2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary to develop and test data systems for establishing an internal measurement of patient satisfaction for timely feedback on improvement plans and corrective actions. In DY3, we will disseminate findings, including lessons learned and best practices, to stakeholders.

Rationale:
The process milestone to establish the baseline rate is necessary to understand the starting point of patient satisfaction scores. The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

The target for the outcome measure is to increase patient satisfaction scores by 20% by the end of the Waiver period. We have implemented some initiatives improve scores however this has not moved score significantly in the last year. We believe a renewed focus is necessary to make significant improvement

In DY2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders (IP /OP, out of hospital providers, etc.) are identified and included in the plan. Identifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan are a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY2 to develop and test data systems for timely measurement of patient satisfaction in order to correctly measure improvement targets. CMS published HCAHPS score are not expedited very timely so the process milestone to develop and test internal

measurements is necessary to have timely feedback for correcting actions for the patients' experience improvement planning.

In DY3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Medical Center of Arlington has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Medical Center of Arlington defined the population that will be directly impacted by the project as patients with Medicare and all patients who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 4 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The rate per Medicare case of $10,661 was used to calculate the estimated loss of revenues using these penalty % for DY 2- 0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.05% . This totaled $1,236,300.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $ 532,000. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $ 539,000.

The total value of the project was calculated at $2,307,724. Approximately 79% of the project value was assigned to the Category 2 project, $1,824,718 and 21% to the Category 3 project, $483,010.

We did not value the process milestones and outcome targets differently in Category 3 as we believe they are all equally important to overall success of the project.

020950401.3.1	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*	
Medical Center of Arlington			*020950401*
Related Category 1 or 2 Projects::	*020950401.2.1*		
Starting Point/Baseline:	*2010Q4-2011Q3 HCAHPS 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)**
Process Milestone 1 [P- 1]: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: submission of plan Goal: Plan Data Source: Patient Satisfaction Improvement Plan Process Milestone 1 Estimated Incentive Payment: $26,696 **Process Milestone 2** [P- 3]: Develop and test data systems Metric 1: Complete testing systems and development of survey Goal: Establish measurement tool from data systems Data Source: Survey tool Process Milestone 2 Estimated Incentive Payment: $26,696	**Process Milestone 3** [P- 5]: Disseminate findings (i.e. resources utilized, feedback from patients and staff, satisfaction scores), including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: stakeholder meetings Data Source: Patient Satisfaction Improvement Plan Process Milestone 3 Estimated Incentive Payment: $92,832	**Outcome Improvement Target 1** [IT 6.1]: Improvement Target: 10% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $99,309	**Outcome Improvement Target 2** [IT 6.1]: Improvement Target: 20% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $237,477

020950401.3.1	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*	
Medical Center of Arlington			*020950401*
Related Category 1 or 2 Projects::	*020950401.2.1*		
Starting Point/Baseline:	*2010Q4-2011Q3 HCAHPS 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $53,392	Year 3 Estimated Outcome Amount: $92,832	Year 4 Estimated Outcome Amount: $99,309	Year 5 Estimated Outcome Amount: $237,477
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $483,010			

Title of Outcome Measure (Improvement Target): IT-4.8- Sepsis mortality (Stand-alone measure)

Unique RHP outcome identification number(s): 020950401.3.2
Performing Provider Name/TPI: Medical Center of Arlington / 020950401

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
In DY2 we will establish baseline rates for sepsis mortality to measure for improvement targets. In DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. By DY4 and DY5, the improvement target is Sepsis mortality reduction of 25%by the end of the Waiver.

Rationale:
The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets.

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. There have been many focused initiatives to decrease mortality and morbidity in the past decade for other top causes of death of influenza and pneumonia. Proving evidence-based initiatives put in place can reduce mortality; implementing initiatives for sepsis follow these plans. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. Each year mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Medical Center Arlington has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Medical Center Arlington defined the population that will be directly impacted by the project as patients diagnosed with Sepsis. Medical Center Arlington defined the population that will be

directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for the Category 2 project, sepsis mortality and average length of stay for sepsis patients. The percentage of the population expected to be positively impacted by the project for mortality is 3%, which was determined based on outcome target for reduction in mortality by 25% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 50. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $500,000 for 5 years.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $500,000.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $440,000.
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The total value of the project then was estimated at $4,643,316. Approximately 79% of the total value was assigned to Category 2 project and the remaining 11% of value assigned to Category 3 outcome for Sepsis Mortality and 9.7% assigned to Category 3 outcome for reduced Average Length of Stay.

The value for the total outcome was determined based on the population targeted for Sepsis, size of the population, and costs and steps necessary to achieve reductions in mortality. We did not value the process and outcome targets differently as we believe they are all equally important to overall success of project.

020950401.3.2	*3.IT-4.8*	*Sepsis mortality*	
Medical Center of Arlington			*020950401*
Related Category 1 or 2 Projects::	*020950401.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
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 Metric 1: Number of patients treated with sepsis resuscitation and management bundles Goal: Baseline Data Source: EHR Process Milestone 1 Estimated Incentive*:* $28,672 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 2 Estimated Incentive Payment*:* $28,672	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 3 Estimated Incentive Payment: $99,703	**Outcome Improvement Target 1** [IT-4.8]: 15% reduction in mortality from baseline, 14 cases/death Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $106,659	**Outcome Improvement Target 2** [IT-4.8]: 25% reduction in mortality from baseline, 23 cases/deaths Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $255,054

020950401.3.2	*3.IT-4.8*	*Sepsis mortality*	
Medical Center of Arlington			*020950401*
Related Category 1 or 2 Projects::	*020950401.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $57,344	Year 3 Estimated Outcome Amount: $99,703	Year 4 Estimated Outcome Amount: $106,659	Year 5 Estimated Outcome Amount: $255,054
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $518,760			

Title of Outcome Measure (Improvement Target): IT-4.9 Average length of stay (Non-stand-alone measure)

Unique RHP outcome identification number(s): 020950401.3.3
Performing Provider Name/TPI: Medical Center of Arlington / 020950401

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
In DY2 we will establish baseline rates for sepsis average length of stay to measure for improvement targets. In DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. By DY4 and DY5, the improvement target is Sepsis average length of stay of TBD by the end of the Waiver. The improvement target will be determined in DY2 and implemented starting in DY3.

Rationale:
The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets.

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. There have been many focused initiatives to decrease mortality and morbidity in the past decade for other top causes of death of influenza and pneumonia. Proving evidence-based initiatives put in place can reduce mortality; implementing initiatives for sepsis follow these plans. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. Each year mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Medical Center Arlington has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Medical Center Arlington defined the population that will be directly impacted by the project as patients diagnosed with Sepsis. The total sepsis population is expected to be positively impacted

by the project for a reduction in length of stay of 2 days from baseline average of 9 days per patient. This was estimated at total of reduced in patient days by DY 5 of 1765. The estimated cost per day for a sepsis patient is $907. This totaled approximately $1,600,000

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 1. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $962,000
To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $641,000.

The total value of the project then was estimated at $4,643,316. Approximately 79% of the total value was assigned to Category 2 project and the remaining 11% of value assigned to Category 3 outcome for Sepsis Mortality and 9.7% assigned to Category 3 outcome for reduced Average Length of Stay.

The value for the total outcome was determined based on the population targeted for sepsis, size of the population, baseline average length of stay, cost avoidance and steps necessary to achieve reductions in average length of stay. We did not value the process and outcome targets differently as we believe they are all equally important to overall success of project.

020950401.3.3	*3.IT-4.9*	*IT-4.9 Average length of stay*	
Medical Center of Arlington			*20950401*
Related Category 1 or 2 Projects:	*020950401.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients diagnosed with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl).* *Target population: patients hospitalized with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl)*		
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 Metric 1: ALOS for patients treated with sepsis resuscitation and management bundles Goal: Baseline Data Source: EHR Process Milestone 1 Estimated Incentive Payment :$25,042 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 2 Estimated Incentive Payment: $25,042	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 3 Estimated Incentive Payment: $87,081	**Outcome Improvement Target 1** [IT-4.9]: reduce 1.5 days from baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $93,157	**Outcome Improvement Target 2** [IT-4.9]: reduce 2 days from baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $222,767

020950401.3.3	*3.IT-4.9*	*IT-4.9 Average length of stay*	
Medical Center of Arlington			*20950401*
Related Category 1 or 2 Projects:	*020950401.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients diagnosed with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl).* *Target population: patients hospitalized with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl)*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $50,084	Year 3 Estimated Outcome Amount: $87,081	Year 4 Estimated Outcome Amount: $93,157	Year 5 Estimated Outcome mount: $222,766
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $453,088			

Title of Outcome Measure (Improvement Target): IT-3.2- Congestive Heart Failure 30-day readmission rate

Unique RHP outcome identification number(s): 020950401.3.4
Performing Provider Name/TPI: Medical Center of Arlington / 020950401

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
The outcome measure is to reduce the readmissions to hospital for those patients with CHF that have had a readmission the prior 12 months. The target for the outcome measure for the CHF 30-day readmission rate is to reduce the rate by 15% by the end of the Waiver period. In DY2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary to establish a baseline rate for readmissions in order to correctly measure a rate reduction. In DY3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This reduction is estimated to be 80 CHF readmissions over course of the waiver.

Rationale:
The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus on. Various data points from both internal and external reporting vary and it will be necessary to ensure the defined population is known so targeted interventions are addressed. The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

The target for the outcome measure of CHF 30-day readmission rate is to reduce the rate by 15% by the end of the Waiver period. We have implemented initiatives to reduce readmissions (i.e. improved discharge planning, etc) but the readmission rate reduction has been moved significantly in the last year. We believe a renewed focus is necessary to make significant reductions in rate.

In DY2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders (IP /OP, out of hospital providers, etc) are identified and included in the plan. Indentifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan are a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY2 to establish a baseline rate for readmissions in order to correctly measure a rate reduction. The process milestone to establish the baseline rate is necessary to understand the starting point of patients to focus on. Various data points from both internal and external reporting vary and it will be necessary to ensure the defined population is known so targeted interventions are addressed

In DY3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

Outcome Measure Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Medical Center of Arlington has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

The value for the total outcome was determined based on the population targeted for CHF, size of the high risk population, and cost avoided from readmissions and mortality and morbidity impacts from achieved reductions in readmission rates. We did not value the process and outcome targets differently as we believe they are all equally important to overall success of project.

Medical Center of Arlington defined the population that will be directly impacted by the project as patients admitted with congestive heart failure who are at risk for readmission. The percentage of the population expected to be positively impacted by the project is 5%, which was determined based on studies of similar projects implemented elsewhere. This was approximately 16 CHF readmissions per year, for 5 years would be 80 readmissions. The cost saved per admission was striated between $7,000 to $8,500 in the region. Our cost estimate was $7250 per readmission saved for a total of $590,000 saved. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted by avoiding a hospitalization, there is an avoided financial burden, better health outcomes and improved quality of life. The value calculated was based on a

proportion of total value of readmission reduction savings of $590,000. An index value of 3 for five years was valued at $354,000.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases, and the burden on society is reduced. The value calculated was based on a proportion of total value of readmission of $590,000. An index value of 1 for five years was valued at $118,000.

The total value for avoided costs, value to the individual and community was calculated at $1,063,000. The Category 3 Project was valued at 20.88% of total value based on the funding protocol guidance on values share by category.

020950401.3.4	*3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate*	
Medical Center of Arlington			*020950401*
Related Category 1 or 2 Projects::	*020950401.2.3*		
Starting Point/Baseline:	*Population: Patients admitted with CHF* *Target population: CHF patients admitted that are high risk for readmission*		
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] Metric 1: submission of Readmission plan Baseline/Goal: Complete Plan Data Source: Readmission Improvement Plan Process Milestone 1 Estimated Incentive Payment *:* $12,313 **Process Milestone 2** [P- 2]: Establish baseline rates Metric 1: Number of patients with CHF determine high risk for readmission Goals: Complete baseline Data Source: Risk assessment plan Process Milestone 2 Estimated Incentive Payment *:* $12,314	**Process Milestone 3** [P- 5]: Disseminate findings (i.e. results of different interventions, feedback from patients, physicians, staff), including lessons learned and best practices, to stakeholders Metric 1**:** submission of documentation of findings and communication Goal: Complete stakeholder meetings Data Source: Readmission Improvement Plan Process Milestone 3 Estimated Incentive Payment: $42,819	**Outcome Improvement Target 1** [IT-3.2]: Improvement Target: 5% reduction over baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $45,806	**Outcome Improvement Target 2** [IT-3.2]: Improvement Target: 10 % reduction over baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $109,536

020950401.3.4	*3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate*	
Medical Center of Arlington			*020950401*
Related Category 1 or 2 Projects::	*020950401.2.3*		
Starting Point/Baseline:	*Population: Patients admitted with CHF* *Target population: CHF patients admitted that are high risk for readmission*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $24,627	Year 3 Estimated Outcome Amount: $42,819	Year 4 Estimated Outcome Amount: $45,806	Year 5 Estimated Outcome Amount: $109,536
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $222,788			

Title of Outcome Measure (Improvement Target): IT-9.2- Right Care, Right Setting. IT-9.2 ED appropriate utilization by establishing more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)

Unique RHP outcome identification number(s): 021184901.3.1
Performing Provider Name/TPI: Cook Children's Medical Center / 021184901

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:

DY2: [P-1] Project planning – engage stakeholders, determine timelines and document implementation plans.
DY2/DY3: [P-2] Establish baseline rates.
DY4/DY5: [IT-9.2] ED appropriate utilization. The new pediatric neighborhood primary care clinic will provide a primary care medical home for children ages 0-14 who live in ZIP 76119 by reducing the number of inappropriate visits to the Cook Children's Medical Center emergency department.

Numerator: The number of visits to the Cook Children's pediatric neighborhood clinic who live in ZIP code 76119.
Denominator: The number of visits to the Cook Children's ED with a triage level of 4 or 5, i.e., primary care for children ages 0-14 who live in ZIP code 76119.
Improvement target: The ratio of NHC visits to ED visit for primary care will show a ratio >1.0 which improves by 10% per year for each demonstration year.

Rationale:
The selection of these process milestones and outcome improvement target is to specifically document and demonstrate expanded primary care and medical home access to an identified population that is currently underserved and achieve the following goals:

1. Expand pediatric primary care capacity by constructing a new primary care clinic.
2. Expand primary care providers by hiring physician, nursing and support staff.
3. Reduce the burden of providing primary care in potentially inappropriate settings.

It is hoped that, upon demonstrating successful outcomes, other providers can replicate this model in other parts of Region 10.

Outcome Measure Valuation:
Valuation assumes the NHC will enroll 6,000 pediatric patients in the 76119 ZIP code that are at high risk for lack of primary care services. The project forecasts an inverse relationship between

ED visits and primary care visits, with a forecasted 10% decrease in ED visits per year, once the clinic is established. Annual pediatric emergency department's visits from 76119 are 1,700 visits per year. The result of the decrease in ED visits also assumes a corresponding decrease in Medicaid and/or other governmental funding sources for high-cost services in the ED. The cost per ED visit, established by the Region 10 Anchor hospital, is $1,200 per visit. We estimate a decrease of 170 ED visits per year from the 76119 ZIP code. The project also assumes that increased access to primary care results in decreased hospital admissions. Cook Children's currently experiences an 11.4% ED admit rate. We estimate a decrease of 19 inpatient admissions from the 76119 ZIP code. On average, a Cook Children's pediatric admission costs $28,475.

021184901.3.1	*9.IT-9.2*	9. Right Care, Right Setting. IT-9.2 ED appropriate utilization by establishing more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)	
Cook Children's Medical Center			*021184901*
Related Category 1 or 2 Projects:	**RHP Project ID:** 021184901.1.1 Establish more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)		
Starting Point/Baseline:	**Baseline data:** The actual ratio of pediatric neighborhood clinic visits to the number of visits to the Cook Children's pediatric neighborhood clinic will be determined / validated in DY2. **Target population:** Children ages 0-14 who live in ZIP 76119. **Specific number**: 8,000 – 10,000 annual primary care visits.		
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 determine timelines and document implementation plans Data Source: Administrative documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $144,226 **Process Milestone 2** [P-2]: Establish (validate) baseline rates Data Source: Administrative documentation Process Milestone 2 Estimated Incentive Payment: $144,226	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization Improvement Target: The ratio of NHC visits to ED visit for primary care will show a ratio >1.0 which improves by 10% per year for each demonstration year Data Source: Administrative documentation Outcome Improvement Target 1 Estimated Incentive Payment*:* $501,530	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization Improvement Target: The ratio of NHC visits to ED visit for primary care will show a ratio >1.0 which improves by 10% per year for each demonstration year Data Source: Administrative documentation Outcome Improvement Target 2 Estimated Incentive Payment*:* $536,520	**Outcome Improvement Target 3** [IT-9.2]: ED appropriate utilization Improvement Target: The ratio of NHC visits to ED visit for primary care will show a ratio >1.0 which improves by 10% per year for each demonstration year Data Source: Administrative documentation Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,282,984

021184901.3.1	*9.IT-9.2*	9. Right Care, Right Setting. IT-9.2 ED appropriate utilization by establishing more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)	
Cook Children's Medical Center			*021184901*
Related Category 1 or 2 Projects:	**RHP Project ID:** 021184901.1.1 Establish more primary care clinics (Develop one additional Cook Children's pediatric neighborhood clinic in an identified area of need.)		
Starting Point/Baseline:	**Baseline data:** The actual ratio of pediatric neighborhood clinic visits to the number of visits to the Cook Children's pediatric neighborhood clinic will be determined / validated in DY2. **Target population:** Children ages 0-14 who live in ZIP 76119. **Specific number**: 8,000 – 10,000 annual primary care visits.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $288,452	Year 3 Estimated Outcome Amount: $501,530	Year 4 Estimated Outcome Amount: $536,520	Year 5 Estimated Outcome Amount: $1,282,984
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $2,609,486			

Title of Outcome Measure (Improvement Target): *IT-9.2-* Right Care, Right Setting. IT-9.2 ED appropriate utilization by establishing more primary care clinics (Develop one additional Cook Children's pediatric urgent care clinic in an identified area of need.)

Unique RHP outcome identification number(s): 021184901.3.2
Performing Provider Name/TPI: Cook Children's Medical Center / 021184901

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
DY2: [P-1] Project planning – engage stakeholders determine timelines and document implementation plans
DY2/DY3: [P-2] Establish baseline rates.
DY4/DY5: [IT-9.2] ED appropriate utilization. The new pediatric urgent care clinic will provide one-time urgent care needs for children ages 0-14 who live in a specific geographic area (to be determined in DY2) reducing the number of inappropriate visits to the Cook Children's Medical Center emergency department.

Numerator: The number of visits to the Cook Children's pediatric urgent care clinic who live in selected geography.
Denominator: The number of visits to the Cook Children's ED with a triage level of 4 or 5, i.e., primary care for children ages 0-14 who live in that same geography.
Improvement target: The ratio of NHC visits to ED visit for primary care will show a ratio >1.0 which improves by 10% per year for each subsequent demonstration year.

Rationale:
The selection of these process milestones and outcome improvement target is to specifically document and demonstrate expanded urgent care access to an identified population that is currently underserved and achieve the following goals:

1. Expand pediatric urgent care capacity by constructing a new pediatric urgent care clinic.
2. Expand pediatric primary care / urgent care providers by hiring physician, nursing and support staff.
3. Reduce the burden of providing urgent care in potentially inappropriate settings.

It is hoped that upon demonstrating successful outcomes other providers can replicate this model in other parts of Region 10.

Outcome Measure Valuation:
Valuation assumes the Urgent Care Clinic will treat 8000 pediatric patients per year in the 76119 ZIP code that are at high risk for lack of urgent care and/or primary care services. The plan projects a 10% decrease in ED visits per year, once the clinic is established. Annual pediatric emergency department's visits from 76119 are 1,700 visits per year. The result of the decrease in

ED visits also assumes a corresponding decrease in Medicaid and/or other governmental funding sources for high-cost services in the ED. The cost per ED visit, established by the Region 10 Anchor hospital, is $1,200 per visit. We estimate a decrease of 170 ED visits per year from the 76119 ZIP code. The project also assumes that increased access to Urgent Care services will result in decreased hospital admissions. Cook Children's currently experiences an 11.4% ED admit rate. We estimate a decrease of 19 inpatient admissions from the 76119 ZIP code. On average, a Cook Children's pediatric admission costs $28,475. Note: the 76119 ZIP code is used in this analysis for modeling purposes, since there is a demonstrated community need in that area. The urgent care center will likely have a wider geographic base and Cook Children's plans to locate this center in an area that is most likely to meet the underserved needs of the broader Tarrant County area.

021184901.3.2	*9.IT-9.2*	9. Right Care, Right Setting. IT-9.2 ED appropriate utilization by establishing more primary care clinics (Develop one additional Cook Children's pediatric urgent care clinic in an identified area of need.)	
Cook Children's Medical Center			*021184901*
Related Category 1 or 2 Projects:	**RHP Project ID:** 021184901.1.2 Establish more primary care clinics (Develop one additional Cook Children's pediatric urgent care clinic in an identified area of need.)		
Starting Point/Baseline:	**Baseline data:** The actual ratio of pediatric urgent care clinic visits to the number of visits to the Cook Children's pediatric neighborhood clinic will be determined / validated in DY3. **Target population:** Children ages 0-14 who live in a defined geographic area **Specific number**: 8,000 – 10,000 annual primary care visits.		
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 determine timelines and document implementation plans Data Source: Administrative documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $250,975	**Process Milestone 2** [*P-1*]: Project planning – engage stakeholders determine timelines and document implementation plans Data Source: Administrative documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $218,185 **Process Milestone 3** [P-2]: Establish (validate) baseline rates Data Source: Administrative documentation Process Milestone 2 Estimated Incentive Payment: $218,184	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization Improvement Target: The ratio of UCC visits to ED visit for primary care will show a ratio >1.0 which improves by 10% per year for each subsequent demonstration year Data Source: Administrative documentation Outcome Improvement Target 1 Estimated Incentive Payment*:* $466,813	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization Improvement Target: The ratio of UCC visits to ED visit for primary care will show a ratio >1.0 which improves by 10% per year for each demonstration year Data Source: Administrative documentation Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,116,293

021184901.3.2	*9.IT-9.2*	9. Right Care, Right Setting. IT-9.2 ED appropriate utilization by establishing more primary care clinics (Develop one additional Cook Children's pediatric urgent care clinic in an identified area of need.)	
Cook Children's Medical Center			*021184901*
Related Category 1 or 2 Projects:	**RHP Project ID:** 021184901.1.2 Establish more primary care clinics (Develop one additional Cook Children's pediatric urgent care clinic in an identified area of need.)		
Starting Point/Baseline:	**Baseline data:** The actual ratio of pediatric urgent care clinic visits to the number of visits to the Cook Children's pediatric neighborhood clinic will be determined / validated in DY3. **Target population:** Children ages 0-14 who live in a defined geographic area **Specific number**: 8,000 – 10,000 annual primary care visits.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $250,975	Year 3 Estimated Outcome Amount: $436,369	Year 4 Estimated Outcome Amount: $466,813	Year 5 Estimated Outcome Amount: $1,116,293
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,270,450			

Title of Outcome Measure (Improvement Target): IT-7.2- Oral Health. IT-7.2 Cavities: Percentage of children with untreated dental caries. (Establish one new Cook Children's Pediatric Dental Clinic in an identified area of need.)

Unique RHP outcome identification number(s): 021184901.3.3
Performing Provider Name/TPI: Cook Children's Medical Center / 021184901

Outcome Measure Description:
Numerator: The number of visits to the Cook Children's pediatric dental clinic for treatment of dental caries whose residence is in the identified service area – to be determined in DY2.
Denominator: The population of children ages 0-14 in the dental clinic's service area.
Improvement target: The percentage of children treated for dental caries in the defined population will show a reduction of 10% per year from baseline for each subsequent demonstration year.

Process Milestones and Outcome Improvement Targets for each year:

- **DY2/DY3:** [P-1] Project planning – engage stakeholders determine timelines and document implementation plans
- **DY3:** [P-2] Establish baseline rates
- **DY4/DY5:** IT-7.2 Cavities: Percentage of children with untreated dental caries. The new pediatric dental care clinic will provide a service for children ages 0-14, thereby reducing the number of children with untreated dental caries.

Rationale:
The selection of these process milestones and outcome improvement targets is to, specifically document and demonstrate expanded pediatric dental care access to a population that is currently underserved and achieve the following goals:

1. Expand pediatric dental care capacity by constructing a new dental clinic.
2. Expand dental care providers by hiring a dentist and support staff.
3. Reduce the burden of providing dental care in potentially inappropriate settings, i.e., outpatient surgery.

It is hoped that upon demonstrating successful outcomes other providers can replicate this model in other parts of Region 10.

Outcome Measure Valuation:
Project valuation assumes 5,400 pediatric dental visits annually beginning DY4 and a 10% growth each year thereafter. Population is comprised primarily of pediatrics with little or no access to dental care. As a result, we assume that a sizable portion of the population has untreated dental caries (30% or 1,620 pediatric patients), with the project expecting to impact 10% or 162 of these patients with caries in year one and a 10% reduction per year thereafter in

the ZIP code where the clinic is located. In addition, the increased access to dental treatments is projected to reduce ambulatory dental surgeries by 10% per year for the corresponding ZIP codes where the clinic is located. Both the reduction in treatment for dental caries and ambulatory surgeries is expected to reduce governmental program costs by at least $201 and $2,741 per case, respectively.

021184901.3.3	*7.IT-7.2*	7. Oral Health. IT-7.2 Cavities: Percentage of children with untreated dental caries. (Establish one new Cook Children's Pediatric Dental Clinic in an identified area of need.)	
Cook Children's Medical Center			*021184901*
Related Category 1 or 2 Projects:	**RHP Project ID:** 021184901.1.3 Increase, Expand and Enhance Oral Health Services (Establish one new Cook Children's Pediatric Dental Clinic.)		
Starting Point/Baseline:	**Baseline data:** The percentage of children treated for dental caries in the defined population will show a reduction of 10% per year from baseline for each subsequent demonstration year. Baseline will be determined / validated in DY3. **Target population:** Children ages 0-14 who live in a defined geographic area **Specific number**: 5,500 annual pediatric dental care visits.		
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 determine timelines and document implementation plans Data Source: Administrative documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $178,275	**Process Milestone 2** [*P-1*]: Project planning – engage stakeholders determine timelines and document implementation plans Data Source: Administrative documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $154,983 **Process Milestone 3** [P-2]: Establish (validate) baseline rates Data Source: Administrative documentation Process Milestone 2 Estimated Incentive Payment: $154,983	**Outcome Improvement Target 1** [IT-7.2]: The percentage of children treated for dental caries in the defined population will show a reduction of 10% per year from baseline for each subsequent demonstration year. Data Source: Administrative documentation Outcome Improvement Target 1 Estimated Incentive Payment*:* $331,591	**Outcome Improvement Target 2** [IT-7.2]: The percentage of children treated for dental caries in the defined population will show a reduction of 10% per year from baseline for each subsequent demonstration year. Data Source: Administrative documentation Outcome Improvement Target 2 Estimated Incentive Payment*:* $792,936

021184901.3.3	*7.IT-7.2*	7. Oral Health. IT-7.2 Cavities: Percentage of children with untreated dental caries. (Establish one new Cook Children's Pediatric Dental Clinic in an identified area of need.)	
Cook Children's Medical Center			*021184901*
Related Category 1 or 2 Projects:	**RHP Project ID:** 021184901.1.3 Increase, Expand and Enhance Oral Health Services (Establish one new Cook Children's Pediatric Dental Clinic.)		
Starting Point/Baseline:	**Baseline data:** The percentage of children treated for dental caries in the defined population will show a reduction of 10% per year from baseline for each subsequent demonstration year. Baseline will be determined / validated in DY3. **Target population:** Children ages 0-14 who live in a defined geographic area **Specific number**: 5,500 annual pediatric dental care visits.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $178,275	Year 3 Estimated Outcome Amount: $309,966	Year 4 Estimated Outcome Amount: $331,591	Year 5 Estimated Outcome Amount: $792,936
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,612,768			

Performing Provider Name: Tarrant County/dba Tarrant County Public Health
Texas Provider Identifier: 022817305
Title of Outcome Measure (Improvement Target):
IT5.1- Improved Cost savings: Demonstrate cost savings in care delivery – ED visits
Unique RHP Outcome Identification Number: -022817305.3.1

Outcome Description:
The selected milestones and metrics (Outcome Measures IT-5.1) will measure the progress of participating RHP Performing Providers with regards to controlling costs arising from emergency department care (cost savings in care delivery) as assisted by HIE data. Using data from Region 10 RHP Providers and the NTAHP, DY2 will consist of project planning wherein stakeholders will be engaged, baseline rates, current capacity and needed resources will be identified, and timelines and document implementation plans will be determined. In DY 3, participating RHP Providers will develop and test data systems which will be followed by PDSA cycles to improve data collection and intervention activities in DY 4. In DY 5 using data from RHP Providers and the NTAHP HIE, cost savings in care delivery performed in Tarrant County hospitals by participating Region 10 RHP Providers will be demonstrated as evidenced by an average savings of $2-9 per -Emergency -Department (ED) visit when comparing patients who were queried against the HIE compared to those for whom such queries were not made. These findings, including lessons learned and best practices, will be disseminated to stakeholders.

Rationale:

By the end of the Waiver Period, because of their use of the data within the HIE, Region 10 RHP performing providers will be able to demonstrate cost savings related to care delivery and per-episode cost of care by eliminating unnecessary or duplicate testing. The collective end results of the project will be decreased potentially avoidable hospitalization and readmission rates and improved cost efficiency, both internal and external to the hospital environment. Participating Region 10 RHP performing providers will establish their own baselines for cost of care delivery and per-episode cost of care, and, at the end of the Waiver Period, they will be able to demonstrate a decrease from their individual baselines. The five-year expected outcome is that TCPH and other Region 10 RHP participants will use the shared information to pinpoint issues and then efficiently and effectively allocate education, preventive and/or management resources to those concerns. Continual reassessment using the data will further highlight additional modes and areas for improvement and refinement. Region 10 performing providers' abilities to communicate with each other regarding individual private health information will also be positively impacted, thus resulting in improved patient safety and satisfaction and decreased health care delivery costs. The project will benefit specific at-risk populations because there will be an emphasis on using the data and subsequent analyses and assessments to facilitate intervention and program development (which may include interventions or programs designed to address care coordination, chronic disease treatment, patient self-management, and/or health promotion and prevention) that is specific to and will best address the needs of these special populations. The project also benefits the disproportionately medically disadvantaged/disenfranchised populations by setting the foundation for a system to stratify outcomes and quality measures by Race, Ethnicity And Language (REAL) demographic information to identify health disparities and develop strategies to ensure equitable outcomes.

Approach/Methodology:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and

outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section_Continuing to work on this section so valuing of the project is in a more consistent manner with the methodology designed by RHP 10.

Rationale/Justification:
Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

-TCPH defined the population directly impacted by the project as Emergency Department (ED) patients who visit facilities participating in the HIE. ED visits totaled 791,926 with a daily average of 2,170 in 2011. The percentage of the Tarrant County population expected to be positively impacted by the project is 0.5% of DY5 ED visits as compared to baseline ED visits. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.27% of the total project valuation was allocated to Category 1 and 2. A cost savings of $29 per visit times 3,960 ED visits (3,960 is the number of 0.5% ED visits with a cost decreases in DY5) equals $114,829. ["The Business Case for Payer Support of a Community-Based Health Information Exchange" by Tzeel, Lawnicki and Pemble] This value is multiplied by individual impact of 3 and community impact of 4 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total project value. The actual HIE total project valuation for 5 years equals $16,455,337. However, due to DSRIP Public Health funding available the project value was discounted by 57.8% to $6,947,507.
-To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3**.** We believe this to be the correct number because; the reduction in tests will save patient time, pain, diagnostic time and money.
To determine the value to the community - impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 4**.** We believe this to be the correct number because; it will save the community resources and money by reducing duplicative radiology and lab tests.

Related Category 1 and/or 2 projects. Please list the projects linked to this outcome below.
022817305.1.1

022817305.3.1	*IT5.1*	***- Performance Improvement and Reporting Capacity – Public Health Surveillance using health information exchange using Outcome Measures IT-5.1, IT-5.2 and IT-5.3***	
Tarrant County/dbaTarrant County Public Health			022817305
Related Category 1 or 2 Projects:	***-022817305.1.1***		
Starting Point/Baseline:	*Estimated number of DY2 Emergency Department visits in Tarrant County hospitals*		
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: RHP Providers and NTAHP Process Milestone 1 Estimated Incentive Payment: $0 Process Milestone 2 [P- 2] Establish baseline rates Baseline: Number and cost of Emergency Department visits in Tarrant County hospitals by participating Region 10 RHP Providers Data Source: RHP Providers Process Milestone 2 Estimated Incentive Payment: $0	Process Milestone 3 [P- 3] Develop and test data systems Data Source: RHP Providers and NTAHP Process Milestone 3 Estimated Incentive Payment: $38,622	-P-4 Outcome Improvement Target Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: RHP Providers and NTAHP Outcome Improvement Target 1 Estimated Incentive Payment: $20,658 Outcome Improvement Target 2 IT-5.1 Improved cost savings: Demonstrate cost savings in - care delivery Improvement Target: Demonstrate 0.25% reduction in cost per Emergency Department visit in Tarrant County hospitals by participating Region 10 RHP Providers in DY5 Data Source: RHP Providers and NTAHP Outcome Improvement Target 2 Estimated Incentive Payment: $20,658	Outcome Improvement Target 3 [IT-5.1] Improved cost savings: Demonstrate cost savings in -care delivery Improvement Target: Demonstrate 0.5% reduction in cost per Emergency Department visit in Tarrant County hospitals by participating Region 10 RHP Providers in DY5 Data Source: RHP Providers and NTAHP - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Outcome Improvement Target 3 Estimated Incentive Payment: $89,818

022817305.3.1	*IT5.1*	***- Performance Improvement and Reporting Capacity – Public Health Surveillance using health information exchange using Outcome Measures IT-5.1, IT-5.2 and IT-5.3***	
Tarrant County/dbaTarrant County Public Health			022817305
Related Category 1 or 2 Projects:	***-022817305.1.1***		
Starting Point/Baseline:	*Estimated number of DY2 Emergency Department visits in Tarrant County hospitals*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $38,622	Year 4 Estimated Outcome Amount: $41,316	Year 5 Estimated Outcome Amount: $89,818
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $169,756			

Performing Provider Name: Tarrant County/dba Tarrant County Public Health
Texas Provider Identifier: 022817305
Title of Outcome Measure (Improvement Target):
-IT-5.2: Improved Cost savings: Demonstrate cost savings per episode cost of care – reduced radiology testing cost
Unique RHP Outcome Identification Number: - 022817305.3.2

Outcome Description:
The selected milestones and metrics (Outcome Measures IT-5.1) will measure the progress of participating RHP Performing Providers with regards to decreasing costs (cost savings in per episode of care) through enhancing capacity through efficient/effective use of radiology resources as assisted by HIE data. Using data from Region 10 RHP Providers and the NTAHP, DY2 will consist of project planning wherein stakeholders will be engaged, baseline rates, current capacity and needed resources will be identified, and timelines and document implementation plans will be determined. In DY 3, participating RHP Providers will develop and test data systems which will be followed by PDSA cycles to improve data collection and intervention activities in DY 4. In DY 5 using data from RHP Providers and the NTAHP, cost savings in per episode of care as evidenced by a 2% reduction in cost of radiology testing performed in Tarrant County hospitals by participating Region 10 RHP Providers will be demonstrated. These findings, including lessons learned and best practices, will be disseminated to stakeholders.

Rationale:

By the end of the Waiver Period, because of their use of the data within the HIE, Region 10 RHP performing providers will be able to demonstrate cost savings related to care delivery and per-episode cost of care by eliminating unnecessary or duplicate testing. The collective end results of the project will be decreased potentially avoidable hospitalization and readmission rates and improved cost efficiency, both internal and external to the hospital environment. Participating Region 10 RHP performing providers will establish their own baselines for cost of care delivery and per-episode cost of care, and, at the end of the Waiver Period, they will be able to demonstrate a decrease from their individual baselines.

The five-year expected outcome is that TCPH and other Region 10 RHP participants will use the shared information to pinpoint issues and then efficiently and effectively allocate education, preventive and/or management resources to those concerns. Continual reassessment using the data will further highlight additional modes and areas for improvement and refinement. Region 10 performing providers' abilities to communicate with each other regarding individual private health information will also be positively impacted, thus resulting in improved patient safety and satisfaction and decreased health care delivery costs. The project will benefit specific at-risk populations because there will be an emphasis on using the data and subsequent analyses and assessments to facilitate intervention and program development (which may include interventions or programs designed to address care coordination, chronic disease treatment, patient self-management, and/or health promotion and prevention) that is specific to and will best address the needs of these special populations. The project also benefits the disproportionately medically disadvantaged/disenfranchised populations by setting the foundation for a system to stratify outcomes and quality measures by Race, Ethnicity And Language (REAL) demographic information to identify health disparities and develop strategies to ensure equitable outcomes.

Approach/Methodology:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section Continuing to work on this section so valuing of the project is in a more consistent manner with the methodology designed by RHP 10.

Rationale/Justification:
Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.
-TCPH defined the population directly impacted by the project as Emergency Department (ED) patients who visit facilities participating in the HIE. ED visits totaled 791,926 with a daily average of 2,170 in 2011. According to the "National Hospital Ambulatory Medical Care Survey 2006 Emergency Department Summary," 44.2% of ED visits resulted in orders for radiological studies. The percentage of the Tarrant County population expected to be positively impacted by the project is 0.5% of DY5 ED visits as compared to baseline ED visits. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.27% of the total project valuation was allocated to Category 1 and 2. An average cost savings per episode of care of $214 per radiology test X 1,000 (based on an overall 2% reduction in radiology tests performed equaling a decrease of 1,000 tests) is $$214,000. [Hospital Costs Index by Cleverly & Associates 2007] This value is multiplied by individual impact of 3 and community impact of 4 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total project value. The actual HIE total project valuation for 5 years equals $16,455,337. However, due to DSRIP Public Health funding available the project value was discounted by 57.8% to $6,947,507. To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3**.** We believe this to be the correct number because; the reduction in tests will save patient time, pain, diagnostic time and money.
To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 4**.** We believe this to be the correct number because; it will save the community resources and money by reducing duplicative radiology tests.
Related Category 1 and/or 2 projects. - 022817305.1.1

-022817305.3.2	*IT5.2*	***-Enhance Performance Improvement and Reporting Capacity using health information exchange (HIE) using Outcome Measures IT-5.1, IT-5.2 and IT-5.3***	
Tarrant County/dba Tarrant County Public Health			022817305
Related Category 1 or 2 Projects:	***-022817305.1.1***		
Starting Point/Baseline:	*Estimated number of DY2 radiology test performed in Tarrant County hospitals*		
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: RHP Providers and NTAHP Process Milestone 1 Incentive Payment:$0 Process Milestone 2 [P- 2] Establish baseline rates Baseline: Number of radiology tests performed in Tarrant County hospitals by participating Region 10 RHP Providers Data Source: RHP Providers Process Milestone 2 Incentive Payment:$0	Process Milestone 3 [P- 3] Develop and test data systems Data Source: RHP Providers and NTAHP Process Milestone 3 Incentive Payment:$92,403	- P-4 Outcome Improvement Target 1 [- Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: RHP Providers and NTAHP Outcome Improvement Target Incentive Payment:$49,425 Outcome Improvement Target 2 [IT-5.2] Improved cost savings: Demonstrate cost savings in per episode of care Improvement Target: Demonstrate 0.05% reduction in cost of radiology testing performed in Tarrant County hospitals by participating Region 10 RHP Providers in DY5 Data Source: RHP Providers and NTAHP Outcome Improvement Target 2 Incentive Payment:$49,425	- Outcome Improvement Target 3 [IT-5.2] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Demonstrate 2% reduction in cost of radiology testing (based on an overall 2% reduction in laboratory tests performed equaling a decrease of 1,000 tests) performed in Tarrant County hospitals by participating Region 10 RHP Providers in DY5 Data Source: RHP Providers and NTAHP P- 5 Disseminate findings, including lessons learned and best practices, to stakeholders Outcome Improvement Target Incentive Payment:$214,892

-022817305.3.2	*IT5.2*	***-Enhance Performance Improvement and Reporting Capacity using health information exchange (HIE) using Outcome Measures IT-5.1, IT-5.2 and IT-5.3***	
Tarrant County/dba Tarrant County Public Health			022817305
Related Category 1 or 2 Projects:	***-022817305.1.1***		
Starting Point/Baseline:	*Estimated number of DY2 radiology test performed in Tarrant County hospitals*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $92,403	Year 4 Estimated Outcome Amount: $98,850	Year 5 Estimated Outcome Amount: $214,892
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $406,145			

Performing Provider Name: Tarrant County/dba Tarrant County Public Health
Texas Provider Identifier: 022817305
Title of Outcome Measure (Improvement Target):
IT-5.3 Improved cost savings: reduced laboratory testing costs
Unique RHP Outcome Identification Number: -022817305.3.3
Outcome Description:
The selected milestones and metrics (Outcome Measures IT-5.3) will measure the progress of participating RHP Performing Providers with regards to decreasing costs (cost savings in per episode of care) through enhancing capacity through efficient/effective use of laboratory resources as assisted by HIE data. Using data from Region 10 RHP Providers and the NTAHP, DY2 will consist of project planning wherein stakeholders will be engaged, baseline rates, current capacity and needed resources will be identified, and timelines and document implementation plans will be determined. In DY 3, participating RHP Providers will develop and test data systems which will be followed by PDSA cycles to improve data collection and intervention activities in DY 4. In DY 5 using data from RHP Providers and the NTAHP, cost savings in per episode of care as evidenced by a 2% reduction in cost of laboratory testing performed in Tarrant County hospitals by participating Region 10 RHP Providers will be demonstrated. These findings, including lessons learned and best practices, will be disseminated to stakeholders.

Rationale:

By the end of the Waiver Period, because of their use of the data within the HIE, Region 10 RHP performing providers will be able to demonstrate cost savings related to care delivery and per-episode cost of care by eliminating unnecessary or duplicate testing. The collective end results of the project will be decreased potentially avoidable hospitalization and readmission rates and improved cost efficiency, both internal and external to the hospital environment. Participating Region 10 RHP performing providers will establish their own baselines for cost of care delivery and per-episode cost of care, and, at the end of the Waiver Period, they will be able to demonstrate a decrease from their individual baselines.

The five-year expected outcome is that TCPH and other Region 10 RHP participants will use the shared information to pinpoint issues and then efficiently and effectively allocate education, preventive and/or management resources to those concerns. Continual reassessment using the data will further highlight additional modes and areas for improvement and refinement. Region 10 performing providers' abilities to communicate with each other regarding individual private health information will also be positively impacted, thus resulting in improved patient safety and satisfaction and decreased health care delivery costs. The project will benefit specific at-risk populations because there will be an emphasis on using the data and subsequent analyses and assessments to facilitate intervention and program development (which may include interventions or programs designed to address care coordination, chronic disease treatment, patient self-management, and/or health promotion and prevention) that is specific to and will best address the needs of these special populations. The project also benefits the disproportionately medically disadvantaged/disenfranchised populations by setting the foundation for a system to stratify outcomes and quality measures by Race, Ethnicity And Language (REAL) demographic information to identify health disparities and develop strategies to ensure equitable outcomes.

Approach/Methodology:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section Continuing to work on this section so valuing of the project is in a more consistent manner with the methodology designed by RHP 10.

Rationale/Justification:
Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

- TCPH defined the population directly impacted by the project as Emergency Department (ED) patients who visit facilities participating in the HIE. ED visits totaled 791,926 with a daily average of 2,170 in 2011. According to the "National Hospital Ambulatory Medical Care Survey 2006 Emergency Department Summary," 38.2% of ED visits resulted in orders for laboratory testing. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.27% of the total project valuation was allocated to Category 1 and 2. An average cost savings per episode of care of $363 per laboratory test times 2,000 (based on an overall 2% reduction in laboratory tests performed equaling a decrease of 2,000 tests) is $726,000. [Hospital Costs Index by Cleverly & Associates 2007]. This value is multiplied by individual impact of 3 and community impact of 4 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total project value. The actual HIE total project valuation for 5 years equals $16,455,337. However, due to DSRIP Public Health funding available the project value was discounted by 57.8% to $6,947,507.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3**.** We believe this to be the correct number because; the reduction in tests will save patient time, pain, diagnostic time and money.

To determine the value to the community - impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 4**.** We believe this to be the correct number because; it will save the community resources and money by reducing duplicative laboratory tests.

Related Category 1 and/or 2 projects. - 022817305.1.1

-022817305.3.3	*IT5.3*	***- Performance Improvement and Reporting Capacity – Public Health Surveillance using health information exchange using Outcome Measures IT-5.1, IT-5.2 and IT-5.3***	
Tarrant County/dbaTarrant County Public Health			022817305
Related Category 1 or 2 Projects:	***022817305.1.1***		
Starting Point/Baseline:	*Estimated number of DY2 lab test performed in Tarrant County hospitals*		
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: RHP Providers and NTAHP Process Milestone 1 Estimated Incentive Payment: $0 Process Milestone 2 [P- 2] Establish baseline rates Baseline: Number of laboratory tests performed in Tarrant County hospitals by participating Region 10 RHP Providers Data Source: RHP Providers Process Milestone 2 Estimated Incentive Payment: $0	Process Milestone 3 [P- 3] Develop and test data systems Data Source: RHP Providers and NTAHP Process Milestone 3 Estimated Incentive Payment: $38,622	-P-4 Outcome Improvement Target Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: RHP Providers and NTAHP Outcome Improvement Target 1 Estimated Incentive Payment: $20,658 Outcome Improvement Target 2 IT-5.3 Improved cost savings: Demonstrate cost savings in per episode cost of care Improvement Target: Demonstrate 0.05% reduction in per episode cost of care related to laboratory testing performed in Tarrant County hospitals by participating Region 10 RHP Providers in DY5 Data Source: RHP Providers and NTAHP Outcome Improvement Target 2 Estimated Incentive Payment: $20,658	Outcome Improvement Target 3 [IT-5.3] Improved cost savings: Demonstrate cost savings in per episode cost of care Improvement Target: Demonstrate 2% reduction in per episode cost of care related to laboratory testing (based on an overall 2% reduction in laboratory tests performed equaling a decrease of 2,000 tests) performed in Tarrant County hospitals by participating Region 10 RHP Providers in DY5 Data Source: RHP Providers and NTAHP - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Outcome Improvement Target 3 Estimated Incentive Payment: $89,818

-022817305.3.3	*IT5.3*	***- Performance Improvement and Reporting Capacity – Public Health Surveillance using health information exchange using Outcome Measures IT-5.1, IT-5.2 and IT-5.3***	
Tarrant County/dbaTarrant County Public Health			022817305
Related Category 1 or 2 Projects:	***022817305.1.1***		
Starting Point/Baseline:	*Estimated number of DY2 lab test performed in Tarrant County hospitals*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $38,622	Year 4 Estimated Outcome Amount: $41,316	Year 5 Estimated Outcome Amount: $89,818
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $169,756			

Title of Outcome Measure (Improvement Target): IT-11.1 Improvement in clinical indicator in identified disparity group.

Unique RHP outcome identification number(s): - 022817305.3.5
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Outcome Measure Description:
Process Milestones and Outcome Improvement Targets for each year:
The Process Milestones include hiring and training an individual to act as coordinator for the PRIDE Program. The individual will be trained to train the community organizational leaders, provide guidance on best practices for communicating with youth, and begin to identify community agencies to incorporate the PRIDE Program. The next process milestone is to provide PRIDE curriculum to 125 youth in the target area. In year the PRIDE curriculum will be reassessed with a focus on outcome indicators to make sure the appropriate messages are being retained by the youth. This program assessment will be performed by The University of North Texas, Health Science Center and will focus on behavioral changes in the youth. In year 5, there should be a reduction in STD case levels in Tarrant County. Using the 2011 annual STD case report, there should be a 15% reduction in cases for 2015 in the 15 – 24 year old category. This reduction will meet the improvement target of Improvement in clinical indicator in the identified disparity group.

Rationale:
The process milestones reflect the steps necessary to provide Sexually transmitted Disease (STD) information to youth populations (15-24) in a non-threatening, non-judgmental environment. The ultimate outcome is a reduction in STD rates for Tarrant County.

Outcome Measure Valuation:

- **Approach/Methodology:** Valuation of each outcome measure is based upon the cost of implementing each component of the PRIDE Program. Cost saving and return on investment occurs, when each participant gains the knowledge and understanding of the PRIDE curriculum and begins to take responsibility for their sexual health. This in-turn will reduce the disease incidence in the community, reducing the medical cost of treatment and/or complications from STD infection.
- **Rationale/Justification:** Early identification and treatment of STD's reduces the risk of complications and hospitalizations for individuals and will reduce the medical cost to the community. This program will increase the knowledge levels of the youth, allowing better choices, understanding what is required to reduce individual risk, and providing factual information to seek medical services when certain symptoms are noticed on the individual or a friend or partner. Early identification and treatment of STD's reduces the risk of complications and hospitalizations for individuals who are diagnosed with an

infection. In 1994 dollars the cost for chlamydia and associated sequelae in the U.S. was $1,513.9 (millions) with the STD total $5.025.0 (millions) nationally. Hospital costs for treating Pelvic Inflammatory Disease (a complication of gonorrhea or chlamydia) was $4.148. Million in direct cost services.

Tarrant County Public Health defined the population that will be directly impacted by the project as individuals identified as the number of Tarrant County minority STDs under age 24. The percentage of the population expected to be positively impacted by the project in DY5 with a 11.11% decrease in chlamydia rates for Tarrant County minority youth ages 15-24 by the end of DY5. That means that a minimum of 537 youth will not contract chlamydia by the end of DY5. The medical cost savings per person is $1,700.42. This total value of $912,279.00 is multiplied by the individual impact of 3 and the community impact of 2 to determine the values per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the project valuation of $11,859,621.00. This actual amount had to be discounted due to Public Health DSRIP available funding to a total value of $5,618,849.00 or a 52.6% valuation discount.
We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

022817305.3.5	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. PRIDE Program*	
[Tarrant County/dba Tarrant County Public Health]			*022817305*
Related Category 1 or 2 Projects:	*022817305.2.2* PRIDE Program		
Starting Point/Baseline:	*5,642 Reported cases of gonorrhea and chlamydia in Tarrant County Youth Age 15-24, 61% of cases Minority Youth or 4,829, for 2011*		
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 [P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data source: TCPH STD Statistics for 2012 Report Process Milestone 1 Estimated Incentive Payment: $0	**Process Milestone** [P-4] Conduct Plan Do Study Act (PDSA) to improve data intervention activity. Assess agency commitment through level of youth participation at each Data source: TCPH STD Statistics for 2013 Report Process Milestone 2 Estimated Incentive Payment: $173,203	**Outcome Improvement Target 1** [11.1]: Chlamydia reduction from 2011 level of 4,829 minority youth cases reported to less than 4,588 cases in youth Improvement target: From 4,829 to 4,588 cases Data source: TCPH STD Statistics for 2014 Report Outcome Improvement Target 1 Estimated Incentive Payment: $146,776	**Outcome Improvement Target 2** [11.1]: Minority Chlamydia reduction from 2011 level of 4,829 minority youth cases reported to less than 4,292 cases in youth Improvement target: From 4,829 cases to 4,292 cases. Data source: TCPH STD Statistics for 2015 Report Outcome Improvement Target 2 Estimated Incentive Payment: $319,077
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $137,203	Year 4 Estimated Outcome Amount: $146,776	Year 5 Estimated Outcome Amount: $319,077
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $603,056			

Title of Outcome Measure (Improvement Target): IT-11.1 –Improvement in Clinical Indicator in identified disparity group– (Improvement in target population to reduce Gonorrhea and Chlamydia STD rates in the City of Arlington)

Unique RHP outcome identification number(s): - 022817305.3.6
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Outcome Measure Description:
IT-11.1 –Improvement in Clinical Indicator in identified disparity group-- (Improvement in target population to reduce Gonorrhea and Chlamydia STD rates in the City of Arlington)

Identify, hire and train medical staff for STD clinical operations in Arlington. Develop schedule to allow a Saturday clinic for at least 6 hours. Begin to advertise and inform the community of the new clinic schedule. Outcome measures in year 3 and 4 will increase clinic utilization by 10% annually. By the end of year 5, with an additional 10% increase in client utilization, there should be a 10% reduction in minority syphilis STD rates reported in Arlington when compared to the baseline rates in 2011.

Process Milestones:

- DY2:
  - P-2– Establish base line rates for each of the reportable STD infections (syphilis, gonorrhea, chlamydia and HIV) in the minority population.

Outcome Improvement Targets for each year:

- DY3:
  - IT-1.1: Arlington Minority STD Rates for gonorrhea and chlamydia are reduced by 3% when compared to baseline 2011 reports.
- DY4:
  - IT-1.1: Arlington Minority STD Rates for gonorrhea and chlamydia are reduced by 6% when compared to baseline 2011 reports.
- DY5:
  - IT-1.1: Arlington Minority STD Rates for gonorrhea and chlamydia are reduced by 10% when compared to baseline 2011 reports.

Rationale:
The number of Sexually Transmitted Diseases (STD) diagnosed cases continues to increase in Tarrant County. The Arlington area continues to produce a high number of new STD infections (11,621 chlamydia, gonorrhea, syphilis and HIV reported by ZIP code to Tarrant County Public Health, Adult Health Services Division, Surveillance Unit in 2011). The Arlington area does not have a full time STD/HIV medical provider to service the population on a daily basis. Minority populations, Blacks and Hispanics, are disproportionately affected by chlamydia, syphilis, gonorrhea and HIV infections. Implementing a full service STD/HIV clinic, 5 days per week,

within the City of Arlington, will provide essential STD services and begin to reduce the STD reservoir. The outcome measure is to reduce STD/HIV morbidity by 10% from 2011 STD/HIV levels.

The process milestones reflect the steps necessary to provide STD services to the clients in the City of Arlington to reduce STD rates in the city and the County.

Outcome Measure Valuation:

- **Approach/Methodology:** The National Centers for Disease Control and Prevention have developed program standards to achieve reductions in STD levels in state, county and city STD Programs. Best practices for program implementation and operation are available at the CDC website. The Texas State Department of Health Services has adopted the same requirements and lists them on the state website. Tarrant County implemented the same basic standards for clinical operations. The outcome measures are related to a reduction of individuals reported with sexually transmitted infections. Baseline data is listed below:
- STD trends continue to increase in Arlington ZIP codes. The target for this intervention is the minority populations in the City of Arlington. The current population is 365,438 (2010 Census) with 29% Hispanic and 17% African-American, 8% "other" (mixed race, Native American, Asian and not listed) for a total minority population of about 54%. Youth under the age of 24 are the fastest growing group of individuals acquiring STD/HIV infections. Current disease trends list ages 1524 as having 51% of new syphilis infections, 73% of the chlamydia cases and 35% of the new HIV cases. This young age group is less likely to seek medical services in other areas of the County, especially since there is a transportation deficit in Arlington. Syphilis and HIV cases have increased in Arlington by 20% over the previous year.
- The cost savings for 143 minority gonorrhea and chlamydia cases at a savings of $1,562.29 per case for each case prevented. This total value of $223,564.00 is multiplied by individual impact of 3 and a community impact of 2 to determine values per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total gonorrhea and chlamydia outcome valuation of $2,906,328.00.
  The combined category 3 valuation equals $6,864,828.00. The actual project value was discounted due to the amount of total Public Health DSRIP funds available to $3,252,417.00. This is a 52.6% valuation discount.

2011 Arlington STD Cases Reported

Chlamydia and Gonorrhea 2,241 Minorities 1,431 or 63.86%

- **Rationale/Justification:** The average direct cost of Gonorrhea and Chlamydia using the Bureau of Labor Statistics inflation calculator to 2012 dollars = $1,562.29 per case. * *The Hidden Epidemic*, Institute of Medicine, 1997. Table D-2, page 342

022817305.3.6	**3-IT-11.1**	***Improvement in target population to reduce Gonorrhea and Chlamydia STD rates in the City of Arlington***	
Tarrant County/dba Tarrant County Public Health			*022817305*
Related Category 1 or 2 Projects:	*022817305.2.3*		
Starting Point/Baseline:	*Total 2011 Arlington Minority Gonorrhea and Chlamydia Cases = 1,431*		
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 [P-2]: Establish baseline rates, for cases identified in Arlington and clinic utilization in 2011. Data Source: AHS semi-annual Narrative Report 2011. Process Milestone 1: Analyze current STD rates & compare to 2011 report. Estimated Incentive Payment *(maximum amount):)$0*	**Outcome Improvement Target 1** [IT-1.1]: Arlington Minority STD Rates for gonorrhea and chlamydia are reduced when compared to baseline 2011 reports. Improvement Target: 3% Data Source: AHS Semi-annual Narrative Report Outcome Improvement Target 1 Estimated Incentive Payment*:* $45,796	**Outcome Improvement Target 2** [IT-1.1]: Arlington Minority STD Rates for gonorrhea and chlamydia are reduced when compared to baseline 2011 reports. Improvement Target: 6% Data Source: AHS Semi-annual Narrative Report Outcome Improvement Target 2 Estimated Incentive Payment*:* $48,991	**Outcome Improvement Target 3** [IT-1.1]: Arlington Minority STD Rates for gonorrhea and chlamydia are reduced when compared to baseline 2011 reports. Improvement Target: 10% 150 fewer cases reported Data Source: AHS Semi-annual Narrative Report Outcome Improvement Target 3 Estimated Incentive Payment*:* $106,502
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $45,796	Year 4 Estimated Outcome Amount: $48,991	Year 5 Estimated Outcome Amount: $106,502
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $201,289			

Title of Outcome Measure (Improvement Target): IT-11.1 –Improvement in Clinical Indicator in identified disparity group – (Improvement in target population to reduce the minority syphilis STD rate in the City of Arlington)

Unique RHP outcome identification number(s): - 022817305.3.7
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Outcome Measure Description:
IT-11.1 –Improvement in Clinical Indicator in identified disparity group – (Improvement in target population to reduce the minority syphilis STD rate in the City of Arlington)

Identify, hire and train medical staff for STD clinical operations in Arlington. Develop schedule to allow a Saturday clinic for at least 6 hours. Begin to advertise and inform the community of the new clinic schedule. Outcome measures in year 3 and 4 will increase clinic utilization by 10% annually. By the end of year 5, with an additional 10% increase in client utilization, there should be a 10% reduction in minority syphilis STD rates reported in Arlington when compared to the baseline rates in 2011.

Rationale:
The number of Sexually Transmitted Diseases (STD) diagnosed cases continues to increase in Tarrant County. The Arlington area continues to produce a high number of new STD infections (11,621 chlamydia, gonorrhea, syphilis and HIV reported by ZIP code to Tarrant County Public Health, Adult Health Services Division, Surveillance Unit in 2011). The Arlington area does not have a full time STD/HIV medical provider to service the population on a daily basis. Minority populations, Blacks and Hispanics, are disproportionately affected by chlamydia, syphilis, gonorrhea and HIV infections. Implementing a full service STD/HIV clinic, 5 days per week, within the City of Arlington, will provide essential STD services and begin to reduce the STD reservoir. The outcome measure is to reduce STD/HIV morbidity by 10% from 2011 STD/HIV levels.

The process milestones reflect the steps necessary to provide STD services to the clients in the City of Arlington to reduce STD rates in the city and the County.

Outcome Measure Valuation:

- **Approach/Methodology:** The National Centers for Disease Control and Prevention have developed program standards to achieve reductions in STD levels in state, county and city STD Programs. Best practices for program implementation and operation are available at the CDC website. The Texas State Department of Health Services has adopted the same requirements and lists them on the state website. Tarrant County

implemented the same basic standards for clinical operations. The outcome measures are related to a reduction of individuals reported with sexually transmitted infections. Baseline data is listed below:

- STD trends continue to increase in Arlington ZIP codes. The target for this intervention is the minority populations in the City of Arlington. The current population is 365,438 (2010 Census) with 29% Hispanic and 17% African-American, 8% "other" (mixed race, Native American, Asian and not listed) for a total minority population of about 54%. Youth under the age of 24 are the fastest growing group of individuals acquiring STD/HIV infections. Current disease trends list ages 15-24 as having 51% of new syphilis infections, 73% of the chlamydia cases and 35% of the new HIV cases. This young age group is less likely to seek medical services in other areas of the County, especially since there is a transportation deficit in Arlington. Syphilis and HIV cases have increased in Arlington by 20% over the previous year.
- The cost savings for a reduction of 20 minority syphilis cases in 3,000 clients using the Arlington location annually, at a potential savings of $15,000.00 for the prevention of a central nervous system case of syphilis. This total value of $304,500.00 is multiplied by individual impact of 3 and a community impact of 2 to determine values per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total syphilis outcome valuation of $3,958,500.00 project valuation.
  The combined category 3 valuation equals $6,864,828.00. The actual project value was discounted due to the amount of total Public Health DSRIP funds available to $3,252,417.00. This is a 52.6% valuation discount.

2011 Arlington Totals STD Cases Reported

Syphilis (early) Reported 245 Minorities = 203 or 83%

Rationale/Justification: Using the Bureau of Labor Statistics inflation calculator to calculate 2012 dollars, preventing a Central Nervous System (CNS) case of syphilis saves $16,473.31 per serious case of CNS Impairment. Serious and very severe CNS Impairment occurs in 6% to 16% of Syphilis cases = $16,473.31. For valuation purposes we utilized $15,000.

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* *The Hidden Epidemic*, Institute of Medicine, 1997, Table 2.5, Table D-2, p59, p 342.

-022817305.3.7	**IT-11.1**	**Implement Evidenced-based Strategies and Referrals for targeted Populations to reduce Minority Syphilis STD Rates in the City of Arlington.**	
Tarrant County/dba Tarrant County Public Health			*022817305*
Related Category 1 or 2 Projects:	*- 022817305.2.3*		
Starting Point/Baseline:	*Arlington Minority Syphilis Rate is 83% of the Total 2011 Arlington Syphilis Cases*		
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-7]: Recruit ,hire and train the following full-time positions: a Clinic RN, LVN or MA, Clerk, and Microbiologist to provide STD assessments and treatment for clients seen in the Arlington STD clinic. Train all staff in current TCPH-DSHS clinical protocols for clinical assessment and treatment. Data Source: AHS Semi-Annual Narrative Report Process Milestone 1 Estimated Incentive Payment *(maximum amount):)$0*	**Outcome Improvement Target 1** [IT-1.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: Increase STD Clinic utilization to 230 clients per month Data Source: STD Clinic Utilization Report Outcome Improvement Target 1 Estimated Incentive Payment*:* $33,623	**Outcome Improvement Target 2**[IT 11.6]: Other (Client clinic utilization increases) Improvement Target: increase to 6% in client utilization Data Source: STD Clinic Utilization Report Outcome Improvement Target 2 Estimated Incentive Payment*:* $35,969	**Outcome Improvement Target 3** : [IT 11.1]: Improvement in Clinical Indicator in identified disparity group (STD Rates in the minority syphilis population is reduced when compared to baseline 2011 reports) Improvement Target: Reduced by 10% 23 fewer syphilis cases reported Data Source: AHS Semi-annual Narrative Report Outcome Improvement Target 3 Estimated Incentive Payment*:* $78,193
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $33,623	Year 4 Estimated Outcome Amount: $35,969	Year 5 Estimated Outcome Amount: $78,193
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $147,785			

Title of Outcome Measure (Improvement Target): IT-2.3: Hypertension Admission Rate

Unique RHP outcome identification number(s): - 022817305.3.8
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Outcome Measure Description:
Process Milestones:
DY2/DY3 Process Milestones:

- P-1: Project planning- engage community stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans community.
- P-2: Establish baseline.
- P-3: Develop and test data systems

Outcome Improvement Targets for each year:
DY4/5 Improvement targets**:**

- IT-6: 20%, 25% and 35% respectively, of the patients in the defined population receiving innovative intervention consistent with evidence-based model will have a reduction in admissions relating to hypertension and strokes.

Rationale:
Tarrant County residents spent Nearly $87 million on preventable hospitalizations relating to hypertension between 2005-2010 [8] . Between 2005 and 2010 the number of PPH increased by 25%[8]. Evidence shows that the CDSMP has helped to decreased the number of hospitalization days thereby saving medical dollars while helping to sustain individual quality of life. [1,2,10] The program has realized a savings between $390 and $520 per participant over a study period of two years due in part to participants being hospitalized fewer days in the first six-months of the program[2]. This project will help clients self-manage their blood pressure and make appropriate use of the primary care provider setting as opposed to using the ED for management[1].

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** Performing providers in Region 10 recognize that Category three outcomes represent the value that CMS hopes to achieve through the Waiver.

Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- Tarrant County Public Health defined the population that will be directly impacted by the project as individuals identified as the number of participants in the Chronic Disease Self-Management Program (CDSMP) education. The percentage of the population expected to be positively impacted by the project in DY5 is 35%. Of that 35%, 10% would possibly have been hospitalized for a stroke. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.
- To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because; with the CDSMP education the participants will have increased knowledge to assist them in managing their hypertension.

  To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when

022817305.3.8	3.IT-2.3	Potentially Preventable Admissions- (PPA)- Hypertension Admission Rate	
Tarrant County Public Health			022817305
Related Category 1 or 2 Projects:	*028817305.2.4* Implement Evidence-based Health Promotion Programs- Establish self-management programs and wellness using evidence-based designs (Tarrant County Chronic Disease Self-Management Program)		
Starting Point/Baseline:	**Baseline data:** The baseline will be obtained in DY2 based upon the actual number of provider contact with clients who have had hypertension admissions. **Target population:** Adult-aged clients identified as having a chronic illness including high blood pressure **Specific Number**: The target number of contacts is ~2600 through DY5. **Description of Population:** Clients being seen in Tarrant County who have a chronic 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-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data source: Meeting minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Milestone 2** [P-2]: Establish baseline rates for cohort participants: Data Source: Physician practice patient records and hospital inpatient statistics Process Milestone 2 Estimated Incentive Payment: $0 **Milestone 3** [P-3] Develop and test data systems for 200 program participants	**Milestone 4** [P-1]**:** Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data source: Meeting minutes Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $35,531 **Outcome Improvement Target 1** [IT-2.3]: Hypertension Admission Rate Improvement Target: The hypertension admission rates for 600 DY3 program participants will be 20% below baseline established in DY2. Data Source: EMR and Self-reporting Outcome Improvement Target 1 Estimated Incentive Payment*:*	**Outcome Improvement Target 2** [IT-2.3]: Hypertension Admission Rate Improvement Target: The hypertension admission rates for 800 DY4 program participants will be 25% less than the baseline established in DY2. Data Source: EMR and self - reporting Outcome Improvement Target 2 Estimated Incentive Payment*:* $76,020	**Outcome Improvement Target 3** [IT-2.3]: Hypertension Admission Rate Improvement Target: The hypertension admission rates for 1,000 DY5 program participants will be 35% less than the baseline established in DY2. Data Source: EMR and self - reporting Outcome Improvement Target 3 Estimated Incentive Payment*:* $165,261

022817305.3.8	3.IT-2.3	Potentially Preventable Admissions- (PPA)- Hypertension Admission Rate	
Tarrant County Public Health			022817305
Related Category 1 or 2 Projects:	*028817305.2.4* Implement Evidence-based Health Promotion Programs- Establish self-management programs and wellness using evidence-based designs (Tarrant County Chronic Disease Self-Management Program)		
Starting Point/Baseline:	**Baseline data:** The baseline will be obtained in DY2 based upon the actual number of provider contact with clients who have had hypertension admissions. **Target population:** Adult-aged clients identified as having a chronic illness including high blood pressure **Specific Number**: The target number of contacts is ~2600 through DY5. **Description of Population:** Clients being seen in Tarrant County who have a chronic 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)**
Data Source: Program records Process Milestone 3 Estimated Incentive Payment: $0	$ 35,531		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $71,062	Year 4 Estimated Outcome Amount: $76,020	Year 5 Estimated Outcome Amount: $165,261
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $312,343			

Title of Outcome Measure (Improvement Target): IT-12.6- Other Outcome Improvement Target

Unique RHP outcome identification number(s): - 022817305.3.9
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Outcome Measure Description:

Process Milestones:

- In DY2 protocols will be created for LTBI treatment with rifapentine, staff will be hired and trained and enrollment in the program will begin. Also the current LTBI database will be maintained and a second one will be created for tracking patients' rifapentine doses.
- In DY3 100% of the patients on rifapentine will have doses tracked in the database created to monitor for patients missing multiple doses. Those missing doses will be contacted by staff to ensure patients are not "lost" and to find areas where the program can improve.
    - LTBI treatment completion rates will increase by 20% compared to baseline established in DY2

Outcome Improvement Targets for each year:

- In DY4 Contacts, homeless shelter residents and refugees LTBI treatment completion rates will continue to improve by 25% over DY2 baseline.
- By the end of DY5, completion rates will increase by 30% for contacts, homeless shelter residents and refugees combined. All of these outcome improvements are possible and could be better because of the shorter treatment duration and following patients' doses in the database.

Rationale:
Currently completion rates among these high risks groups is less than 60%. Much of this can be attributed to the 9 month (270 doses) regimen required to complete LTBI treatment. Although this 12 dose regimen is more expensive than other types of treatment a CDC study has shown greater compliance and completion of treatment. Also the price of treating a single case of TB without having any complications of drug resistances can still be much more than treating the 15 people a single case of TB can expose.

The process milestones setup involve creating protocols, hiring/ training staff and creating a database specifically designed to track patients on rifapentine and document all information required for treatment.

The outcome improvements reflect the increasing LTBI treatment completion rates that will be a result of the shorter rifapentine regimen.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community.*(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** Tarrant County Public Health defined the population that will be directly impacted by the project as individuals indentified as the number of LTBI clients receiving rifapentine medication. The percentage of the population expected to be positively impacted by the project is 30%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.27% of the total project valuation was allocated to Category 1 and 2. The goal by the end of DY5 is local hospitals will not report more than a 30% increase in Active TB cases (among Tarrant County residents). The cost savings for the 174 additional LTBI clients that complete their LTBI medication treatment is the cost to the medical system to restart the medication treatment after the failure of $1,092 per client (174 X $1,092 = $190,008). This total value of $190,008 is multiplied by individual impact of 3 and community impact of 3 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the actual total outcome valuation of IT-5.1 of $2,717,114.

- To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person is does not successfully complete the medication treatment it is possible for the latent TB to convert to a case of Active TB. Once converted to active TB the individual health is affected. If the medication treatment was partially completed there is an enhanced chance of developing a drug resistant strain of TB. This type TB is usually treated with IV therapy. Drug resistant TB is more serious and costly.
- To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because; when a person does not successfully complete the

medication treatment it is possible for the latent TB to convert to a case of Active TB. Once converted to an Active TB case it is possible for the individual to transmit TB to others. The completion of LTBI medication treatment provides the client with a lifelong health benefit with the prevention of the conversion to an active case of TB. Without the LTBI medication completion a conversion to active TB could occur anytime within the individuals lifetime. In addition to the clients health benefits LTBI medication treatment completion also protects and provides benefits to the clients family members and other close connect individuals.

Outcome Measure 1: 3.IT-5.1 –Valuation Reference
$1,092 cost to the system to restart medication treatment after failure
Baylor Specialty Care

022817305.3.9	3.IT-12.6	Other Outcome Improvement Target- Primary Prevention for Active TB (treating with rifapentine)	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**022817305.2.5 Implement Evidence-based Disease Prevention Program (TB Medication Management)**		
Starting Point/Baseline:	Baseline Date: Current LTBI treatment completion rates for contacts to TB cases is 46% and homeless 28% from 2007-2011. LTBI completion rate for refugees in 2011 was 54%. Target Population: Contacts to TB Cases, Homeless Shelter Residents and Refugees Diagnosed with LTBI. Specific Number: The number will vary but is around 580 annually. Description of population: Patients who are diagnosed as LTBI and belong to one of the high risk groups mentioned above.		
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. Develop protocols/ procedures, hire/ train staff and begin enrollment in Rifapentine program. By the end of DY2 all staff members will have been hired, trained and familiar with TB Division Policies and Procedures, including the Rifapentine Procedures that will be developed. Poor LTBI treatment completion rates are a problem facing Tarrant County and the rest of the nation. The poor rates led to a study conducted by the CDC to improve completions through decreasing the number of doses and length of treatment. Data Source: TB Division Policies and Procedures, HR Records and Rifapentine Treatment Database, the current	**Process Milestone 2** [P-7]: Rifapentine Treatment Database analyzed to identify those in the program missing multiple doses and questioning to indentify areas of improvement. P-7.1 100% of patients on Rifapentine treatment will have their doses updated in the database. All patients who are noted to miss multiple doses without notifying TB Staff will be contacted to identify reason for missing. Monitoring for patients missing multiple doses and contacting them will help to ensure they are not "lost", and it will help to identify areas where the program can improve. Data Source: Rifapentine Treatment Database Process Milestone 2 Estimated Incentive Payment: - $12,972 **Outcome Improvement Target 1**	**Outcome Improvement Target 2** [IT-12.6]: Other: Primary Prevention for Active TB (treating with Rifapentine) Numerator: Percentage of individuals completing Rifapentine treatment by the end of 2015. Denominator: Percentage of individuals beginning Rifapentine treatment by the end of DY4. Improvement Target: LTBI treatment completion rates will improve by 25% for the 3 high-risk groups over DY2 baseline. Data Source: Rifapentine Treatment Database Outcome Improvement Target 2 Estimated Incentive Payment: $27,755	**Outcome Improvement Target 3** [IT-12.6]: Other: Primary Prevention for Active TB (treating with Rifapentine) Numerator: Percentage of individuals completing Rifapentine treatment by the end of 2016. Denominator: Percentage of individuals beginning Rifapentine treatment by the end of DY5. Improvement Target: LTBI treatment completion rates will improve by 30% for contacts, homeless shelter residents and refugees combined over DY2 baseline. Data Source: Rifapentine Treatment Database Outcome Improvement Target 3 Estimated Incentive Payment: $60,337

022817305.3.9	**3.IT-12.6**	**Other Outcome Improvement Target- Primary Prevention for Active TB (treating with rifapentine)**	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**022817305.2.5 Implement Evidence-based Disease Prevention Program (TB Medication Management)**		
Starting Point/Baseline:	Baseline Date: Current LTBI treatment completion rates for contacts to TB cases is 46% and homeless 28% from 2007-2011. LTBI completion rate for refugees in 2011 was 54%. Target Population: Contacts to TB Cases, Homeless Shelter Residents and Refugees Diagnosed with LTBI. Specific Number: The number will vary but is around 580 annually. Description of population: Patients who are diagnosed as LTBI and belong to one of the high risk groups mentioned above.		
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)**
LTBI Database will be analyzed for years 2007-2011 to establish DY2's baseline for contacts and homeless; 2011 for refugees. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	[IT-12.6]: Other: Primary Prevention for Active TB (treating with Rifapentine)There have been studies conducted that prove LTBI treatment with Rifapentine increases completion rates and in the long term is actually less expensive. In Dec 2011 the CDC approved Rifapentine for LTBI treatment and highlights the benefits of this treatment. Numerator: Percentage of individuals completing Rifapentine treatment by the end of 2014. Denominator**:** Percentage of individuals beginning Rifapentine treatment by the end of DY3. Improvement Target: LTBI treatment completion rates for contacts, homeless shelter residents and refugees will improve by a combined 20% over DY2 baseline. Data Source: Rifapentine Treatment Database		

022817305.3.9	**3.IT-12.6**	**Other Outcome Improvement Target- Primary Prevention for Active TB (treating with rifapentine)**	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**022817305.2.5 Implement Evidence-based Disease Prevention Program (TB Medication Management)**		
Starting Point/Baseline:	Baseline Date: Current LTBI treatment completion rates for contacts to TB cases is 46% and homeless 28% from 2007-2011. LTBI completion rate for refugees in 2011 was 54%. Target Population: Contacts to TB Cases, Homeless Shelter Residents and Refugees Diagnosed with LTBI. Specific Number: The number will vary but is around 580 annually. Description of population: Patients who are diagnosed as LTBI and belong to one of the high risk groups mentioned above.		
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 Estimated Incentive Payment: $12,973		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $25,945	Year 4 Estimated Outcome Amount: $27,755	Year 5 Estimated Outcome Amount: $60,337
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*:- $114,037			

Title of Outcome Measure (Improvement Target): 3.IT-5.1: Improved cost savings: Demonstrate cost savings in care delivery

Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/022817305
Unique RHP Outcome Identification Number: 022817305.3.15 (Pass 2)

Outcome Measure Description:
By the conclusion of the Waiver, our goal is to increase the number of clients who complete their LTBI treatment by 20% and show cost savings by having assisted those patients with completion of their plan of care.

Process Milestones:

- **DY2:** Establish projects plans and baseline rates for LTBI treatment completion to be compared with project completion rates.
- **In DY3:** Test the current data collection system and serve the first clients in the after-hours clinic.

Outcome Improvement Targets:

- **DY4:** Improvement in patients who complete LTBI treatment by 10% over DY2 baseline
- **DY5:** Improvement in patients who complete LTBI treatment by 20% over DY2 baseline. Of that 20% increase, 10% would have been expected to convert to active TB. Cost savings are calculated on 10% of the clients who completed LTBI treatment. Ten percent is the known percentage that would be expected to convert to active TB when LTBI treatment is not completed. This is calculated by multiplying the cost of treatment of active TB case times the number that would have converted to active TB if left untreated.

Rationale:
Both the milestones and improvement targets were set to improve the cost of treating tuberculosis in Tarrant County. By increasing completing LTBI treatment before progressing to active disease, the cost to individuals and the health care system is reduced. LTBI patients accrue a cost of approximately $205 for a nine-month treatment course and the cost of six months of standard treatment for TB disease is approximately $12,511.71. Since approximately 10% of identified contacts to known cases will progress to active disease, the savings will be substantial. Tarrant County identifies approximately 990 LTBI cases per year that are initiated on treatment. Currently 46% complete LTBI treatment. By increasing TB clinic hours, it is anticipated that the LTBI completion rate at the end of DY5 will be 66%, with a cost valuation goal of preventing nine additional LTBI clients from converting to an active TB case.

Outcome Measure Valuation:

Approach/Methodology:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed

at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:
Tarrant County Public Health defined the population that will be directly impacted by the project as the number of LTBI clients seen in DY5 compared to the number seen in 2011. The percentage of the population expected to be positively impacted by the project is a 20% increase in LTBI clients seen. Of that 20% seen, 10% would have been expected to convert to active TB; therefore approximately nine will be positively impacted by nonconversion to active TB. Based on HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 10.74% of the total project valuation was allocated to Category 3. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. **Outcome Measure 2: 3.IT-5.1** 91 additional clients are expected to complete LTBI treatment of those 91 clients 10% would have been expected to convert to active time without LTBI treatment completion or 9. At least $12,307 is saved for each of the 9 LTBI treatment completion clients ($12,307 X 9 = $110,763. $110,763 is multiplied by the individual impact of 3 and the community impact of 3 to determine the value per year. The total value is multiplied by 5 years and a halo effect of 1.3 to determine the IT-1.20 actual total outcome valuation of $1,583,911. However due to Public Health DSRIP funding availability the project was discounted 7.8% .

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person is does not successfully complete the medication treatment, it is possible for latent TB to convert to active TB. Once converted to active TB, the individual's health is affected. If the medication treatment is partially completed, there is increased likelihood of developing a drug-resistant strain of TB. Usually treated with IV therapy, drug-resistant TB is more serious and costly.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person does not successfully complete the medication treatment it is possible for latent TB to convert to active TB. Once converted to active TB, it is possible for the individual to transmit TB to others. If the TB strain transmitted is a drug-resistant strain, treatment costs are further increased.

Valuation Reference
Outcome Measure : 3.IT-5.1
$12,307 saved on each non conversion to active TB compared to the cost of LTBI treatment Holland et al. Costs and cost-effectiveness of four treatment regimens for latent tuberculosis infection.

022817305.3.15	3.IT 5.1	IT5.1:Improved cost saving: Demonstrate cost savings in care delivery-	
Tarrant County/dba Tarrant County Health Dept.			**022817305**
Related Category 1 or 2 Projects::	**022817305.1.2 Expand Primary Care Capacity-TB Clinic Expansion**		
Starting Point/Baseline:	**Baseline Data:** The actual number of LTBI patients currently accepting treatment and serviced by the Tarrant County Public Health Tuberculosis Clinic as noted in the current database managed at the clinic. **Target Population:** The diagnosed Tarrant County Population who have latent tuberculosis and who accept preventive 6-9 month treatment for that infection. **Specific Number:** The number varies yearly but is expected to be approximately 990 cases per year. **Description of the Population:** The majority of the population served is low income families exposed to a recent case of tuberculosis, homeless or otherwise in congregate settings. In addition special contacts occur within schools, jails, hospitals, as new immigrants/refugees, and medically underserved.		
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:** Policy and Procedure guidelines, Department documentation Process Milestone 1 Estimated Incentive Payment (maximum amount): $0 **Process Milestone 2 [P-2]** Data Source: LTBI database and department documentation of statistical evaluation process Process Milestone 2 Estimated Incentive Payment: $0	**Process Milestone 3 [P-3]:** Develop and Test data systems **Data Source:** LTBI database, American Journal of Respiratory Critical Care Medicine June 2009:179(11):1055-1060 Tarrant County Public Health TB department statistical documentation. Process Milestone 3 Estimated Incentive Payment: **$35,626**	**Outcome Improvement Target 1** [IT-5.1]: Improved cost savings Improvement Target: 10% increase in LTBI completion rates over the DY2 Baseline. Data Source: Tarrant County LTBI database Outcome Improvement Target 1 Estimated Incentive Payment: **$38,175**	**Outcome Improvement Target 2** [IT-5.1] Improved Cost Savings: Improvement Target: 20% increase in LTBI completion rates over the DY2 Baseline. Of those, 10% would have been expected to convert to Active TB had they not completed LTBI treatment. Data Source: Tarrant County LTBI database Outcome Improvement Target 2 Estimated Incentive Payment: **$82,988**

022817305.3.15	3.IT 5.1	IT5.1:Improved cost saving: Demonstrate cost savings in care delivery-	
Tarrant County/dba Tarrant County Health Dept.			**022817305**
Related Category 1 or 2 Projects::	**022817305.1.2 Expand Primary Care Capacity-TB Clinic Expansion**		
Starting Point/Baseline:	**Baseline Data:** The actual number of LTBI patients currently accepting treatment and serviced by the Tarrant County Public Health Tuberculosis Clinic as noted in the current database managed at the clinic. **Target Population:** The diagnosed Tarrant County Population who have latent tuberculosis and who accept preventive 6-9 month treatment for that infection. **Specific Number:** The number varies yearly but is expected to be approximately 990 cases per year. **Description of the Population:** The majority of the population served is low income families exposed to a recent case of tuberculosis, homeless or otherwise in congregate settings. In addition special contacts occur within schools, jails, hospitals, as new immigrants/refugees, and medically underserved.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: - $35,626**	**Year 4 Estimated Outcome Amount: - $38,175**	**Year 5 Estimated Outcome Amount: - $82,988**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**: - $156,789**			

Title of Outcome Measure (Improvement Target): IT-10.1: Quality of Life

Unique RHP Outcome Identification Number: 022817305.3.16 (Pass 3)
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/022817305

Outcome Measure Description:
Process Milestones:
By the end of the waiver, our goal is to reach 60% of smokers who have Medicaid and are patients in the Texas Health Resources (THR) network. **DY2** initial phase will be to conduct project planning whereby we engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans to establish a tobacco-cessation program that THR and other stakeholders will use. **In DY2** we will also establish baseline rates of Health Related Quality of Life (HRQOL) survey for tobacco users in Tarrant County. In **DY3** as a part of our CQI requirements we will conduct the Plan Do Study Act in order to ensure that we are on the right track to help facilitate the smoking cessation and quality of life improvements we are aiming to realize among program participants.

Outcome Improvement Targets:
In DY3, DY4 and DY5 we will see enrollment of 40%, 50% and 60% respectively of target population into the program, with 90% of program participants having an improved HRQOL survey result upon completion of the program. In DY5, 60% or 600 program participants will have an improved HRQOL survey result upon program completion.

Rationale:
We selected our process outcomes and improvement targets to develop a program that stakeholders and community partners will want to access and refer clients to. We selected the five-year target of 60% referral rate because we want to impact the smoking Medicaid population in Tarrant County, and realize that not all smokers will want to enroll into our program, but may choose to use an alternative tobacco-cessation program upon being introduced to it through our program. By the end of DY5, 25% of DY4 participants will remain smoke-free for one year. We selected to measure quality of life because it includes all aspects of life that can directly or indirectly affect the appropriate use of medical services, productivity and sustainability of employment, all of which affect the finances of Tarrant County, Texas and the federal government. According to research conducted by Megan Piper and the University of Wisconsin School of Medicine, Tobacco Research and Intervention from 2005-2007, those who practiced tobacco-ce324ssation experienced improved mood and fewer stressors for up to three years after stopping tobacco use.[325]

Outcome Measure Valuation:
Approach/Methodology:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed

[324] Texas Behavioral Risk Factor Surveillance System, 2010.Center for Health Statistics, Texas Department of State Health Services.
[325] See Cardiovascular Disease Risk Among the Poor and Homeless – What We Know So Far by Charlotte A. Jones et al. Curr. Cardio. Rev. 2009, January; 5(1):69-77; The Centers for Disease Control 2011 National Fact Sheet on Diabetes

at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V. B. for a full explanation of the model.)*

Rationale/Justification:
Tarrant County Public Health computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V. B. for a full explanation of the model.)*

Tarrant County Public Health defined the population that will be directly impacted by the project as individuals identified as Tarrant County smokers with Medicaid who participate in Tarrant County Public Health smoking-cessation classes. The total number of the Tarrant County population expected to be positively impacted by the end of DY5 is approximately 2,400 cessation class participants. The goal by the end of DY5 is 60% or approximately 600, will have an improved HRQOL survey result upon program completion. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.26% of the total project valuation was allocated to Category 1 and 2 . The 600 participants with improved quality of life times two quality of life values (productivity of $3,961.88 and medical cost of $2,342.56) or 600 X $6,304 equals $3,782,664. This amount is multiplied by individual impact of 5 and community impact of 4 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the total project valuation. The actual Tobacco Intervention total project valuation for 5 years equals $68,844,485. However, due to the DSRIP Public Health funding available and the project valuation maximum the Tobacco Intervention project was discounted by 67.5% to a total project valuation of $22,405,703.
We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Dollar valuations for the expected impact are from Penn State, "Potential costs and benefits of smoking cessation for Texas, Tables 2 and 3, April 30, 2010.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 5**.** We believe this to be the correct number because upon being tobacco free for one year it is assumed the participant will remain smoke free for life. This has great impact on of the health improvement, increase in productivity and the reduction in medical cost as a results of being a non-smoker/ex-smoker. We believe this to be the correct number because as the FDA warnings on cigarette packages and advertising state, "cigarettes causes fatal lung disease,", "cigarettes cause cancer," and "cigarettes cause strokes and heart disease."

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because reducing the number of smokers for a life time also reduces the harm to nonsmokers in the community from secondhand smoke. The FDA warnings on cigarette packages and advertising state, "tobacco smoke can harm your children" and "smoking during pregnancy can harm your baby." In addition, it will save community resources and medical costs by reducing smoke-related medical services for both the new non-smokers and those with health issues as a result of the second hand smoke.

022817305.3.16	IT-10.1	Quality of Life / Functional Status	
Tarrant County/dba Tarrant County Public Health			022817305
Related Category 1 or 2 Projects:	022817305.2.8 Implement innovative evidence-based strategies to reduce tobacco use (Tarrant County Tobacco Intervention Program)		
Starting Point/Baseline:	**Baseline data:** We do not have the actual number of Tarrant County tobacco users who are Medicaid covered clients receiving medical care from our target providers. We will establish this baseline in DY2. **Target Population:** Adults aged 18 and older who are tobacco users in Tarrant County. **Specific Number:** Number will vary, but we are targeting 2400 unique individuals. **Description of Population:** Adult-aged tobacco users in Tarrant 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: Meeting minutes and program protocols Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2[P-2]** Establish baseline rates of Health Related Quality of Life survey for tobacco users in Tarrant County **Data Source:** HRQOL survey scores Process Milestone 2 Estimated Incentive Payment: $0	**Process Milestone 3[P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Data collected from Program participants. **Outcome Improvement Target 1** [IT-10.1]: Program participants will recognize an improvement in their HRQOL survey results from baseline **Improvement Target**: 40% above baseline **Data Source**: Program participant survey results, program data Outcome Improvement Target 1 Estimated Incentive Payment*:* **$546,635**	**Outcome Improvement Target 2** [IT-10.1]: Program participants will see an improvement in their HRQOL survey results from their baseline **Improvement Target**: 50% above baseline **Data Source**: Program participant survey results, program data Outcome Improvement Target 2 Estimated Incentive Payment*:* $585,734	**Outcome Improvement Target -3** [IT-10.1]: Program participants will see an improvement in their HRQOL survey results from their baseline **Improvement Target** 60% above baseline **Data Source**: Program participant survey results, program data Outcome Improvement Target 4 Estimated Incentive Payment*:* **$1,273,336**

022817305.3.16	IT-10.1	Quality of Life / Functional Status	
Tarrant County/dba Tarrant County Public Health			022817305
Related Category 1 or 2 Projects:	022817305.2.8 Implement innovative evidence-based strategies to reduce tobacco use (Tarrant County Tobacco Intervention Program)		
Starting Point/Baseline:	**Baseline data:** We do not have the actual number of Tarrant County tobacco users who are Medicaid covered clients receiving medical care from our target providers. We will establish this baseline in DY2. **Target Population:** Adults aged 18 and older who are tobacco users in Tarrant County. **Specific Number:** Number will vary, but we are targeting 2400 unique individuals. **Description of Population:** Adult-aged tobacco users in Tarrant 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)**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $546,635**	**Year 4 Estimated Outcome Amount: $585,734**	**Year 5 Estimated Outcome Amount: $1,273,336**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,405,705			

Title of Outcome Measure (Improvement Target): IT-2.14- Other Admission Rate

Unique RHP outcome identification number(s): 022817305.3.17
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Outcome Measure Description:

Process Milestones:

- In DY2 a baseline rate for TB cases reported to TCPH-TB Division will be established. This will be done by reviewing data of TB cases from 2002-2012 and dividing the number of those reported by Tarrant County hospitals by the total number of cases during that timeframe. Based on the data collected the baseline rate for local hospitals reporting new TB cases is 59 per year.

Outcome Improvement Targets for each year:

- In DY3 the number of Tarrant County residents admitted to local hospitals for undiagnosed, Active Tuberculosis will decrease by 1% compared to the baseline established in DY2.
- In DY4 the number of Tarrant County hospitals admitting undiagnosed TB cases will decrease by 2% from DY2 baseline.
- By the end of DY5 the number of undiagnosed TB cases admitted to local hospitals will decrease by 3% from baseline established in DY2. The outcome improvement targets above are possible, and with Rifapentine treatment being offered to those at high risk of developing Active TB, undiagnosed cases of TB within Tarrant County could be better than projected. This treatment for Latent TB Infection (LTBI) will not only impact the next 3 years but many more in the future as TB Infection can become active at any point in someone's life.

Rationale:
Three groups of people with higher risks of developing Active TB are: contacts to TB cases, homeless shelter residents and refugees (foreign born). Each of these groups has a greater risk of developing the disease for various reasons.
By introducing a shorter medication regimen to treat LTBI; these groups of high risk individuals are more likely to complete treatment and a result prevent them from going on to develop Active TB. The more high risk individuals completing LTBI treatment will lead to fewer of them developing Active TB later in life and passing the bacteria on to others.

The process milestone created involves analyzing data for TB cases from 2002-2012 and establishing a baseline percentage for Tarrant County hospital reported cases.

The outcome improvements reflect an expected decrease in the number of TB cases admitted to hospitals within the County as a result of the LTBI regimen.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community.*(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** Tarrant County Public Health defined the population that will be directly impacted by the project as individuals indentified as the number of LTBI clients receiving Rifapentine medication. The percentage of the population expected to be positively impacted by the project is 30%, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 89.27% of the total project valuation was allocated to Category 1 and 2. The goal by the end of DY5 is local hospitals will have a reduction of 3% in reported TB cases. Based on a 10 year average 59 TB cases per year are hospital reported cases. There is a savings of $20,100 per potentially preventable TB hospital admissions for the 3% decrease in hospital reported TB cases ($20,100 X 2 = $40,200). $40,200 is then multiplied by the individual impact of 3 and the community impact of 3 to determine the value per year. The total value is multiplied by 5 years and a halo effect of 1.3 to determine the IT-2.14 actual total outcome valuation of $574,860.

- To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person is does not successfully complete the medication treatment it is possible for the latent TB to convert to a case of Active TB. Once converted to active TB the individual health is affected. If the medication treatment was partially completed there is an enhanced chance of developing a drug resistant strain of TB. This type TB is usually treated with IV therapy. Drug resistant TB is more serious and costly.
- To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because; when a person does not successfully complete the medication treatment it is possible for the latent TB to convert to a case of Active TB.

Once converted to an Active TB case it is possible for the individual to transmit TB to others. The completion of LTBI medication treatment provides the client with a lifelong health benefit with the prevention of the conversion to an active case of TB. Without the LTBI medication completion a conversion to active TB could occur anytime within the individuals lifetime. In addition to the clients health benefits LTBI medication treatment completion also protects and provides benefits to the clients family members and other close connect individuals.

Outcome Measure 2: 3.IT-2.14
$20,100 TB case hospital cost
"Tuberculosis Stays in US Hospitals, 2006", Laurel Homquist, M.S., C. Allison Russo M.P.H., and Anne Elixhaurser PhD

022817305.3.17	**3.IT-2.14**	**Other Admission Rate- Undiagnosed Active Tuberculosis hospital admissions (treating LTBI with Rifapentine to prevent Active TB development)**	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**022817305.2.5 Implement Evidence-based Disease Prevention Program (TB Medication Management)**		
Starting Point/Baseline:	Baseline Date: From 2002-2012, 52% of all TB cases were reported from local hospitals (652 out of 1254). Based on this data the baseline is 59 new, active TB cases/year reported by local hospitals (Tarrant County residents). Target Population: Contacts to TB Cases, Homeless Shelter Residents and Refugees Diagnosed with LTBI. Specific Number: The number will vary but is around 580 annually. Description of population: Patients who are diagnosed as LTBI and belong to one of the high risk groups mentioned above. Many of these people do not have a medical home and are in and out of the ER for TB signs and symptoms prior to diagnosis.		
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. Look over data from previous TB cases and analyze to determine the percentage of TB cases reported to Health Department by hospitals in Tarrant County from 2002-2012. DY2 baseline is 59. Data Source: TB Case Database Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Outcome Improvement Target 1** [IT-2.14]: Other Admission Rate: TB Case Admission Rate (treating LTBI with Rifapentine to prevent Active TB development) Numerator: TB cases residing in Tarrant County, reported to Health Department by hospitals within the county in DY3. Denominator**:** Total number of Tarrant County residents diagnosed with Active TB in DY3. Improvement Target: The number of TB cases (Tarrant County residents) reported to the Health Department by local hospitals will decrease by 1% from DY2 baseline. Data Source: TB Case Database Outcome Improvement Target 1 Estimated Incentive Payment*: $5,489*	**Outcome Improvement Target 2** [IT-2.14]: Other Admission Rate: TB Case Admission Rate (treating LTBI with Rifapentine to prevent Active TB development) Numerator: TB cases residing in Tarrant County, reported to Health Department by hospitals within the county in DY4. Denominator**:** Total number of Tarrant County residents diagnosed with Active TB in DY4. Improvement Target: The number of TB cases (Tarrant County residents) reported to the Health Department by local hospitals will decrease by 2% from DY2 baseline. Data Source: TB Case Database Outcome Improvement Target 2 Estimated Incentive Payment*: $5,872*	**Outcome Improvement Target 3** [IT-2.14]: Other Admission Rate: TB Case Admission Rate (treating LTBI with Rifapentine to prevent Active TB development) Numerator: TB cases residing in Tarrant County, reported to Health Department by hospitals within the county in DY5. Denominator**:** Total number of Tarrant County residents diagnosed with Active TB in DY5. Improvement Target: The number of TB cases (Tarrant County residents) reported to the Health Department by local hospitals will decrease by 3% from DY2 baseline. Data Source: TB Case Database Outcome Improvement Target 3 Estimated Incentive Payment*: $12,766*

022817305.3.17	**3.IT-2.14**	**Other Admission Rate- Undiagnosed Active Tuberculosis hospital admissions (treating LTBI with Rifapentine to prevent Active TB development)**	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**022817305.2.5 Implement Evidence-based Disease Prevention Program (TB Medication Management)**		
Starting Point/Baseline:	Baseline Date: From 2002-2012, 52% of all TB cases were reported from local hospitals (652 out of 1254). Based on this data the baseline is 59 new, active TB cases/year reported by local hospitals (Tarrant County residents). Target Population: Contacts to TB Cases, Homeless Shelter Residents and Refugees Diagnosed with LTBI. Specific Number: The number will vary but is around 580 annually. Description of population: Patients who are diagnosed as LTBI and belong to one of the high risk groups mentioned above. Many of these people do not have a medical home and are in and out of the ER for TB signs and symptoms prior to diagnosis.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $5,489	Year 4 Estimated Outcome Amount: $5,872	Year 5 Estimated Outcome Amount:$12,766
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$24,127			

Title of Outcome Measure (Improvement Target): IT-2.14 Other Admission Rate

Unique RHP Outcome Identification Number: 022817305.3.18 (Pass 2)
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/022817305

Outcome Measure Description:
Process Milestone:
DY2: A Baseline rate for TB cases reported to TCPH-TB Division will be established. This will be accomplished by reviewing the data of TB cases reported from 2002-2012 and dividing the number of those reported by Tarrant County hospitals by the total number of cases during that time frame.

Outcome Improvement Targets:
DY3: The number of Tarrant County residents admitted to local hospitals for undiagnosed, Active Tuberculosis will decrease by 1% over the baseline established in DY2.
DY4: The number of Tarrant County hospitals admitting undiagnosed TB cases will decrease by 2% of the DY2 baseline.
DY5: By the end of DY5, the number of undiagnosed TB cases admitted to local hospitals will decrease by 3% over the baseline established in DY2. The outcome improvement targets above are possible in combination with the Rifapentine treatment project that targets high risk populations and the increased LTBI treatment follow up hours that provide flexibility in treatment follow through. Improved Latent TB Infection (LTBI) treatment will impact the community not only in these 3 years but significantly for the future by curtailing the transition of latent infection into active disease.

Rationale:

The number of patients identified to smear positive tuberculosis cases fluctuates from year to year. Some cases have larger families and significant community contact points that must be evaluated. Others do not live with anyone and may be employed in areas with limited contact with others. In a five-year retrospective look at completion rates, the trend in Tarrant County is below the targeted number set by the CDC as described in Healthy People 2020. To improve on that rate, the opportunity for more contact with clients diagnosed with latent tuberculosis has the potential to decrease active disease in the community.

The process milestone create involves analyzing data for TB cases from 2002-2012 and establishing a baseline percentage for Tarrant County hospital reported cases. The outcome improvements reflect the expected decrease in the potential number of TB cases admitted to hospitals within the County as a result of the LTBI treatment programs.

Valuation:

Approach/Methodology: Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V. B. for a full explanation of the model.)*

Rationale/Justification:

Tarrant County Public Health defined the population that will be directly impacted by the project as the number of LTBI clients seen in DY5 compared to the number seen in 2011. A 20% increase in LTBI clients seen is the positive population impact of this project. The positive impact is a 3% decrease in the annual hospital reported TB cases. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. Based on HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 10.74% of the total project valuation was allocated to Category 3. **Outcome Measure 3: 2.14** Based on a 10 year average 59 TB cases per year are hospital reported cases. There is a savings of $20,100 per potentially preventable TB hospital admissions for the 3% decrease in hospital reported TB cases ($20,100 X 2 = $40,200). $40,200 is then multiplied by the individual impact of 3 and the community impact of 3 to determine the value per year. The total value is multiplied by 5 years and a halo effect of 1.3 to determine the IT-2.14 actual total outcome valuation of $574,860. However due to Public Health DSRIP funding availability the project was discounted 7.8% .

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person does not successfully complete the medication treatment, it is possible for latent TB to convert to active TB. Once converted to active TB, the individual's health is affected. Active TB can result in long-term negative health effects and, in some cases, death. If the medication treatment is partially completed, there is increased likelihood of developing a drug-resistant strain of TB. Usually treated with IV therapy, drug-resistant TB is more serious and costly.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person does not successfully complete the medication treatment, it is possible for latent TB to convert to active TB. Once converted to active TB, it is possible to infect other individuals in the community.

Valuation Reference:

Outcome Measure 3: 3.IT-2.14

$20,100 TB case hospital cost

“Tuberculosis Stays in US Hospitals, 2006”, Laurel Homquist, M.S., C. Allison Russo M.P.H., and Anne Elixhaurser PhD

022817305.3.18	**3 .IT-2.14**	**Other Admission Rate-Decrease in Tuberculosis hospital admissions (providing additional treatment follow up hours/access with routine LTBI treatment and Rifapentine short coarse treatment to prevent active disease)**	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**022817305.1.2 :Expand Primary Care Capacity-TB Clinic Expansion**		
Starting Point/Baseline:	**Baseline Data**: From 2002-2012, 52% of all TB cases were reported from local hospitals (652 out of 1254). *Based on this data, the baseline is 59 new active TB cases/year reported by local hospitals of Tarrant county residents.* ***Target Population:*** *The diagnosed Tarrant County Population who have latent tuberculosis and who accept preventive 6-9 month treatment for that infection.* ***Specific Number:*** *The number varies yearly but is expected to be approximately 990 cases per year.* ***Description of the Population:*** *The majority of the population served is low income families exposed to a recent case of tuberculosis, homeless or otherwise in congregate settings. In addition special contacts occur within schools, jails, hospitals, as new immigrants/refugees, medically underserved and all others who meet the medical criteria for treatment per the health and safety code. Many of these people do not have a medical home and use the hospital as their primary care.*		
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: Look over data from previous TB cases and analyze to determine the percentage of TB cases reported to the Health Department by hospitals in Tarrant County from 2002-2012. DY2 Baseline is 59. Data Source: TB Case Database Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Outcome Improvement Target 1** [IT-2.14] Other Admission Rate: TB case admission rate (offering more treatment access for LTBI medication pick up, staff case management of LTBI clients, and flexible clinic hours) Numerator: TB cases residing in Tarrant County reported to the Health Department by hospitals within the county in DY3 Denominator: Total number of Tarrant County residents diagnosed with active TB in DY3. Improvement Target: The number of TB cases (Tarrant County residents) reported to the Health Department will decrease by 1% over DY2 baseline. **Data Source**: TB Case Database Outcome Improvement Target 1	**Outcome Improvement Target 2** [IT-2.14]: Other Admission Rate: TB case admission rate (offering more treatment access for LTBI medication pick up, staff case management of LTBI clients, and flexible clinic hours) Numerator: TB cases residing in Tarrant County reported to the Health Department by hospitals within the county in DY4 Denominator: Total number of Tarrant County residents diagnosed with active TB in DY4 Improvement Target: The number of TB cases (Tarrant County residents) reported to the Health Department will decrease by 2% over DY2 baseline. **Data Source**: TB Case database Outcome Improvement Target 2	**Outcome Improvement Target 3** [IT-2.14]: Other Admission Rate: TB case admission rate (offering more treatment access for LTBI medication pick up, staff case management of LTBI clients, and flexible clinic hours) Numerator: TB cases residing in Tarrant County reported to the Health Department by hospitals within the county in DY4 Denominator: Total number of Tarrant County residents diagnosed with active TB in DY4 Improvement Target: The number of TB cases (Tarrant County residents) reported to the Health Department will decrease by 3% over DY2 baseline approximately 2. **Data Source**: TB Case database

022817305.3.18	**3 .IT-2.14**	**Other Admission Rate-Decrease in Tuberculosis hospital admissions (providing additional treatment follow up hours/access with routine LTBI treatment and Rifapentine short coarse treatment to prevent active disease)**	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**022817305.1.2 :Expand Primary Care Capacity-TB Clinic Expansion**		
Starting Point/Baseline:	**Baseline Data**: From 2002-2012, 52% of all TB cases were reported from local hospitals (652 out of 1254). *Based on this data, the baseline is 59 new active TB cases/year reported by local hospitals of Tarrant county residents.* ***Target Population:*** *The diagnosed Tarrant County Population who have latent tuberculosis and who accept preventive 6-9 month treatment for that infection.* ***Specific Number:*** *The number varies yearly but is expected to be approximately 990 cases per year.* ***Description of the Population:*** *The majority of the population served is low income families exposed to a recent case of tuberculosis, homeless or otherwise in congregate settings. In addition special contacts occur within schools, jails, hospitals, as new immigrants/refugees, medically underserved and all others who meet the medical criteria for treatment per the health and safety code. Many of these people do not have a medical home and use the hospital as their primary care.*		
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)**
	Estimated Incentive Payment: $12,930	Estimated Incentive Payment: *$13,855*	Outcome Improvement Target 3 Estimated Incentive Payment: *$30,119*

022817305.3.18	**3 .IT-2.14**	**Other Admission Rate-Decrease in Tuberculosis hospital admissions (providing additional treatment follow up hours/access with routine LTBI treatment and Rifapentine short coarse treatment to prevent active disease)**	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**<u>022817305.1.2 :Expand Primary Care Capacity-TB Clinic Expansion</u>**		
Starting Point/Baseline:	**Baseline Data**: From 2002-2012, 52% of all TB cases were reported from local hospitals (652 out of 1254). *Based on this data, the baseline is 59 new active TB cases/year reported by local hospitals of Tarrant county residents.* ***Target Population:*** *The diagnosed Tarrant County Population who have latent tuberculosis and who accept preventive 6-9 month treatment for that infection.* ***Specific Number:*** *The number varies yearly but is expected to be approximately 990 cases per year.* ***Description of the Population:*** *The majority of the population served is low income families exposed to a recent case of tuberculosis, homeless or otherwise in congregate settings. In addition special contacts occur within schools, jails, hospitals, as new immigrants/refugees, medically underserved and all others who meet the medical criteria for treatment per the health and safety code. Many of these people do not have a medical home and use the hospital as their primary care.*		
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)**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $12,930**	**Year 4 Estimated Outcome Amount: $13,855**	**Year 5 Estimated Outcome Amount: $30,119**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**: $56,905***			

Title of Outcome Measure (Improvement Target): IT-- 8.4 Reduce incidence of - preterm births in women with a history of spontaneous preterm birth.

Unique RHP outcome identification number(s): - -022817305.3.19
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Outcome Measure Description:
Process Milestones:

- DY2 – -Develop training plan for providers regarding the use of antenatal steroids.
- DY3 –Develop campaign to educate women with a history of preterm birth about the option of using antenatal steroids.

-**Outcome Improvement Targets for each year:**

- DY4 – - Reduce the incidence of preterm birth for women with a history of spontaneous preterm births by 10%.
- DY5 – -Reduce the incidence of preterm birth for women with a history of spontaneous preterm births by 20%.

-**Rationale:**
Selection of the Category 2 project to implement the use of antenatal steroids for the prevention of preterm birth, in women with a history of preterm birth is listed as an evidenced based practice. Reducing preterm births and low birth weight will lower costs and improve quality of life. The data include Texas Vital Statistics Reports, the Tarrant County Infant Mortality Report, and the TCFIMR reports.

Outcome Measure Valuation:

- **Approach/Methodology:** Please describe your approach for valuing each outcome measure (and its associated process milestones and outcome improvement targets). Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community.*(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:
Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 10.73% of the total project valuation was allocated to Category 3. The DY5 goal is for

the estimated 110 pregnant women with a history of spontaneous preterm birth at least 20% will have infants born full term or approximately 22 full term births.

Outcome Measure 1: -IT 8.4 Reduce Preterm birth The 2005 United States annual societal economic cost associated with preterm birth is $51,600 per infant (22 X $51,600 = $1,135,200). This total value is multiplied by individual impact of 3 and community impact of 2 to determine the value per year. The annual total value is multiplied by 5 years and a halo effect of 1.3 to determine the actual total outcome valuation of IT-8.4 of $14,757,600. Based on the RHP 10 valuation model Category 3 is 10.73% of the total project value or $1,583,894.

If the Bureau of Labor Statistics Consumer Price Index calculation was applied to the 2005 societal economic costs for 2012 dollars the cost would be $60,660 per preterm birth. In 2012 dollars the total project valuation would be $17,348,760. Therefore the project valuation is discounted by 14.9% to the $14,757,600 total project valuation.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because a full term birth contributes to improved outcomes and quality of life.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2**.** We believe this to be the correct number because reducing preterm births reduces the annual societal economic cost associated with preterm birth.

Valuation Reference
Outcome Measure 1: -IT 8.4 Reduce Preterm birth rate

$51,600 per infant born preterm. This is the annual societal economic burden associated with a preterm birth in the United States in 2005.
Institute of Medicine of the National Academies
Preterm Birth Causes, Consequences, and Prevention 2007 Report

022817305.3.19	*3.IT--8.4*	~~**PRETERM BIRTH** – Reducing Preterm Birth Using Antenatal Steroids~~ **IMPLEMENT EVIDENCE-BASED STRATEGIES TO REDUCE PRETERM BIRTH AND LOW BIRTH WEIGHT** – Reducing Preterm Birth and Low Birth Weight Using Antenatal Steroids	
Tarrant County/ dba Tarrant County Public Health			*028817305*
Related Category 1 or 2 project	**022817305.2.1**		
Starting Point/Baseline:	*Baseline: - -)* *330 (number of pregnant women ~~who delivered a preterm birth~~ with a history of spontaneous preterm birth)*		
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 (Inform stakeholders [delivery hospitals/providers] of project plans and baseline regarding the use of antenatal steroids for the prevention of preterm birth and low birth weight in women with a history of spontaneous preterm birth. **Data Source:** Meeting minutes/attendance logs Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-5]: Disseminate education to providers regarding the use of the antenatal steroids. **Data Source:** Meeting minutes/attendance logs Documentation of other media used for the providers. Process Milestone 2 Estimated Incentive Payment *(maximum amount):-* $180,179 **Outcome Improvement Target 1** [IT--] 8.4: Increase in the use of antenatal steroids to help prevent preterm birth. **Data Source**: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* - $180,179	**Outcome Improvement Target 2** [IT--] 8.4: -Preterm birth to woman with a history of spontaneous preterm birth. -Decrease in percent of preterm births by 10%. **Data Source~~:~~** Electronic Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* - $385,499	**Outcome Improvement Target 3** [IT--]8.4: -Preterm birth to woman with a history of spontaneous preterm birth. -Decrease in percent of preterm births by20%. **Data Source:** -Electronic Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $838,037

022817305.3.19	*3.IT-8.4*	~~**PRETERM BIRTH** – Reducing Preterm Birth Using Antenatal Steroids~~ **IMPLEMENT EVIDENCE-BASED STRATEGIES TO REDUCE PRETERM BIRTH AND LOW BIRTH WEIGHT** – Reducing Preterm Birth and Low Birth Weight Using Antenatal Steroids	
Tarrant County/ dba Tarrant County Public Health			*028817305*
Related Category 1 or 2 project	**022817305.2.1**		
Starting Point/Baseline:	*Baseline: - -)* *330 (number of pregnant women ~~who delivered a preterm birth~~ with a history of spontaneous preterm birth)*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $360,358	Year 4 Estimated Outcome Amount: $385,499	Year 5 Estimated Outcome Amount $838,037
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** - $1,583,894			

Title of Outcome Measure (Improvement Target):. IT--8.2 Reduce incidence of low birth weight in women with a history of spontaneous preterm birth.

Unique RHP outcome identification number(s): - -022817305.3.21
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/ 022817305
Outcome Measure Description:
Process Milestones:

- DY2 – -Develop training plan for providers regarding the use of antenatal steroids.
- DY3 –Develop campaign to educate women with a history of preterm birth about the option of using antenatal steroids.

-**Outcome Improvement Targets for each year:**

- DY4 -- Reduce the incidence of low birth weight for women with a history of spontaneous preterm births by 10%.
- DY5 --Reduce the incidence of low birth weight for women with a history of spontaneous preterm births by 20%.

-**Rationale:**
Selection of the Category 2 project to implement the use of antenatal steroids for the prevention of preterm birth, in women with a history of preterm birth is listed as an evidenced based practice. Reducing preterm births and low birth weight will lower costs and improve quality of life. The data include Texas Vital Statistics Reports, the Tarrant County Infant Mortality Report, and the TCFIMR reports.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community.*(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:
Based on the HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 10.73% of the total project valuation was allocated to Category 3. The DY5 goal is for the estimated 110 pregnant women with a history of spontaneous preterm birth at least 20% or 22 births greater than 2500 grams.

Valuation Reference

Outcome Measure 2: - IT 8.2 – Reduce low birth weight

This measure is valued at zero. As the population that is being addressed is the same population that is being addressed in Outcome Measure IT 8.4. It is expected that the increased gestational age will yield increased birth weights.

022817305.3.21	*3.IT--8.2*	**IMPLEMENT EVIDENCE-BASED STRATEGIES TO REDUCE PRETERM BIRTH AND LOW BIRTH WEIGHT** – Reducing Preterm Birth and Low Birth Weight Using Antenatal Steroids	
Tarrant County/ dba Tarrant County Public Health			*028817305*
Related Category 1 or 2 project	**022817305.2.1**		
Starting Point/Baseline:	*Baseline: - -)* *330 (number of pregnant women ~~who delivered a preterm birth~~ with a history of spontaneous preterm birth)*		
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 (Inform stakeholders [delivery hospitals/providers] of project plans and baseline regarding the use of antenatal steroids for the prevention of preterm birth and low birth weight in women with a history of spontaneous preterm birth. **Data Source:** Meeting minutes/attendance logs Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-5]: Disseminate education to providers regarding the use of the antenatal steroids. **Data Source:** Meeting minutes/attendance logs Documentation of other media used for the providers. Process Milestone 2 Estimated Incentive Payment *(maximum amount):-* $0 **Outcome Improvement Target 1** [IT--] 8.2: Increase in the use of antenatal steroids to help prevent low birth weight. **Data Source**: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* - $0	**Outcome Improvement Target 2** [IT--] 8.2: -Low birth weight births to woman with a history of spontaneous preterm birth. -Decrease in percent of low birth weight births by 10%. **Data Source~~:~~** Electronic Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $0	**Outcome Improvement Target 3** [IT--]8.2: -Low birth weight births to woman with a history of spontaneous preterm birth. -Decrease in percent of low birth weight births by20%. **Data Source:** -Electronic Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* - $0

022817305.3.21	*3.IT--8.2*	**IMPLEMENT EVIDENCE-BASED STRATEGIES TO REDUCE PRETERM BIRTH AND LOW BIRTH WEIGHT** – Reducing Preterm Birth and Low Birth Weight Using Antenatal Steroids	
Tarrant County/ dba Tarrant County Public Health			*028817305*
Related Category 1 or 2 project	**022817305.2.1**		
Starting Point/Baseline:	*Baseline: - -)* *330 (number of pregnant women ~~who delivered a preterm birth~~ with a history of spontaneous preterm birth)*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $0	Year 4 Estimated Outcome Amount: $0	Year 5 Estimated Outcome Amount $0
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** - $0			

Title of Outcome Measure (Improvement Target): IT 12.6 Improved Patient Treatment Access

Unique RHP Outcome Identification Number: - 022817305.3.20 (Pass 2)
Performing Provider Name/TPI: Tarrant County/dba Tarrant County Public Health/022817305

Outcome Measure Description:
Process Milestone:
DY2: Process Milestone 1 provides for setting the targeted baseline for the population of patients diagnosed with latent tuberculosis who are offered preventive treatment. Included in this data will be a retrospective look at the number of patients who were offered treatment and accepted treatment but assessing the number of subsequent visits each of those people actually completed. This is where we will establish the baseline visits that reflect the patients who did not complete and the efforts needed to have them access the new clinic hours to assist in completion. At this current time it is estimated that there are 2,106 annual patient visits with LTBI.
DY3: Process Milestone 2 provides for engaging stakeholders and specifically identifying resources needed to improve treatment completion (staff and additional clinic hours) through offering of nontraditional service hours. This milestone allows for training and equipping staff with tools to improve client interactions and client understanding of the benefits of preventive tuberculosis treatment. Development of tools such as a database that tracks visits that are missed even when a patient is told that the service is walk in and not a formal appointment, using reminder calls and texts to improve utilization, and case management to assist patients with workable refill times that are routine or flexible to increase the visits. 13% of walk in clinic time is evening focused and an increase by 9 evening hours will provide the opportunity for a 20% increase in evening treatment access. (31 total clinic hours/4 evening hours currently improved to 40 total clinic hours/13 evening hours).

Outcome Improvement Targets:
The improvement targets for DY4 and DY5 are the evaluation of the percentage increase in patients coming for follow-up treatment over baseline after initiating the program. The expected improvements are 10% in **DY4** over baseline and 20% in **DY5** over baseline.

Rationale:
The number of patients identified to smear positive tuberculosis cases fluctuates from year to year. Some cases have larger families and significant community contact points that must be evaluated. Others do not live with anyone and may be employed in areas with limited contact with others. In a five-year retrospective look at completion rates, the trend in Tarrant County is below the targeted number set by the CDC as described in Healthy People 2020. The milestones were chosen to identify a starting point and provide staff training to improve Tarrant County completion of therapy rates in this group. The improvement targets were designed to set an attainable goal toward the overall national objectives set forth in 2010 of 79-85% completion of

therapy rates. (CDC MMWR-Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis, Dec 16, 2005/Vol. 54/No. RR-15, pp 1-37.)

Outcome Measure Valuation:

Approach/Methodology: Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Tarrant County Public Health has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V. B. for a full explanation of the model.)*

Rationale/Justification:

Tarrant County Public Health defined the population that will be directly impacted by the project as the number of LTBI clients seen in DY5 compared to the number seen in 2011. A 20% increase in LTBI clients seen is the positive population impact of this project. Based on HHSC funding protocol for Public Health Funding and the RHP 10 valuation model 10.74% of the total project valuation was allocated to Category 3. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. **Outcome Measure 1: 3.IT-12.6** $4,000 economic benefit for the 20% increase in LTBI client seen by the TB Clinic expansion with 66% of those clients expected to complete LTBI or 91 additional LTBI clients completing treatment ($4,000 X 91=$364,000). $364,000 is multiplied by the individual impact of 3 and the community impact of 3 to determine the value per year. The total value is multiplied by 5 years and a halo effect of 1.3 to determine the IT-12.6 actual total outcome valuation of $5,205,200. However due to Public Health DSRIP funding availability the project was discounted 7.8% .

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person does not successfully complete the medication treatment, it is possible for latent TB to convert to active TB. Once converted to active TB, the individual's health is affected. Active TB can result in long-term negative health effects and, in some cases, death. If the medication treatment is partially completed, there is increased likelihood of developing a drug-resistant strain of TB. Usually treated with IV therapy, drug-resistant TB is more serious and costly.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 3**.** We believe this to be the correct number because when a person does not successfully complete the medication treatment, it is possible for latent TB to convert to active TB. Once converted to active TB, it is possible to infect other individuals in the community.

Valuation Reference

Outcome Measure 1: 3.IT 12.6

$4,000 economic benefit of each LTBI client completing treatment.
http://www.businessgrouphealth.org/preventive/topics/tuberculosis.cfm.

-022817305.3.20	**3 .IT-12.6**	**Other Outcome Improvement Target: IT 12.6 Improved Patient Treatment Access**	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**022817305.1.2 :Expand Primary Care Capacity-TB Clinic Expansion**		
Starting Point/Baseline:	**Baseline Data**: The actual number of LTBI patients currently accepting treatment and served by the Tarrant County *Public Health Tuberculosis Clinic as noted in the current database managed at the clinic.* ***Target Population:*** *The diagnosed Tarrant County Population who have latent tuberculosis and who accept preventive 6-9 month treatment for that infection.* ***Specific Number:*** *The number varies yearly but is expected to be approximately 990 cases per year.* ***Description of the Population:*** *The majority of the population served is low income families exposed to a recent case of tuberculosis, homeless or otherwise in congregate settings. In addition special contacts occur within schools, jails, hospitals, as new immigrants/refugees, medically underserved and all others who meet the medical criteria for treatment per the health and safety code..*		
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 [12.6]: Establish Baseline Rates : At this time the estimated patient visits for patients with LTBI is 2,106 reflecting the 26% completion rate of above noted patients. Data Source: LTBI database and EMR. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 0	**Process Milestone 2 [12.6]** Project Planning: engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation. Data Source: Policy and Procedures Manual, DSHS protocols and guidelines, MMWR on treatment of LTBI (CDC), CDC TB module training and testing, other training as needed i.e. phlebotomy training. Process Milestone 2 Estimated Incentive Payment: $-$117,078	**Outcome Improvement Target 1** [IT-12.6]: Other: Improve the number of patients seen for follow up visits by 10% over the baseline from DY2 Improvement Target: 10% increase in the number of patients seen over DY2 baseline **Data Source**: EMR, LTBI database Outcome Improvement Target 1 Estimated Incentive Payment*:* $125,453	**Outcome Improvement Target 2** [IT-12.6]: Other: Improve the number of patients seen for follow up visits by 20% over the baseline from DY2 Improvement Target: 20% increase in the number of patients seen noted over DY2 baseline **Data Source:** EMR, LTBI database Outcome Improvement Target 2 Estimated Incentive Payment*:* $272,723

-022817305.3.20	**3 .IT-12.6**	**Other Outcome Improvement Target: IT 12.6 Improved Patient Treatment Access**	
Tarrant County/dba Tarrant County Public Health			**022817305**
Related Category 1 or 2 Projects:	**022817305.1.2 :Expand Primary Care Capacity-TB Clinic Expansion**		
Starting Point/Baseline:	**Baseline Data**: The actual number of LTBI patients currently accepting treatment and served by the Tarrant County *Public Health Tuberculosis Clinic as noted in the current database managed at the clinic.* ***Target Population:*** *The diagnosed Tarrant County Population who have latent tuberculosis and who accept preventive 6-9 month treatment for that infection.* ***Specific Number:*** *The number varies yearly but is expected to be approximately 990 cases per year.* ***Description of the Population:*** *The majority of the population served is low income families exposed to a recent case of tuberculosis, homeless or otherwise in congregate settings. In addition special contacts occur within schools, jails, hospitals, as new immigrants/refugees, medically underserved and all others who meet the medical criteria for treatment per the health and safety code..*		
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)**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: - $117,078**	**Year 4 Estimated Outcome Amount: -$125,453**	**Year 5 Estimated Outcome Amount: - $272,723**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: - $515,254**			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 081599501.3.1
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501

Outcome Measure Description:
IT-9.2 ED appropriate utilization

Reduce Emergency Department visits for target conditions: Behavioral Health/Substance Abuse. By enhancing behavioral health services availability to increase services to uninsured adults who are currently identified as waiting for psychiatric care, ED visits for wait list clients will be reduced by 25-% of baseline.

Process Milestones:

- DY3:
    - P-2 – Establish baseline rates

Outcome Improvement Targets for each year:

- DY4: Reduce Emergency Department visit for MHMRTC -clients no longer on wait list by 15% from baseline for target conditions: Behavioral Health/Substance Abuse
- -DY5: Reduce Emergency Department visit for MHMRTC clients no longer on wait list by 25% from baseline for target conditions: Behavioral Health/Substance Abuse

-**Rationale:**
One in 8 visits to the emergency room is related to mental illness. Without access to appropriate treatment, people with mental illnesses are more likely to experience crises that lead them to utilize costly emergency room services.[2] More than 40% of emergency room visits related to mental health or substance abuse result in an inpatient admission.[3]

-Admission and readmission to Emergency Departments is disruptive and deleterious to recovery of behavioral health disorders. Interventions, such as adequate staffing and access to services in outpatient behavioral health clinics, which can prevent individuals from cycling through the Emergency Department can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning for the individuals served.

The supply of behavioral health care providers is inadequate in most of the State. In 2011, 195 (77%) of Texas 254 counties held federal designations as whole county Health Professional

[2] http://www.thenationalcouncil.org/galleries/policy-file/Spill%20Over%20Effect_State%20Budgets_NCSL.pdf
[3] http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf

Shortage Areas (HPSAs) in relation to behavioral health.- Indeed, Texas ranks far below the national average in the number of mental health professionals per 100,000 residents.- By enhancing our workforce by increasing the volume of staff in outpatient settings, -patients will receive the services they need in the right place at the right time.

Outcome Measure Valuation:

Approach:

Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing our the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:

The calculation of the value of successful interventions for this project was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses cost-utility analysis (CUA) to measure the cost of the program in dollars and the health consequences in utility-weighted units satisfying our valuation factors regarding patient experience, community benefit, and savings to the health care system. This valuation uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Our target population of 7,050 clients will be impacted by this project as our capacity increase will increase access to services. Of that population, 884 are expected to come off of the wait list and into services during the waiver period. Others will be identified through other service providers or as the result of the availability of additional capacity. The full value of this additional capacity will not be limited to the interventions delivered during the waiver period

since we intend to permanently operate with the 500 additional patients annually as we move to transform the system rather than make temporary changes for the sake of the waiver. The volume and intensity of services will vary spanning from very high intensity case management and counseling to outpatient services such as medication refills. Data shows that we deliver between 3 and 5 services per month to each of our clients which will keep them engaged and drive our identified value for the project.

For this project, the QALY analysis shows this intervention to yield 0.1859 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $929,500. At full implementation we will be serving 500 additional people annually, yielding a value of $4,647,500. We then applied the incentive multiplier of 5 deriving a full valuation of $23,237,500. (No value is built in for additional services provided to existing clients) Due to our funding limitation in pass 1, we had to discount each of our Pass 1 projects. The discounted value of this project is $20,833,325 of which $18,607,529 has been spread to Category 1 and $2,225,796 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

We selected this outcome because data is available and the outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

081599501.3.1	**3.IT-9.2**	**ED appropriate utilization**	
MHMR of Tarrant County			**081599501**
Related Category 1 or 2 Projects:	**1.12** Enhance Service Availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care		
Starting Point/Baseline:	**Specific Number: x/9-00—those individuals waiting to be served in Outpatient settings who utilize JPS ED for psychiatric services.** **Description of Population:** Adults with Severe and persistent mental illness inclusive of Schizophrenia, Bipolar, and Depressive Disorders as well as residents of Tarrant County **Baseline data: Baseline data collection through local reports, CMHC, MBOW, and JPS psychiatric ED records.**		
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)**
n/a	**Process Milestone 1** [P-2]: Establish baseline rates Data Source: Claims/ encounter and clinical record data and- JPS hospital EHR Process Milestone 1 Estimated Incentive Payment: $506,398	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization *(Stand-alone measure).* Improvement Target: Reduce Emergency Department visit for MHMRTC wait list clients by 15% for target conditions: Behavioral Health/Substance Abuse a. Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to a ED setting within the measurement period. b. Denominator: The number of individuals receiving project intervention(s) Data Source: Claims/ encounter and clinical record data and JPS hospital EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $541,728	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization *(Stand-alone measure).* Improvement Target Reduce Emergency Department visit for MHMRTC wait list clients by 25% for target conditions: Behavioral Health/Substance Abuse a Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to a ED setting within the measurement period. b Denominator: The number of individuals receiving project intervention(s) Data Source: Claims/ encounter and clinical record data and JPS hospital EHR -$ Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,177,670

081599501.3.1	**3.IT-9.2**	**ED appropriate utilization**	
MHMR of Tarrant County			**081599501**
Related Category 1 or 2 Projects:	**1.12** Enhance Service Availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care		
Starting Point/Baseline:	**Specific Number: x/9-00—those individuals waiting to be served in Outpatient settings who utilize JPS ED for psychiatric services.** **Description of Population:** Adults with Severe and persistent mental illness inclusive of Schizophrenia, Bipolar, and Depressive Disorders as well as residents of Tarrant County **Baseline data: Baseline data collection through local reports, CMHC, MBOW, and JPS psychiatric ED records.**		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $506,398	Year 4 Estimated Outcome Amount: $541,728	Year 5 Estimated Outcome Amount: $1,177,670
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,225,796			

Title of Outcome Measure (Improvement Target): IT-6.1Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 081599501.3.2
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501

Outcome Measure Description:
IT-6.1 Percent improvement over baseline of patient satisfaction scores-(Stand-alone measure).

Process Milestones and Outcome Improvement Targets for each year:
By the end of the Waiver, our goal is to have 10% improvement over the baseline of patient satisfaction scores relative to consumers getting timely care, appointments and information.

- In DY3 we will establish a baseline rate of consumer satisfaction using a newly selected standardized satisfaction survey. We currently measure consumers' level of satisfaction in more than 20 domains using a survey that was developed by our agency.
- In DY4 consumers' level of satisfaction relative to getting timely care, appointments and information will improve by 5% from the baseline score
- .In DY5- consumers' level of satisfaction relative to getting timely care, appointments and information will improve by 10% from the baseline score

Rationale:

Ford and Zarate indicate in their article, "Closing the Gaps: The Impact of Inpatient Detoxification and Continuity of Care on Client Outcomes," that psychosocial areas will improve when treatment services are provided.[326] Client outcomes were positive, particularly outcomes of clients who completed detoxification treatment services and received follow-up care. Their functioning relative to sobriety, employment, homelessness improved and arrests and days incarcerated decreased as compared to measures prior to clients participating in treatment services. The quality of life improvements resulting from enhanced detoxification services should be reflected in patient satisfaction scores.

Outcome Measure Valuation:

Approach:

Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper

[326] http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=359390af-460e-4be4-9310-1046dc8b8c72%40sessionmgr4&vid=2&hid=25

method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:

We will be serving 1900 people in total with an additional 550 over our current baseline throughout the waiver period. The full value of this additional capacity will not be limited to the interventions delivered during the waiver period since we intend to permanently operate at the higher capacity as we move to transform the system rather than make temporary changes for the sake of the waiver.

Economic benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers, as study performed by the University of Pennsylvania identified reductions from baseline in medical status, psychiatric status, employment, criminal activity, and in treatment accounting for $12,437 per consumer. In addition the study showed Medicare/Medicaid savings in the amount of $4,439 bringing the total value for one successful intervention to $16,876. At full implementation we will be serving an additional 300 patients annually, yielding a value of $4,219,000. (This amount was originally computed on 250 patients – we have since increased our population) We then applied the incentive multiplier of 5 deriving a full valuation of $21,095.000. Due to our funding limitation in pass 1, we had to discount the project to $13,508,921, of which $12,065,652 has been spread to Category 2 and $1,443,269 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

The valuation above was computed on an additional 250 clients annually we planned (we have since increased our population) but does not account for the improved level of care we anticipate delivering to the current 500 clients we are seeing. Because the value on

250 patients is already higher than that the maximum DSRIP payment, we have opted not to value the increased outcomes for the original 500 clients or for the increase in our original population estimate.

We selected this outcome because we are able to develop and analyze the data internally. Based on the evidence, the outcome is also a strong indicator of successfully delivering the value calculated Patient satisfaction is a strong indicator of successfully delivering the value of this project because consumers utilizing the detoxification services will be responding to a list of questions which address the various components of value identified by the research.

081599501.3.2	*3. IT-6.1*	Patient Satisfaction – *Percent improvement over baseline of patient satisfaction scores*	
Mental Health Mental Retardation of Tarrant County(MHMR of Tarrant County)			*081599501*
Related Category 1 or 2 Projects:	*081599501.2.1*		
Starting Point/Baseline:	*An evidence- based practice consumer satisfaction survey will be selected during DY2 and implemented beginning DY3. It is anticipated that a 10% improvement in patient satisfaction will be shown by DY5.*		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* **$164,182**	**Outcome Improvement Target 1** [IT-6.1]: 5% improvement over baseline of patient satisfaction scores. Improvement Target: 5% improvement Data Source: Satisfaction Survey Results Outcome Improvement Target 1 Estimated Incentive Payment*:* **$175,636**	**Outcome Improvement Target 2** [IT-6.1]: 10% improvement over baseline of patient satisfaction scores. Improvement Target: 10% improvement Data Source: Satisfaction Survey Results Outcome Improvement Target 2 Estimated Incentive Payment*:* **$381,818**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: **$164,182**	Year 4 Estimated Outcome Amount: **$175,636**	Year 5 Estimated Outcome Amount: **$381,818**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$**721,635**			

Title of Outcome Measure (Improvement Target): IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)

Unique RHP outcome identification number(s): 081599501.3.3
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501

Outcome Measure Description:
IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)

By the end of the Waiver, our goal is to have 10-% of patients with hypertension to have their blood pressure adequately controlled (BP less than 140/90mm).

Process Milestones and Outcome Improvement Targets for each year:
Our milestones include the following:

- -In DY 3, we establish the baseline for this project by identifying the percentage of patients at the MHMRTC center aged 18 to 85 who have a diagnosis of hypertension.
- In DY 4 and 5, we implement measures to control the high blood pressure of persons receiving both primary care and behavioral health services.

Rationale:
Approximately -21.6% of seriously mentally ill individuals have high blood pressure. Numerous clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure-. A pool of past clinical trials demonstrated that a 5mm to 6mm Hg reduction in diastolic blood pressure was associated with a 42% reduction in stroke mortality and 14% to 20% reduction in mortality from coronary heart disease (CHD). Literature from clinical trials indicates that 53% to 75% of people under treatment achieved control of their blood pressure. The specifications for this measure are consistent with current guidelines, such as those of the U.S. Preventive Services Task Force and the Joint National Committee.

Outcome Measure Valuation:

Approach/Methodology: Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant

incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale/Justification: The calculation of the value of a successful intervention was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The study was conducted to determine the benefit of implementing a project to integrate primary care services and behavioral health services for the population impacted by this project. Consequently, the study provides a measurement for the triple aim elements. The performing provider has determined that tracking HbA1c , blood pressure and ED visits within the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

The QALY analysis shows this intervention to yield 0.335 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $1,675,000. At full implementation we will be serving 500 additional people annually, yielding a DY5 value of $8,375,000. We then applied the incentive multiplier of 5 deriving a full valuation of $41,875,000 related to patient experience.

Due to our funding limitation in pass 1, we had to discount each of our projects. The discounted value of this project is $22,435,239 of which $20,000,000 is for category 2 and $2,435,239 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

We selected this outcome because data is available and the outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

081599501.3.3	*3.IT-1.7*	*Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)*	
MHMR of Tarrant County			**081599501**
Related Category 1 or 2 Projects:	**081599501.2.2**		
Starting Point/Baseline:	Patients in the population identified 18 to 85 years of age with a diagnosis of hypertension		
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 notes, agendas, memorandums of understanding/agreement, project planning/management documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $92,342 **Process Milestone 2** [P-2]**:** Establish baseline rates (percentage of target population with high blood pressure) Data Source: EHR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $92,342	**Outcome Improvement Target 1** [IT-1.7]: Controlling high blood pressure a. Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. b .Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension who have been included in the primary care/behavioral health intervention for at least 6 months. Improvement Target: 5% from baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $197,568	**Outcome Improvement Target 2** [IT-1.7]: Controlling high blood pressure a. Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. b. Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension who have been included in the primary care/behavioral health intervention for at least 6 months Improvement Target: 10% from baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $429,495
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $184,683	Year 4 Estimated Outcome Amount: $197,568	Year 5 Estimated Outcome Amount: $429,495

081599501.3.3	*3.IT-1.7*	*Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018)*	
MHMR of Tarrant County			**081599501**
Related Category 1 or 2 Projects:	**081599501.2.2**		
Starting Point/Baseline:	Patients in the population identified 18 to 85 years of age with a diagnosis of hypertension		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$811,746			

Title of Outcome Measure (Improvement Target): IT-10.1 – Quality of Life/Functional Status

Unique RHP outcome identification number(s): 081599501.3.4
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501
Outcome Measure Description:
IT-10.1 – Quality of Life

Process Milestones and Outcome Improvement Targets for each year:
By the end of the Waiver, our goal is to have 10% improvement in quality of life scores as measured by the AQoL or another validated quality of life assessment tool for the IDD population.

- In DY 3 we will establish a baseline rate. We don't currently measure quality of life.
- In DY4 we will improve quality of life scores by 5% from baseline.
- In DY5 we will improve quality of life scores by 10% from baseline.

Rationale:
The RN care management project is designed to help improve symptoms and function, two essential components of quality of life. According to the National Quality Forum, care coordination is foundational to quality health services including quality of life (National Quality Forum, 2010). -Leonard, McGlone and Boardman (2012), used a "feet to the street" integrated care management model, which showed improved health outcomes and patient satisfaction as well as reduction in inpatient and ED services.[327] -There was a 45.9% reduction in total inpatient costs in the two years after enrollment and 44.7% decrease in number of admissions.[328]

Outcome Measure Valuation:
Approach:
Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing our the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the

[327] National Quality Forum. (2010, October). Quality connections: care Coordination. http://www.qualityforum.org/Publications/2010/10/Quality_Connections__Care_Coordination.aspx
[328] Leonard M, McGlone S, & Boardman A. (2012). Operation: we care. *CMSA Today*, 12-16.

reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:
The calculation of the value of successful interventions for this project was based on an extensive literature review utilizing studies in which similar interventions were implemented and the impacts to the healthcare system were recorded.

Our target population of 1,100 clients will be impacted by this project as RN care coordination services will be available to all. Of that population 480 are expected to come into services during the waiver period. The full value of these intensive supports will not be limited to the interventions delivered during the waiver period since we intend to permanently operate a RN Care Coordination model as we move to transform the system rather than make temporary changes for the sake of the waiver.

For this project, cost savings have been identified in several areas including $9,964 savings versus the inpatient setting, savings with regard to the level of claims expenditures in the amount of $6,359, and $483 of net Medicare/Medicaid savings totaling $16,806 for each consumer. At full implementation we will be serving 480 additional people annually, yielding a value of $8,066,880. We then applied the incentive multiplier of 5 deriving a full valuation of $40,334,400. Due to our funding limitation in Pass 1, we had to discount each of our Pass 1 projects. The discounted value of this project is $21,521,621, of which $19,224,968 has been spread to Category 2 and $2,299,653 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

The performing provider has determined that tracking quality of life, ED utilization, and inpatient admissions with the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

081599501.3.4	*3.IT-10.1*	*Quality of Life(RN Care Management)*	
MHMR of Tarrant County			*081599501*
Related category 1 or 2 projects		081599501.2.3	
Starting Point/Baseline:	**Baseline data:** In DY3 we will establish a baseline rate. We don't currently measure 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)**
N/A Process Milestone Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 1** [P-2]: -Establish baseline rates Data Source: -Quality of life testing Process Milestone 1 Estimated Incentive Payment: $174,400	**Outcome Improvement Target 1** [IT-10.1]: improvement in quality of life scores as measured by the AQoL or another validated quality of life assessment tool for the IDD population Improvement Target: 5% over baseline determined in DY3 Data Source: needs assessment/ EHR/disease management system Outcome Improvement Target 1 Estimated Incentive Payment*:* $186,568	**Outcome Improvement Target 2** [IT-10.1]: improvement in quality of life scores as measured by the AQoL or another validated quality of life assessment tool for the IDD population Improvement Target: 10% over baseline determined in DY3 Data Source: needs assessment/ EHR/disease management system Outcome Improvement Target 2 Estimated Incentive Payment*:* $405,582
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $174,400	Year 4 Estimated Outcome Amount: $186,568	Year 5 Estimated Outcome Amount: $405,582
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$766,550			

Title of Outcome Measure (Improvement Target): 3.IT-6.1 Percent improvement over baseline of patient satisfaction scores

Unique Project ID: 081599501.3.6 (Pass 3)
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501

Outcome Measure Description

By the end of the waiver, our goal is to achieve 20% improvement over baseline of patient satisfaction scores-.

Process Milestones:
In DY3, we will establish the baseline-of patient satisfaction scores.
Outcome Improvement Targets for each year:

- In DY 4, Improvement Target-6.1 is to achieve 10% improvement over baseline of patient satisfaction scores- Percentage will be measured by percent improvement in targeted patient satisfaction.
- In DY5, Improvement Target-6.1 is to achieve 20% improvement over baseline of patient satisfaction scores. -Percentage will be measured by percent improvement in targeted patient satisfaction-.

Rationale:
Assuming this project is successful, people who currently have needs that cannot be met in the community and therefore must rely on emergency services will be able to manage their conditions more successfully. The goal is to avoid crises and the resulting stress on patients and their caregivers. Thus, success at meeting our goals will mean that patients are more satisfied with the services they are receiving.

Outcome Measure Valuation:
Approach/Methodology: Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate

incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale/Justification: The calculation of the value of a successful intervention was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The study was conducted to determine the benefit of implementing a project to develop crisis prevention and intervention services in populations impacted by this project. Consequently, the study provides a measurement for all of the triple aim goals. The performing provider has determined that tracking patient satisfaction, ED utilization, and psychiatric inpatient admissions with the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

Our target population of 900 clients will be impacted by this project due to the supports developed. Of that population, 350 unique patients per year are expected to receive full START services at full implementation. Full implementation is expected by DY4 meaning that 500 clients are targeted to be served during the waiver period. The full value of these additional supports will not be limited to the interventions delivered during the waiver period since we intend to continue the program as we move forward to transform the system rather than make temporary changes for the sake of the waiver.

For this project, the QALY analysis shows this intervention to yield 0.03 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $150,000, or $1,500 per consumer. At full implementation we will be serving 350 additional people annually, yielding a value of $5,552,750. We then applied the incentive multiplier of 5 deriving a full valuation of $27,763,750. Due to our funding limitation in pass 1, we had to discount each of our Pass 2&3 projects. The discounted value of this project is $17,035,361, of which $15,206,473 has been spread to Category 1 and $1,828,888 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

We selected the patient satisfaction outcome because we can administer the patient satisfaction surveys internally rather than relying on outside data. The outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

081599501.3.6	3.IT-6.1	3.IT-6.1	*Percent improvement over baseline of patient satisfaction scores*
Mental Health Mental Retardation of Tarrant County (MHMRTC)			081599501
Related Category 1 Outcome Measure(s):	**081599501.1.2**	**1.13.1**	Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

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)**
N/A Process Milestone Estimated Incentive Payment *(maximum* *amount):* $0	**Process Milestone 1 [P-2]:** Establish baseline for patient satisfaction. Data Source: Patient Survey Process Milestone 1 Estimated Incentive Payment*:* $138,571	**Outcome Improvement Target 1 [IT-6.1]:** Percent improvement over baseline of patient satisfaction scores Improvement Target: 10% improvement over baseline of patient satisfaction scores Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment:$148,415	**Outcome Improvement Target 2 [IT-6.1]:** Percent improvement over baseline of patient satisfaction scores Improvement Target: 20% improvement of patient satisfaction scores from DY4 Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment:$322,642
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $0	Year 3 Estimated Milestone Bundle Amount: $138,571	Year 4 Estimated Milestone Bundle Amount: $148,415	Year 5 Estimated Milestone Bundle Amount: $322,642

081599501.3.6	3.IT-6.1	3.IT-6.1	*Percent improvement over baseline of patient satisfaction scores*
Mental Health Mental Retardation of Tarrant County (MHMRTC)			081599501
Related Category 1 Outcome Measure(s):	**081599501.1.2**	**1.13.1**	Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

Year 2	Year 3	Year 4	Year 5
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**	**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $609,628

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059

Unique RHP outcome identification number(s): 081599501.3.7
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501

Outcome Measure Description: IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059
By the end of the waiver, it is our goal to reduce by 10% the number of patients in the served population with HbA1c >9.0%.

Process Milestones and Outcome Improvement Targets for each year:
Our milestones include the following:

- In DY 3, we establish the baseline for this project by identifying the percentage of patients at the MHMRTC center aged 18 to 75 who have a diagnosis of diabetes.
- In DY 4 and 5, we implement measures to control the HbA1c of persons receiving both primary care and behavioral health services.

Rationale:
According to the Substance Abuse and Mental Health Services Administration, 7.7% of patients with serious mental illness have diabetes, which is a rate nearly 17% above the average in the population. Medications used to treat mental health problems often create worse problems with the management of glucose levels. Moreover, these patients are much less likely to receive appropriate care for their diabetes, which exacerbates any issues with glucose levels. As a result, the population can be expected to experience significant diabetic complications.

Outcome Measure Valuation:

Approach/Methodology: Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive

portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale/Justification: The calculation of the value of a successful intervention was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The study was conducted to determine the benefit of implementing a project to integrate primary care services and behavioral health services for the population impacted by this project. Consequently, the study provides a measurement for the triple aim elements. The performing provider has determined that tracking HbA1c , blood pressure and ED visits within the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

The QALY analysis shows this intervention to yield 0.335 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $1,675,000. At full implementation we will be serving 500 additional people annually, yielding a DY5 value of $8,375,000. We then applied the incentive multiplier of 5 deriving a full valuation of $41,875,000 related to patient experience.

Due to our funding limitation in pass 1, we had to discount each of our projects. The discounted value of this project is $22,435,239 of which $20,000,000 is for category 2 and $2,435,239 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

We selected this outcome because data is available and the outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

081599501.3.7	***3.IT-1.10***	***Diabetes Care; HbA1c poor control (>9.0%) – NQF 0059***	
MHMR of Tarrant County			**081599501**
Related Category 1 or 2 Projects:	**081599501.2.2**		
Starting Point/Baseline:	Patients in the population identified 18 to 75 years of age with a diagnosis of diabetes who had hemoglobin A1c control >9.0%		
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 notes, agendas, memorandums of understanding/agreement, project planning/management documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $92,342 **Process Milestone 2** [P-2]**:** Establish baseline rates (percentage of target population with HbA1c >9.0%)) Data Source: EHR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $92,342	**Outcome Improvement Target 1** [IT-1.10]: Diabetes Care: HbA1c poor control (>9.0%) a. Numerator: The number of patients in the denominator whose most recent HbA1c during the measurement year is <9.0%. b .Denominator: Patients 18 to 75 years of age as of December 31 of the measurement year with a diagnosis of diabetes who have been included in the primary care/behavioral health intervention for at least 6 months Improvement Target: 5% from baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $197,568	**Outcome Improvement Target 2** [IT-1.10]: Diabetes Care: HbA1c poor control (>9.0%) a. Numerator: The number of patients in the denominator whose most recent HbA1c during the measurement year is <9.0%. b .Denominator: Patients 18 to 75 years of age as of December 31 of the measurement year with a diagnosis of diabetes who have been included in the primary care/behavioral health intervention for at least 6 months Improvement Target: 10% from baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $429,495
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $184,683	Year 4 Estimated Outcome Amount: $197,568	Year 5 Estimated Outcome Amount: $429,495

081599501.3.7	*3.IT-1.10*	*Diabetes Care; HbA1c poor control (>9.0%) – NQF 0059*	
MHMR of Tarrant County			**081599501**
Related Category 1 or 2 Projects:	**081599501.2.2**		
Starting Point/Baseline:	Patients in the population identified 18 to 75 years of age with a diagnosis of diabetes who had hemoglobin A1c control >9.0%		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$811,746			

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization

Unique RHP outcome identification number(s): 081599501.3.8
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501

Outcome Measure Description: IT-9.2 ED Appropriate Utilization
By the end of the waiver, it is our goal to reduce by 9% ED visits from the baseline average number of ED visits in the target population.

Process Milestones and Outcome Improvement Targets for each year:
Our milestones include the following:

- In DY 3, we establish the baseline for this project by identifying the number of patients at the MHMRTC center with ED visits in the prior year and the number of those visits.
- In DY 4 and 5, we measure the number of ED visits of persons receiving both primary care and behavioral health services.

Rationale:
The Center for Health Care Strategies issued a report evaluating a 2 year Pennsylvania project that integrated primary care and behavioral health services in a severely mentally ill population. In that population the rate of emergency department use was an estimated 9% below the control population. While the performing provider believes this to be an aggressive improvement target, it has chosen 9% as a result of these findings.[12]

Outcome Measure Valuation:
Approach/Methodology: Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until

[12] The full report, submitted to the Center for Health Care Strategies by Mathematica Policy Research on October 12, 2012 can be reviewed at: http://www.mathematica-mpr.com/Publications/pdfs/health/SMI_Innovations_PA_final.pdf

the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale/Justification: The calculation of the value of a successful intervention was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The study was conducted to determine the benefit of implementing a project to integrate primary care services and behavioral health services for the population impacted by this project. Consequently, the study provides a measurement for the triple aim elements. The performing provider has determined that tracking HbA1c , blood pressure and ED visits within the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

The QALY analysis shows this intervention to yield 0.335 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $1,675,000. At full implementation we will be serving 500 additional people annually, yielding a DY5 value of $8,375,000. We then applied the incentive multiplier of 5 deriving a full valuation of $41,875,000 related to patient experience.

Due to our funding limitation in pass 1, we had to discount each of our projects. The discounted value of this project is $22,435,239 of which $20,000,000 is for category 2 and $2,435,239 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

We selected this outcome because data is available and the outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

081599501.3.8	***3.IT-9.2***	***ED Appropriate Utilization***	
MHMR of Tarrant County			**081599501**
Related Category 1 or 2 Projects:	**081599501.2.2**		
Starting Point/Baseline:	Average number of ED visits at JPS in target population not receiving primary care services 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 (average number of ED visits at JPS in population) Data Source: Will work with JPS to develop the baseline Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $184,683	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization Goal: The average number of ED visits by patients with treatment plans in place for 12 months or more reduced by 5% from baseline Data Source: To be developed with JPS Outcome Improvement Target 1 Estimated Incentive Payment*:* $197,568	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Goal: The average number of ED visits by patients with treatment plans in place for 12 months or more reduced by 9% from baseline Data Source: To be developed with JPS Outcome Improvement Target 2 Estimated Incentive Payment*:* $429,495
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $184,683	Year 4 Estimated Outcome Amount: $197,568	Year 5 Estimated Outcome Amount: $429,495
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$811,747			

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.

Performing Provider Name/TPI: MHMR of Tarrant County/081599501
Unique RHP outcome identification number(s): - 081599501.3.9 (Pass 2)

Outcome Measure Description:
IT-9.1 - *IT-9.1* Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons..

DY3: Project planning by engaging stakeholders, identifying current capacity and needed resources, determining timelines and documentation of implementation plans. In addition, a process for - collecting data from CMBHS ASI assessments will be established and the baseline percentage of jail admissions for mental health/substance use disorder patients will be determined.
DY4:-Reduce jail admissions by 5% for patients who are involved in treatment program

DY5: Reduce jail admissions by 10% for patients who are involved in treatment program

Rationale:
A study conducted by the National Center on Addiction and Substance Abuse at Columbia University found that 24.4% of prison and jail inmates have both mental illness and substance abuse problems. Incarceration is expensive for the community and has a significant negative impact on the individual.

Outcome Measure Valuation:

Approach:
Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system

adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:
The calculation of the value of successful interventions for this project was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses cost-utility analysis (CUA) to measure the cost of the program in dollars and the health consequences in utility-weighted units satisfying our valuation factors regarding patient experience, community benefit, and savings to the health care system. This valuation uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Our target population of 3,000 clients will be impacted by this project as integrated substance abuse services will be available to all. Of that population 1,350 are expected to come into services during the waiver period. The full value of this integration will not be limited to the interventions delivered during the waiver period since we intend to permanently operate in an integrated model as we move to transform the system rather than make temporary changes for the sake of the waiver.

For this project, the QALY analysis shows this intervention to yield 0.11135 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $556,750. At full implementation we will be serving 725 additional people annually, yielding a value of $4,036,438. We then applied the incentive multiplier of 5 deriving a full valuation of $20,182,188.

Due to our funding limitation in passes 2 and 3, we had to discount each of our Pass 2 and 3 projects. The discounted value of this project is $19,217,415, of which $17,154,265 has been spread to Category 2 and $2,063,150 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

We selected this outcome because data is available and the outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

-081599501.3.9	*IT-91.1*	*- Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.*	
Mental Health Mental Retardation of Tarrant County(MHMR of Tarrant County)			*081599501*
Related Category 1 or 2 Projects:	*081599501.2.4*		
Starting Point/Baseline:	*-A 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 2** [P-2]: Establish baseline rates Data Source: CMBHS ASI assessments Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $-156,321	**Outcome Improvement Target 1** [OD 9 Right Care, Right Setting] -Metric 1 : [IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Goal: Reduce jail admissions by 5% for individuals involved in treatment program Data Source: CMBHS ASI assessments Outcome Improvement Target 1 Estimated Incentive Payment*:* $167,426	**Outcome Improvement Target 2** [OD 9 Right Care, Right Setting] Metric 1 : [IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Goal: Reduce jail admissions by 10% for individuals involved in treatment program Data Source: CMBHS ASI assessments -Outcome Improvement Target 2 Estimated Incentive Payment*:* $363,970
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: $156,321**	**Year 4 Estimated Outcome Amount: $167,426**	**Year 5 Estimated Outcome Amount: $363,970**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$687,717			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Performing Provider Name/TPI: MHMR of Tarrant County/081599501
Unique RHP outcome identification number(s): 081599501.3.10 (Pass 2)

Outcome Measure Description:
IT-9.2 ED appropriate utilization - Percent improvement over baseline of patients incurring an ED admission during substance use disorder treatment. (Stand-alone measure). By the end of the Waiver, our goal is to have 10% reduction from the baseline-.

DY3: Determine the baseline of how many patients with substance use disorder are presenting in the emergency department at JPS hospital.

DY4: Reduce emergency room visits by substance use disorder patients by 5% from the baseline determined in DY3.

DY5: Reduce emergency room visits by substance use disorder patients by 10% from the baseline determined in DY3.

Rationale:
In a report to Congress, SAMHSA reported that the combination of mental illness and substance abuse disorder can result in poor response to traditional treatments and increases the risk for other serious medical problems. As a result, individuals with co-occurring disorders often require high-cost services such as inpatient and emergency room care.[329] In 2007, 1 in 8 emergency room visits was related to mental health or substance abuse. Almost 12% of those visits were for co-occurring disorders.[330]

Outcome Measure Valuation:

Approach:
Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate

[329] http://www.nasmhpd.org/docs/Policy/Behavioral%20Health%20Primary_CoOccurringRTC.pdf
[330] http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.jsp

valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing -the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:
Our target population of 3,000 clients will be impacted by this project as integrated substance abuse services will be available to all. Of that population 1,350 are expected to come into services during the waiver period. The full value of this integration will not be limited to the interventions delivered during the waiver period since we intend to permanently operate in an integrated model as we move to transform the system rather than make temporary changes for the sake of the waiver.

For this project, the QALY analysis shows this intervention to yield 0.11135 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $556,750. At full implementation we will be serving 725 additional people annually, yielding a value of $4,036,438. We then applied the incentive multiplier of 5 deriving a full valuation of $20,182,188.

Due to our funding limitation in passes 2 and 3, we had to discount each of our Pass 2 and 3 projects. The discounted value of this project is $19,217,415, of which $17,154,265 has been spread to Category 2 and $2,063,150 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

We selected this outcome because data is available and the outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

081599501.3.10	*3. IT-9.2*	*ED appropriate utilization*	
Mental Health Mental Retardation of Tarrant County(MHMR of Tarrant County)			*081599501*
Related Category 1 or 2 Projects:	*081599501.2.4*		
Starting Point/Baseline:	*Reducing ED visits by establishing a baseline in DY 3 and reducing by 25% in DY 4 and 50% in DY 5.*		
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]: Establish baseline – determine current ED utilization for patients prior to receiving substance use disorder services. Data Source: EHR records from JPS Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $156,321	**Outcome Improvement Target 1** [OD 9 Right Care, Right Setting] Metric 1 : [IT-9.2]: ED appropriate utilization - Reduce ED admissions for patients receiving substance use disorder services. Goal: 5% reduction in ED visits Data Source: EHR records from JPS Outcome Improvement Target 1 Estimated Incentive Payment*:* $167,426	**Outcome Improvement Target 2** [OD 9 Right Care, Right Setting] Metric 1 : [IT-9.2]: ED appropriate utilization - Reduce ED admissions for patients receiving substance use disorder services. Goal: 10% reduction in ED visits Data Source: EHR records from JPS Outcome Improvement Target 2 Estimated Incentive Payment*:* $363,970
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: $156,321**	**Year 4 Estimated Outcome Amount: $167,426**	**Year 5 Estimated Outcome Amount: $363,970**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$ 687,717			

Title of Outcome Measure (Improvement Target): *IT-10.7* Functional status assessment for patients discharged from substance use disorder treatment program.

Performing Provider Name/TPI: MHMR of Tarrant County/081599501
Unique RHP outcome identification number(s): 081599501.3.11 (Pass 2)

Outcome Measure Description:
IT-10.7 The Percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instrument (Addiction Severity Index, ASI).

DY3: Project planning for measuring functional status – engage stakeholders, identify current capacity and needed resources, determine timelines for assessments and document implementation plans.

DY4: 20% of individuals in program demonstrate improved functional status.

DY5: 35% of individuals in program demonstrate improved functional status.

Rationale:
Functional status measures the improvement that patients have achieved over the course of the program and a reduced abuse of unhealthy substances. -Patients with reduced dependence on substances such as alcohol and drugs will increase functioning in life. This increased functioning can lead to employment, stable housing, and reduced dependence on entitlement programs.

Outcome Measure Valuation:

Approach:
Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing -the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system

adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:
The calculation of the value of successful interventions for this project was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses cost-utility analysis (CUA) to measure the cost of the program in dollars and the health consequences in utility-weighted units satisfying our valuation factors regarding patient experience, community benefit, and savings to the health care system. This valuation uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Our target population of 3,000 clients will be impacted by this project as integrated substance abuse services will be available to all. Of that population 1,350 are expected to come into services during the waiver period. The full value of this integration will not be limited to the interventions delivered during the waiver period since we intend to permanently operate in an integrated model as we move to transform the system rather than make temporary changes for the sake of the waiver.

For this project, the QALY analysis shows this intervention to yield 0.11135 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $556,750. At full implementation we will be serving 725 additional people annually, yielding a value of $4,036,438. We then applied the incentive multiplier of 5 deriving a full valuation of $20,182,188.

Due to our funding limitation in passes 2 and 3, we had to discount each of our Pass 2 and 3 projects. The discounted value of this project is $19,217,415, of which $17,154,265 has been spread to Category 2 and $2,063,150 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

We selected this outcome because data is available and the outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

081599501.3.11	*3. IT-10.7*	*Functional status assessment*	
Mental Health Mental Retardation of Tarrant County(MHMR of Tarrant County)			*081599501*
Related Category 1 or 2 Projects:	*081599501.2.4*		
Starting Point/Baseline:	*A 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-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Needs Assessment Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $156,321	**Outcome Improvement Target 1** [IT-10.7]: Functional Status Metric 1 : The Percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instrument (Addiction Severity Index, ASI). Goal: 20% of individuals demonstrate improved functional status. Data Source: Clinical Management for Behavioral Health Services (CMBHS) Outcome Improvement Target 1 Estimated Incentive Payment*:* $167,426	**Outcome Improvement Target 2** [IT-10.7]: Functional Status Metric 1: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instrument (Addiction Severity Index, ASI). . Goal: 35% of individuals demonstrate improved functional status. Data Source: Clinical Management for Behavioral Health Services (CMBHS) Outcome Improvement Target 2 Estimated Incentive Payment*:* $363,970
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: $156,321**	**Year 4 Estimated Outcome Amount: $167,421**	**Year 5 Estimated Outcome Amount: $363,970**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$687,717			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Performing Provider Name/TPI: MHMR of Tarrant County/081599501
Unique RHP outcome identification number(s): 081599501.3.12

Outcome Measure Description:
IT-9.2 ED appropriate utilization - Percent improvement over baseline. (Stand-alone measure). Our goal is to reduce ED utilization in the year following discharge from the detoxification unit by-20% from the baseline.

DY3: Determine the baseline of average ED visits in the year following detoxification unit discharge for patients discharged prior to implementing the enhanced services.

DY4: Reduce emergency room visits by substance use disorder patients by 10% from the baseline determined in DY3.

DY5: Reduce emergency room visits by substance use disorder patients by 20% from the baseline determined in DY3.

Rationale:
The study about which Ford and Zarate's article was written resulted in an approximate 19% decrease in ED visits post-discharge from the detoxification unit.

Outcome Measure Valuation:

Approach:
Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed

that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:
We will be serving 1900 people in total with an additional 550 over our current baseline throughout the waiver period. The full value of this additional capacity will not be limited to the interventions delivered during the waiver period since we intend to permanently operate at the higher capacity as we move to transform the system rather than make temporary changes for the sake of the waiver.

Economic benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers, as study performed by the University of Pennsylvania identified reductions from baseline in medical status, psychiatric status, employment, criminal activity, and in treatment accounting for $12,437 per consumer. In addition the study showed Medicare/Medicaid savings in the amount of $4,439 bringing the total value for one successful intervention to $16,876. At full implementation we will be serving an additional 300 patients annually, yielding a value of $4,219,000. (This amount was originally computed on 250 patients – we have since increased our population) We then applied the incentive multiplier of 5 deriving a full valuation of $21,095.000. Due to our funding limitation in pass 1, we had to discount the project to $13,508,921, of which $12,065,652 has been spread to Category 2 and $1,443,269 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

The valuation above was computed on an additional 250 clients annually we planned (we have since increased our population) but does not account for the improved level of care we anticipate delivering to the current 500 clients we are seeing. Because the value on 250 patients is already higher than that the maximum DSRIP payment, we have opted not to value the increased outcomes for the original 500 clients or for the increase in our original population estimate.

We selected this outcome because while data is held by other entities, we should be able to work with others to determine outcomes. Based on the evidence, the outcome is also a strong indicator of successfully delivering the value calculated.

081599501.3.12	*3. IT-9.2*	*ED appropriate utilization*	
Mental Health Mental Retardation of Tarrant County(MHMR of Tarrant County)			*081599501*
Related Category 1 or 2 Projects:	*081599501.2.1*		
Starting Point/Baseline:	*Reducing ED visits by establishing a baseline in DY 3 and reducing by 10% in DY 4 and 20% in DY 5.*		
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]: Establish baseline. Goal: Determine the baseline of average ED visits in the year following detoxification unit discharge for patients discharged prior to implementing the enhanced services. Data Source: Client Medical Records, EHR Process Milestone 1 Estimated Incentive Payment (maximum amount): **$164,181**	**Outcome Improvement Target 1** [OD 9 Right Care, Right Setting] Metric 1 : [IT-9.2]: ED appropriate utilization - Reduce ED admissions for patients receiving substance use disorder services. Goal: 10% reduction in ED visits from baseline Data Source: Client Medical Records, EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* **$175,636**	**Outcome Improvement Target 2** [OD 9 Right Care, Right Setting] Metric 1 : [IT-9.2]: ED appropriate utilization - Reduce ED admissions for patients receiving substance use disorder services. Goal: 20% reduction in ED visits Data Source: Client Medical Records, EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $**$381,817**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: $164,181**	**Year 4 Estimated Outcome Amount: $175,636**	**Year 5 Estimated Outcome Amount: $381,817**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$ **721,634**			

Title of Outcome Measure (Improvement Target): 3.IT-9.2 ED Appropriate Utilization

Unique Project ID: 081599501.3.13 (Pass 3)
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501

Outcome Measure Description

By the end of the waiver, our goal is to achieve a 40% decrease over baseline of ED utilization by patients in this program.

Process Milestones:

- In DY3, we will develop and test data systems
- In DY3, we will establish the baseline of ED utilization

Outcome Improvement Targets for each year:

- In DY 4, Improvement Target-9.2 is to achieve 20% improvement over baseline of ED utilization. Percentage will be measured by percent decrease in targeted patient ED utilization.
- In DY 5, Improvement Target-9.2 is to achieve 40% improvement over baseline of ED utilization. Percentage will be measured by percent decrease in targeted patient ED utilization.

Rationale:
1 in 8 emergency department visits is for mentally ill patients. IDD/ASD patients with mental illness present unique problems and are even more likely to use emergency mental health services that other forms of community mental health care. This intervention is designed to fill the gaps in the community system that cause the overuse of the emergency system. A reduction in ED visits by this population will be a good measure of whether the goals of the project were realized.

Outcome Measure Valuation:
Approach/Methodology: Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate

incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale/Justification:
The calculation of the value of a successful intervention was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The study was conducted to determine the benefit of implementing a project to develop crisis prevention and intervention services in populations impacted by this project. Consequently, the study provides a measurement for all of the triple aim goals. The performing provider has determined that tracking patient satisfaction, ED utilization, and psychiatric inpatient admissions with the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

Our target population of 900 clients will be impacted by this project due to the supports developed. Of that population, 350 unique patients per year are expected to receive full START services at full implementation. Full implementation is expected by DY4 meaning that 500 clients are targeted to be served during the waiver period. The full value of these additional supports will not be limited to the interventions delivered during the waiver period since we intend to continue the program as we move forward to transform the system rather than make temporary changes for the sake of the waiver.

For this project, the QALY analysis shows this intervention to yield 0.03 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $150,000, or $1,500 per consumer. At full implementation we will be serving 350 additional people annually, yielding a value of $5,552,750. We then applied the incentive multiplier of 5 deriving a full valuation of $27,763,750. Due to our funding limitation in pass 1, we had to discount each of our Pass 2&3 projects. The discounted value of this project is $17,035,361, of which $15,206,473 has been spread to Category 1 and $1,828,888 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

While we do not control ED visit data internally, most of our patients present at JPS' ED. We anticipate being able to work with that entity to obtain the data we need to establish baselines and track progress. The outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

081599501.3.13	3.IT-9.2	3.IT-9.2	*ED Appropriate Utilization*
Mental Health Mental Retardation of Tarrant County (MHMRTC)			081599501
Related Category 1 Outcome Measure(s):	**081599501.1.2**	**1.13.1**	Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

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)**
N/A Process Milestone Estimated Incentive Payment *(maximum* *amount):* $0	**Process Milestone 1 [P-3]:** Develop and test data systems. Data Source: Client Medical Records, EHR Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $69,285 **Process Milestone 2 [P-2]:** Establish baseline for ED utilization. Data Source: Client Medical Records, EHR Process Milestone 2 Estimated Incentive Payment*:* $69,286	**Outcome Improvement Target 1 [IT-9.2]:** ED appropriate utilization. Improvement Target: 20% decrease in ED visits from baseline Data Source: Client Medical Records, EHR Outcome Improvement Target 1 Estimated Incentive Payment:$148,416	**Outcome Improvement Target 2 [IT-9.2]:** ED appropriate utilization. Improvement Target: 40% decrease in ED visits Data Source: Client Medical Records, EHR Outcome Improvement Target 2 Estimated Incentive Payment:$322,642
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments*	Year 3 Estimated Milestone Bundle Amount: $138,571	Year 4 Estimated Milestone Bundle Amount: $148,416	Year 5 Estimated Milestone Bundle Amount: $322,642

081599501.3.13	3.IT-9.2	3.IT-9.2	*ED Appropriate Utilization*	
Mental Health Mental Retardation of Tarrant County (MHMRTC)				081599501
Related Category 1 Outcome Measure(s):	**081599501.1.2**	**1.13.1**	Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.	
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)**
amounts from each milestone): $0				
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $609,629				

Title of Outcome Measure (Improvement Target): 3.IT-2.13 Other Admissions Rate

Unique Project ID: 081599501.3.14 (Pass 3)
Performing Provider Name/TPI: MHMR of Tarrant County / 081599501

Outcome Measure Description

By the end of the waiver, our goal is to achieve a 40% decrease over baseline of psychiatric inpatient hospitalizations.

Process Milestones:

- In DY3, we will develop and test data systems.
- In DY3, we will establish the baseline of psychiatric admissions.

Outcome Improvement Targets for each year:

- In DY 4, Improvement Target-9.13 is to achieve a 20% improvement over baseline of psychiatric admissions.
- In DY 5, Improvement Target-9.13 is to achieve a 40% improvement over baseline of psychiatric admissions.

Rationale:
A similar START intervention developed in North Carolina noted 43% of the patients referred had a psychiatric inpatient stay in the year prior to involvement in START. Most of these hospitalizations could have been avoided had appropriate alternatives been present. Meeting the goals of this intervention would show decreases in the need for psychiatric inpatient care in the IDD/ASD population. A reduction in psychiatric admissions by this population will be a good measure of whether the goals of the project were realized.

Outcome Measure Valuation:
Approach/Methodology: Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful

intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale/Justification:
The calculation of the value of a successful intervention was based on an economic evaluation model and extensive literature review conducted by professors H. Shelton Brown, Ph.D at the UT Houston School of Public Health and Thomas Bohman, Ph.D of the UT Austin Center for Social Work Research. The model uses a quality-adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

The study was conducted to determine the benefit of implementing a project to develop crisis prevention and intervention services in populations impacted by this project. Consequently, the study provides a measurement for all of the triple aim goals. The performing provider has determined that tracking patient satisfaction, ED utilization, and psychiatric inpatient admissions with the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

Our target population of 900 clients will be impacted by this project due to the supports developed. Of that population, 350 unique patients per year are expected to receive full START services at full implementation. Full implementation is expected by DY4 meaning that 500 clients are targeted to be served during the waiver period. The full value of these additional supports will not be limited to the interventions delivered during the waiver period since we intend to continue the program as we move forward to transform the system rather than make temporary changes for the sake of the waiver.

For this project, the QALY analysis shows this intervention to yield 0.03 quality-adjusted life years gained for each consumer. The calculation of value takes into account the value of $50,000 per life year gained, which is standard threshold for valuing life years in cost-based evaluation of interventions. The value generated for QALY gained per 100 people calculates to $150,000, or $1,500 per consumer. At full implementation we will be serving 350 additional people annually, yielding a value of $5,552,750. We then applied the incentive multiplier of 5 deriving a full valuation of $27,763,750. Due to our funding limitation in pass 1, we had to discount each of our Pass 2&3 projects. The discounted value of this project is $17,035,361, of which $15,206,473 has been spread to Category 1 and $1,828,888 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

While we do not control psychiatric admissions data internally, most of our patients present at JPS' ED. We anticipate being able to work with that entity to obtain the data we need to

establish baselines and track progress. The outcome is also a strong indicator of successfully delivering the value calculated with the QALY analysis.

081599501.3.14	3.IT-2.13	3.IT-2.13	*Other Admissions Rate*
Mental Health Mental Retardation of Tarrant County (MHMRTC)			081599501
Related Category 1 Outcome Measure(s):	**081599501.1.2**	**1.13.1**	Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

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)**
N/A Process Milestone Estimated Incentive Payment *(maximum* *amount):* $0	**Process Milestone 1 [P-3]:** Develop and test data systems. Data Source: Client Medical Records, EHR Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $69,286 **Process Milestone 2 [P-2]:** Establish baseline for psychiatric admissions. Data Source: Client Medical Records, EHR Process Milestone 2 Estimated Incentive Payment*:* $69,286	**Outcome Improvement Target 1 [IT-2.13]:** Other admissions rate. Improvement Target: 20% decrease in psychiatric inpatient admissions over baseline Data Source: Client Medical Records, EHR Outcome Improvement Target 1 Estimated Incentive Payment:$148,416	**Outcome Improvement Target 2 [IT-2.13]:** Other admissions rate. Improvement Target: 40% decrease in psychiatric inpatient admissions over baseline Data Source: Client Medical Records, EHR Outcome Improvement Target 2 Estimated Incentive Payment:$322,643
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments*	Year 3 Estimated Milestone Bundle	Year 4 Estimated Milestone Bundle	Year 5 Estimated Milestone Bundle

081599501.3.14	3.IT-2.13	3.IT-2.13	*Other Admissions Rate*	
Mental Health Mental Retardation of Tarrant County (MHMRTC)				081599501
Related Category 1 Outcome Measure(s):	**081599501.1.2**	**1.13.1**	Development of behavioral health crisis stabilization services as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.	
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)**	
amounts from each milestone): $0	Amount: $138,572	Amount: $148,416	Amount: $322,643	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $609,631				

Title of Outcome Measure (Improvement Target): 3.IT-9.2 – ED Appropriate Utilization

Unique RHP outcome identification number(s): 081599501.3.15
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501
Outcome Measure Description:

By the end of the waiver, our goal is to achieve a 15% decrease over baseline of ED utilization by patients in this program.

Process Milestones and Outcome Improvement Targets for each year:

- In DY 3 we will establish a baseline rate.
- In DY 4, our goal is to achieve 5% improvement over baseline of ED utilization.
- In DY 5, our goal is to achieve 15% improvement over baseline of ED utilization.

Rationale:
Problems with the health care delivery system related to chronic disease management are exacerbated in the IDD population because of communication problems and problems with understanding what is needed to manage disease. Without proper understanding, chronic conditions are likely to become acute episodes resulting in the need for emergency care, often ending in hospitalization.

Outcome Measure Valuation:
Approach:
Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing our the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:
The calculation of the value of successful interventions for this project was based on an extensive literature review utilizing studies in which similar interventions were implemented and the impacts to the healthcare system were recorded.

Our target population of 1,100 clients will be impacted by this project as RN care coordination services will be available to all. Of that population 480 are expected to come into services during the waiver period. The full value of these intensive supports will not be limited to the interventions delivered during the waiver period since we intend to permanently operate a RN Care Coordination model as we move to transform the system rather than make temporary changes for the sake of the waiver.

For this project, cost savings have been identified in several areas including $9,964 savings versus the inpatient setting, savings with regard to the level of claims expenditures in the amount of $6,359, and $483 of net Medicare/Medicaid savings totaling $16,806 for each consumer. At full implementation we will be serving 480 additional people annually, yielding a value of $8,066,880. We then applied the incentive multiplier of 5 deriving a full valuation of $40,334,400. Due to our funding limitation in Pass 1, we had to discount each of our Pass 1 projects. The discounted value of this project is $21,521,621, of which $19,224,968 has been spread to Category 2 and $2,299,653 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

The performing provider has determined that tracking quality of life, ED utilization, and inpatient admissions with the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

081599501.3.15	*3.IT-9.2*	*ED Appropriate Utilization*	
MHMR of Tarrant County			*081599501*
Related category 1 or 2 projects		081599501.2.3	
Starting Point/Baseline:	**Baseline data:** In DY3 we will establish a baseline 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)**
N/A Process Milestone Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 1 [P-2]:** Establish baseline for ED utilization. Data Source: Client medical records, EHR Process Milestone 2 Estimated Incentive Payment*:* $174,400	**Outcome Improvement Target 1 [IT-9.2]:** ED appropriate utilization. Improvement Target: 5% decrease in ED visits from baseline Data Source: Client medical records, EHR Outcome Improvement Target 1 Estimated Incentive Payment:$186,568	**Outcome Improvement Target 2 [IT-9.2]:** ED appropriate utilization. Improvement Target: 15% decrease in ED visits from baseline Data Source: Client medical records, EHR Outcome Improvement Target 1 Estimated Incentive Payment:$405,582
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $174,400	Year 4 Estimated Outcome Amount: $186,568	Year 5 Estimated Outcome Amount: $405,582
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$766,550			

Title of Outcome Measure (Improvement Target): 3.IT-2.13 – Other Admissions Rate (inpatient admissions for IDD clients in RN care management)

Unique RHP outcome identification number(s): 081599501.3.16
Performing Provider Name/TPI: MHMR of Tarrant County (MHMRTC) / 081599501
Outcome Measure Description:

By the end of the waiver, our goal is to achieve a 40% decrease over baseline of psychiatric inpatient hospitalizations by patients in this program.

Process Milestones and Outcome Improvement Targets for each year:

- In DY 3 we will establish a baseline rate.
- In DY 4, Improvement Target-9.13 is to achieve a 20% improvement over baseline of inpatient admissions.
- In DY 5, Improvement Target-9.13 is to achieve a 40% improvement over baseline of inpatient admissions.

Rationale:
Problems with the health care delivery system related to chronic disease management are exacerbated in the IDD population because of communication problems and problems with understanding what is needed to manage disease. Without proper understanding, chronic conditions are likely to become acute episodes resulting in the need for emergency care, often ending in hospitalization.

Outcome Measure Valuation:
Approach:
Performing providers in Region 10 recognize that the outcomes of our projects represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the outcomes connected to each project. In RHP 10, performing providers collaborated to identify the proper method for the computation of value for our projects. In order to align with the Triple Aim, a method has been devised for identifying three sets of valuation factors: factors related to the patient experience, the community benefit, and savings to the healthcare system. In order to calculate the ultimate valuation, performing providers considered the waiver goal to transform the health care delivery system and agreed that the waiver was designed to create significant incentives over a relatively short period of time. Our agreed upon basis for valuing our the incentive portion of our valuation takes into account three basic principles; the investment to get the projects off the ground, value associated with the services delivered for a reasonable time until the reimbursement system adapts to the transformation, and an incentive for the performing provider to accelerate transformation to the delivery system. In order to set an appropriate incentive RHP 10 agreed that a multiplier should be applied to the annual value of benefits provided to the

consumer at full implementation by calculating the value of a single successful intervention and multiplying by the anticipated interventions per year at full implementation. The full outline of our regional valuation methodology and principles can be found in section V.B. of the RHP plan.

Rationale:
The calculation of the value of successful interventions for this project was based on an extensive literature review utilizing studies in which similar interventions were implemented and the impacts to the healthcare system were recorded.

Our target population of 1,100 clients will be impacted by this project as RN care coordination services will be available to all. Of that population 480 are expected to come into services during the waiver period. The full value of these intensive supports will not be limited to the interventions delivered during the waiver period since we intend to permanently operate RN Care Coordination model as we move to transform the system rather than make temporary changes for the sake of the waiver.

For this project, cost savings have been identified in several areas including $9,964 savings versus the inpatient setting, savings with regard to the level of claims expenditures in the amount of $6,359, and $483 of net Medicare/Medicaid savings totaling $16,806 for each consumer. At full implementation we will be serving 480 additional people annually, yielding a value of $8,066,880. We then applied the incentive multiplier of 5 deriving a full valuation of $40,334,400. Due to our funding limitation in Pass 1, we had to discount each of our Pass 1 projects. The discounted value of this project is $21,521,621, of which $19,224,968 has been spread to Category 2 and $2,299,653 has been spread to Category 3 to adhere to the value spread regulation in the funding and mechanics protocol.

The performing provider has determined that tracking quality of life, ED utilization, and inpatient admissions with the population served by the intervention will validate that the project is achieving its goals, thus justifying the value computed through the study.

081599501.3.16	*3.IT-2.13*	*Other Admissions Rate*	
MHMR of Tarrant County			*081599501*
Related category 1 or 2 projects		081599501.2.3	
Starting Point/Baseline:	**Baseline data:** In DY3 we will establish a baseline rate for hospital admission.		
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)**
N/A Process Milestone Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 1 [P-2]:** Establish baseline for inpatient admissions. Data Source: Client medical records, EHR Process Milestone 2 Estimated Incentive Payment*:* $174,401	**Outcome Improvement Target 1 [IT-2.13]:** Other admissions rate. Improvement Target: 20% decrease in inpatient admissions over baseline Data Source: Client medical records, EHR Outcome Improvement Target 1 Estimated Incentive Payment:$186,568	**Outcome Improvement Target 2 [IT-2.13]:** Other admissions rate. Improvement Target: 40% decrease in inpatient admissions over baseline Data Source: Client medical records, EHR Outcome Improvement Target 2 Estimated Incentive Payment:$405,583
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $174,401	Year 4 Estimated Outcome Amount: $186,568	Year 5 Estimated Outcome Amount: $405,583
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$766,553			

Title of Outcome Measure (Improvement Target): IT-4.8- Sepsis mortality (Stand-alone measure)
Unique RHP outcome identification number(s): 094105602.3.1
Performing Provider Name/TPI: North Hills Hospital / 094105602

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
In DY2 we will establish baseline rates for sepsis mortality to measure for improvement targets. In DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. By DY4 and DY5, the improvement target is Sepsis mortality reduction of 25%by the end of the Waiver.

Rationale:
The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets.

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. There have been many focused initiatives to decrease mortality and morbidity in the past decade for other top causes of death of influenza and pneumonia. Proving evidence-based initiatives put in place can reduce mortality; implementing initiatives for sepsis follow these plans. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. Each year mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. North Hills Hospital has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

North Hills Hospital defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The percentage of the population expected to be positively impacted by the project for mortality is 4%, which was determined based on outcome

target for reduction in mortality by 25% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 21. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $218,700 for 5 years.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $218,700.
To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 5. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $210,700.

The total value of the project then was estimated at $1,844,000. Approximately 79% of the total value was assigned to Category 2 project and the remaining 9% of value assigned to Category 3 outcome for Sepsis Mortality and 11.8% assigned to Category 3 outcome for reduced Average Length of Stay.

The value for the total outcome was determined based on the population targeted for sepsis, size of the population, and costs and steps necessary to achieve reductions in mortality. We did not value the process and outcome targets differently as we believe they are all equally important to overall success of project.

094105602.3.1	*3.IT-4.8*	*Sepsis mortality*	
North Hills Hospital			*094105602*
Related Category 1 or 2 Projects::	*094105602.2.1*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
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 Metric 1: Number of patients treated with sepsis resuscitation and management bundles Goal: Baseline Data Source: EHR Process Milestone 1 Estimated Incentive*:* $9,208 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 2 Estimated Incentive Payment*:* $9,208	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 3 Estimated Incentive Payment: $32,019	**Outcome Improvement Target 1** [IT-4.8]: 15% reduction in mortality from baseline, 6 cases Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $34,253	**Outcome Improvement Target 2** [IT-4.8]: 25% reduction in mortality from baseline, 9 cases Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $81,910

094105602.3.1	*3.IT-4.8*	*Sepsis mortality*	
North Hills Hospital			*094105602*
Related Category 1 or 2 Projects::	*094105602.2.1*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $18,416	Year 3 Estimated Outcome Amount: $32,019	Year 4 Estimated Outcome Amount: $34,253	Year 5 Estimated Outcome Amount: $81,910
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $166,598			

Title of Outcome Measure (Improvement Target): IT-4.9- Average length of stay (Non-stand-alone measure)

Unique RHP outcome identification number(s): 094105602.3.2
Performing Provider Name/TPI: North Hills Hospital / 094105602

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
In DY2 we will establish baseline rates for sepsis average length of stay to measure for improvement targets. In DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. By DY4 and DY5, the improvement target is Sepsis average length of stay of TBD by the end of the Waiver. The improvement target will be determined in DY2 and implemented starting in DY3.

Rationale:
The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets.

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. There have been many focused initiatives to decrease mortality and morbidity in the past decade for other top causes of death of influenza and pneumonia. Proving evidence-based initiatives put in place can reduce mortality; implementing initiatives for sepsis follow these plans. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. Each year mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. North Hills Hospital has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*
North Hills Hospital defined the population that will be directly impacted by the project as patients diagnosed with Sepsis. There were 2 outcomes for this project, sepsis mortality and

average length of stay for sepsis patients. The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 7.3 days per patient. This was estimated at total of reduced in patient days by DY 5 of 650. The estimated cost per day for a sepsis patient is $828. This totaled approximately $544,000.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 3. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $326,000.

To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 3. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $326,000.

The total value of the project then was estimated at $1,844,000. Approximately 79% of the total value was assigned to Category 2 project and the remaining 9% of value assigned to Category 3 outcome for Sepsis Mortality and 11.8% assigned to Category 3 outcome for reduced Average Length of Stay.

The value for the total outcome was determined based on the population targeted for Sepsis, size of the population, baseline average length of stay, cost avoidance and steps necessary to achieve reductions in average length of stay. We did not value the process and outcome targets differently as we believe they are all equally important to overall success of project.

094105602.3.2	*3.IT-4.9*	*IT-4.9 Average length of stay*	
North Hills Hospital			**0***94105602*
Related Category 1 or 2 Projects::	0*94105602.2.1*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients diagnosed with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl).* *Target population: patients hospitalized with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl)*		
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 Metric 1: ALOS for patients treated with sepsis resuscitation and management bundles Goal: Complete baseline Data Source: EHR Process Milestone 1 Estimated Incentive Payment :$12,125 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 2 Estimated Incentive Payment: $12,125	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 3 Estimated Incentive Payment: $42,163	**Outcome Improvement Target 1** [IT-4.9]: Reduce by 1.5 days from baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $45,105	**Outcome Improvement Target 2** [IT-4.9]: Reduce 2 days from baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $107,859

094105602.3.2	*3.IT-4.9*	*IT-4.9 Average length of stay*	
North Hills Hospital			**0***94105602*
Related Category 1 or 2 Projects::	0*94105602.2.1*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients diagnosed with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl).* *Target population: patients hospitalized with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl)*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $24,250	Year 3 Estimated Outcome Amount: $42,163	Year 4 Estimated Outcome Amount: $45,105	Year 5 Estimated Outcome Amount: $107,859
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $219,377			

Title of Outcome Measure (Improvement Target): IT-6.1- Percent Improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 094193202.3.1
Performing Provider Name/TPI: Plaza Medical Center Fort Worth / 094193202

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
In DY2 we will establish baseline data to measure for patient satisfaction scores. The target for the outcome measure is 10% improvement in scores over baseline in DY4 and 20% in DY5. In DY2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. It will also be necessary to develop and test data systems for establishing an internal measurement of patient satisfaction for timely feedback on improvement plans and corrective actions. In DY3, we will disseminate findings, including lessons learned and best practices, to stakeholders.

Rationale:
The process milestone to establish the baseline rate is necessary to understand the starting point of patient satisfaction scores. The outcome improvement targets were selected as they are congruent with other goals of the organization and will result in improved health outcome of patients and reduce cost to the health system.

The target for the outcome measure is to increase patient satisfaction scores by 20% by the end of the Waiver period. We have implemented some initiatives improve scores however this has not moved score significantly in the last year. We believe a renewed focus is necessary to make significant improvement

In DY2, we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plan. These are necessary steps to ensure all stakeholders (IP /OP, out of hospital providers, etc) are identified and included in the plan. Indentifying capacity and resource needed to implement are required for budgeting purposes. Establishing timelines and documenting a plan are a guide to knowing when things need to occur, who is responsible for making them happen and the ultimate expectations and goals of the project. The documented plan and timelines serve as a tool to measure the performance in executing the project.

It will also be necessary in DY2 to develop and test data systems for timely measurement of patient satisfaction in order to correctly measure improvement targets. CMS published HCAHPS score are not expedited very timely so the process milestone to develop and test internal

measurements is necessary to have timely feedback for correcting actions for the patients' experience improvement planning

In DY3, we will disseminate findings, including lessons learned and best practices, to stakeholders. This would include intervention impacts, learning from follow up on successes or failures and identified best practices. This feedback is significant to adjusting plans findings and continued engagement of stakeholders.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Plaza Medical Center Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

The percentage of the population expected to be positively impacted by the project is all patients surveyed, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. It was estimated based on CMS published penalties that in 4 years for not achieving satisfactory patient experience levels, 1.5% of Medicare revenues were in jeopardy. The rate per Medicare case of $11,759 was used to calculate the estimated loss of revenues using these penalty % for DY 2-0.50%, DY 3- 0.75%, DY 4-0.94%, and DY5 -1.05% . This totaled $2,161,220.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduced costs. This was estimated a portion of potential revenue value and totaled $1,396,542. To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, his or quality of life is improved, productivity is increased, and there is a reduced burden on society. This was estimated a portion of potential revenue value and totaled $1,294,779.

The total value of the project was calculated at $4,852,541. Approximately 79% of the project value was assigned to the Category 2 project, $3,836,901 and 21% to the Category 3 project, $1,015,640.

We did not value the process and outcome targets differently as we believe they are all equally important to overall success of the project.

094193202.3.1	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*	
Plaza Medical Center Fort Worth			*094193202*
Related Category 1 or 2 Projects::	*094193202.2.1*		
Starting Point/Baseline:	*2010Q4-2011Q3 HCAHPS 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)**
Process Milestone 1 [P- 1]: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: submission of plan Goal: Plan Data Source: Patient Satisfaction Improvement Plan Process Milestone 1 Estimated Incentive Payment: $56,134 **Process Milestone 2** [P- 3]: Develop and test data systems Metric 1: Complete testing systems and development of survey Goal: Establish measurement tool from data systems Data Source: Survey tool Process Milestone 2 Estimated Incentive Payment: $56,134	**Process Milestone 3** [P- 5]: Disseminate findings (i.e. resources utilized, feedback from patients and staff, satisfaction scores), including lessons learned and best practices, to stakeholders Metric 1: submission of documentation of findings and communication Goal: stakeholder meetings Data Source: Patient Satisfaction Improvement Plan Process Milestone 3 Estimated Incentive Payment: $195,201	**Outcome Improvement Target 1** [IT 6.1]: Improvement Target: 10% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $208,820	**Outcome Improvement Target 2** [IT 6.1]: Improvement Target: 20% improvement over baseline Data Source: HCAHPS hospitals survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $499,351

094193202.3.1	*3.IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*	
Plaza Medical Center Fort Worth			*094193202*
Related Category 1 or 2 Projects::	*094193202.2.1*		
Starting Point/Baseline:	*2010Q4-2011Q3 HCAHPS 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $112,268	Year 3 Estimated Outcome Amount: $195,201	Year 4 Estimated Outcome Amount: $208,820	Year 5 Estimated Outcome Amount: $499,351
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,015,640			

Title of Outcome Measure (Improvement Target): IT-4.8- Sepsis mortality (Stand-alone measure)

Unique RHP outcome identification number(s): 094193202.3.2
Performing Provider Name/TPI: Plaza Medical Center Fort Worth / 094193202

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
In DY2 we will establish baseline rates for sepsis mortality to measure for improvement targets. In DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. By DY4 and DY5, the improvement target is Sepsis mortality reduction of 25% by the end of the Waiver.

Rationale:
The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets.

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. There have been many focused initiatives to decrease mortality and morbidity in the past decade for other top causes of death of influenza and pneumonia. Proving evidence-based initiatives put in place can reduce mortality; implementing initiatives for sepsis follow these plans. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. Each year mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Plaza Medical Center Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Plaza Medical Center Fort Worth defined the population that will be directly impacted by the project as patients diagnosed with sepsis. There were 2 outcomes for this project, sepsis mortality and average length of stay for sepsis patients. The percentage of the population expected to be positively impacted by the project for mortality is 3.5%, which was determined based on outcome target for reduction in mortality by 25% from baseline by DY 5. This was estimated at total of reduced deaths/lives saved of 31. The estimated pricing for morality of $10,000 per life was used. This reflected such considerations a costs for care, lost wages , and quality of life. This totaled approximately $315,000 for 5 years.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for mortality is a 5. We believe this to be the correct number because when a person is positively impacted, mortality will decrease, reducing costs and resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced mortality was $315,000.

To determine the value to the community of each individual positively impacted by reduced mortality, we concluded that, on a scale of 1 to 5, the value of this project is a 4. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of mortality reduction at $252.000.

The total value of the project then was estimated at $1,943,133. Approximately 79% of the total value was assigned to Category 2 project and the remaining 6.3% of value assigned to Category 3 outcome for Sepsis Mortality and 14.69% assigned to Category 3 outcome for reduced Average Length of Stay.

The value for the total outcome was determined based on the population targeted for Sepsis, size of the population, and costs and steps necessary to achieve reductions in mortality. We did not value the process and outcome targets differently as we believe they are all equally important to overall success of project.

094193202.3.2	*3.IT-4.8*	*Sepsis mortality*	
Plaza Medical Center Fort Worth			*094193202*
Related Category 1 or 2 Projects::	*094193202.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
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 Metric 1: Number of patients treated with sepsis resuscitation and management bundles Goal: Complete baseline Data Source: EHR Process Milestone 1 Estimated Incentive*:* $6,695 **Process Milestone** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 2 Estimated Incentive Payment*:* $6,695	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: : Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Initiative Plan Process Milestone 3 Estimated Incentive Payment: $23,282	**Outcome Improvement Target 1** [IT-4.8]: 15% reduction in mortality from baseline, 8 cases/deaths Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $24,906	**Outcome Improvement Target 2** [IT-4.8]: 25% reduction in mortality from baseline, 14 cases/deaths Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $59,558

094193202.3.2	*3.IT-4.8*	*Sepsis mortality*	
Plaza Medical Center Fort Worth			*094193202*
Related Category 1 or 2 Projects::	*094193202.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients hospitalized with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.* *Target population: patients hospitalized with severe sepsis or septic shock and/or an infection and organ dysfunction.*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $13,390	Year 3 Estimated Outcome Amount: $23,282	Year 4 Estimated Outcome Amount: $24,906	Year 5 Estimated Outcome Amount: $59,558
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $121,136			

Title of Outcome Measure (Improvement Target): IT-4.9 Average length of stay (Non-stand-alone measure)

Unique RHP outcome identification number(s): 094193202.3.3
Performing Provider Name/TPI: Plaza Medical Center Fort Worth / 094193202

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
In DY2 we will establish baseline rates for sepsis average length of stay to measure for improvement targets. In DY2 and 3 we will conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. By DY4 and DY5, the improvement target is Sepsis average length of stay of TBD by the end of the Waiver. The improvement target will be determined in DY2 and implemented starting in DY3.

Rationale:
The process milestone selected for conducting Plan Do Study Act (PDSA) will implement a continuous quality improvement model consisting of a logical sequence of four repetitive steps for continuous improvement and learning that will assist in the achievement of improvement targets.

According to the Center for Disease Control and Prevention (CDC) 2007 statistics, septicemia is the 10th leading cause of death in the United States. There have been many focused initiatives to decrease mortality and morbidity in the past decade for other top causes of death of influenza and pneumonia. Proving evidence-based initiatives put in place can reduce mortality; implementing initiatives for sepsis follow these plans. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. Each year mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Plaza Medical Center Fort Worth has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Plaza Medical Center Fort Worth defined the population that will be directly impacted by the project as patients diagnosed with sepsis. The total sepsis population is expected to be positively impacted by the project for a reduction in length of stay of 2 days from baseline average of 8.7

days per patient. This was estimated at total of reduced in patient days by DY 5 of 1017. The estimated cost per day for a sepsis patient is $750. This totaled approximately $763,000.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project for reduced length stay is a 1. We believe this to be the correct number because when length of stay is reduced, there is less risk for complications resulting in better health outcomes and improved quality of life. The total value estimated as proportion of reduced length of stay is $152,685.

To determine the value to the community of each individual positively impacted by reduced length of stay, we concluded that, on a scale of 1 to 5, the value of this project is a 1. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improves, productivity increases and the burden on society is reduced.
This value was estimated as a proportion of length of stay reduction at $145,385.

The total value of the project then was estimated at $1,943,133. Approximately 79% of the total value was assigned to Category 2 project and the remaining 6.3% of value assigned to Category 3 outcome for Sepsis Mortality and 14.69% assigned to Category 3 outcome for reduced Average Length of Stay.

The value for the total outcome was determined based on the population targeted for Sepsis, size of the population, baseline average length of stay, cost avoidance and steps necessary to achieve reductions in average length of stay. We did not value the process and outcome targets differently as we believe they are all equally important to overall success of project.

094193202.3.3	*3.IT-4.9*	*IT-4.9 Average length of stay (Non-standalone measure)IT-4.9 Average length of stay stand-alone*	
Plaza Medical Center Fort Worth			**094193202**
Related Category 1 or 2 Projects::	*094193202.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients diagnosed with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl).* *Target population: patients hospitalized with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl)*		
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 Metric 1: ALOS for patients treated with sepsis resuscitation and management bundles Goal: Complete baseline Data Source: EHR Process Milestone 1 Estimated Incentive Payment :$15,784 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 2 Estimated Incentive Payment: $15,784	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Number of PDSA cycles Goal: complete all steps in cycles Data Source: Sepsis Improvement Plan Process Milestone 3 Estimated Incentive Payment: $54,888	**Outcome Improvement Target 1** [IT-4.9]: Reduce by 1.5 days from baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $58,717	**Outcome Improvement Target 2** [IT-4.9]: Reduce 2 days from baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $140,411

094193202.3.3	*3.IT-4.9*	*IT-4.9 Average length of stay (Non-standalone measure)IT-4.9 Average length of stay stand-alone*	
Plaza Medical Center Fort Worth			**094193202**
Related Category 1 or 2 Projects::	*094193202.2.2*		
Starting Point/Baseline:	*Population: patients hospitalized with sepsis* *Baseline Population: patients diagnosed with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl).* *Target population: patients hospitalized with severe sepsis or septic shock and/or an lactate >4mmol/L (36mg/dl)*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,568	Year 3 Estimated Outcome Amount: $54,888	Year 4 Estimated Outcome Amount: $58,717	Year 5 Estimated Outcome Amount: $140,411
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $285,584			

Title of Outcome Measure (Improvement Target): 1.10 Diabetes Care: HbA1c poor control (>9.0%)

Unique RHP outcome identification number(s): 112677302.3.4

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Outcome Measure Description:

Our goal is that diabetes program participants will demonstrate improvement in HbA1c, compared to their initial or baseline value. By the end of the Waiver, our goal is to decrease by 25% the number of diabetes program participants whose HbA1c is >9%.

Process Milestones:

- In DY2, we will:
  - Complete project planning, including identification and hiring of necessary staff, development of policies / procedures and processes
  - Develop and test reporting

Outcome Improvement Targets for each year:

- In DY3, our goal is to reduce by 10% the rate of participants with HbA1c > 9%, and to conduct Plan Do Study Act cycles to identify and improve collection and intervention activities.
- In DY4 we will reduce by 15% from baseline the rate of diabetes patients whose HbA1c is > 9.0%, and
- in DY5, reduce by 25% from baseline the rate of diabetes patients whose HbA1c is >9.0%.

Rationale:

The goal of this project is to develop and implement a more comprehensive care management program, using a CARE team of clinical and support staff to link project participants to a medical home and diabetes management resources to help reduce the rates of uncontrolled diabetes. Our goal is provide seamless care for low income and uninsured residents of Tarrant County, to improve the health outcomes and diabetes self-management competency and decrease inappropriately high reliance on acute and emergent care community resources. While chronic conditions are a growing concern for all U.S. populations, the uninsured and Medicaid beneficiaries with chronic conditions are at the greatest risk of unnecessary disease-related complications and avoidable hospitalizations. THFW data indicates that of the patients readmitted within 30 days for diabetes, about 13% have Medicaid, and an additional 6% are self-pay or uninsured. They are without access to the resources and self-management education needed to prevent these hospitalizations and readmissions.

The identified process milestones will assist our organization in developing and implementing the structure needed to coordinate care for these patients. Process milestones identified in DY2

include (P-1) project planning involving the establishment of a comprehensive care management program and formalization of the multidisciplinary Diabetes CARE team to link these patients to a medical home and resources / self-management education. In DY2, we will also (P-3) develop and test data systems to provide a mechanism for identifying and tracking high risk patients with diabetes and monitoring the effectiveness of interventions to begin analysis of information and determine potential improvement opportunities.

In DY3, conducting Plan Do Study Act (PDSA) cycles (P-4) will allow us to implement performance improvement initiatives based on opportunities identified. In addition, a reporting mechanism will be developed to disseminate information regarding the project.

In DY4 and DY5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

89% of medically managed patients who enrolled the current outpatient diabetes self-management training program at THFW achieved HbA1c <7% by program completion. Using this comparison for this higher-risk, economically disadvantaged population of people with diabetes, we conservatively project a goal of decreasing by 25% the number of diabetes program participants whose HbA1c is >9% by DY5.

Outcome Measure Valuation:

- **Approach/Methodology:** For every inpatient admission avoided, $8,297 in cost is saved by the health care system. Health care costs are calculated by multiplying $8,297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

112677302.3.4	*3.IT-1.10*	*Primary Care and Chronic Disease Management –* *IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 (Stand-alone measure)*	
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	***Baseline Data:*** *Baseline will be determined in DY2. Numerator estimated to be ~30% (new THFW outpatients today who had initial HbA1c>9%). Denominator estimated to be ~260, based on applying a 15% enrollment rate to the volume of diabetes patients (1,952) who visited the THFW ED more than 2 times in 2011.* ***Target Population:*** *Low income, disadvantaged community members with a diagnosis of diabetes identified through the ED, inpatient hospital stay or community partnerships and do not have access to diabetes care and education*		
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]:** Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,492 **Milestone 2 [P-2]:** Establish baseline rates Goal/Baseline: Anticipate approximately 210 meet criteria Data Source: EMR, laboratory data Process Milestone 2 Estimated Incentive Payment: $5,492	**Milestone 4** **[P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $13,022 **Outcome Improvement Target 1** [IT-1.10] Diabetes care: HbA1c poor control (>9%): Rate of participants with HbA1c >9 Improvement Target: 10% reduction from baseline Data Source: Identified database determined DY2. Outcome Improvement Target 1	**Outcome Improvement Target 2** [IT-1.10] Diabetes Care: HbA1c poor control (>9%), Rate of participants with HbA1c >9.0 Improvement Target: 25 % reduction from baseline Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $27,862	**Outcome Improvement Target 3** [IT1.10]: Diabetes Care: HbA1c poor control (>9%), Rate of participants with HbA1c >9.0 Improvement Target: 50% reduction from baseline Data Source: Identified database determined in DY2. Outcome Improvement Target 3 Estimated Incentive Payment*:* $66,626

112677302.3.4	*3.IT-1.10*	*Primary Care and Chronic Disease Management – IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 (Stand-alone measure)*	
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	***Baseline Data:*** *Baseline will be determined in DY2. Numerator estimated to be ~30% (new THFW outpatients today who had initial HbA1c>9%). Denominator estimated to be ~260, based on applying a 15% enrollment rate to the volume of diabetes patients (1,952) who visited the THFW ED more than 2 times in 2011.* ***Target Population:*** *Low income, disadvantaged community members with a diagnosis of diabetes identified through the ED, inpatient hospital stay or community partnerships and do not have access to diabetes care and education*		
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 3 [P-3]: Develop and test data systems Data Source: Internally developed data base using EMR clinic data to monitor project and produce reports Process Milestone 3 Estimated Incentive Payment: $5,492	Estimated Incentive Payment: $13,023		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $16,477	Year 3 Estimated Outcome Amount: $26,045	Year 4 Estimated Outcome Amount: $27,862	Year 5 Estimated Outcome Amount: $66,626
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $137,010			

Title of Outcome Measure (Improvement Target): Potentially Preventable Complications – 3.3 Diabetes 30 day readmission rate

Unique RHP outcome identification number(s): 112677302.3.5

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Outcome Measure Description:
3.3 Diabetes 30 day readmission rate
Our goal is to decrease readmissions (all-cause) for diabetes. By the end of the Waiver, our goal is to decrease 30 day readmission (all-cause) for diabetes patients by 15%.
Process Milestones:

- In DY2, we will:
  - Complete project planning including identification and hiring of necessary staff, development of policies /procedures and processes
  - Develop and test reporting and monitoring process to evaluate
  - Establish the baseline for this rate.

Outcome Improvement Targets for each year:

- In DY3, our goal is to reduce this rate by 4% and to conduct Plan Do Study Act cycles to improve collection and intervention activities.
- In DY4, to reduce diabetes patient readmissions by 10% from baseline, and
- In DY5, to reduce diabetes patient readmissions by 15% from baseline.

Rationale:
The goal of this project is to develop and implement a more comprehensive care management program, using a CARE team of clinical and support staff to link project participants to a medical home and diabetes management resources to help reduce the rates of uncontrolled diabetes. Our goal is provide seamless care for low income and uninsured residents of Tarrant County, to improve the health outcomes and diabetes self-management competency and decrease inappropriately high reliance on acute and emergent care community resources. While chronic conditions are a growing concern for all U.S. populations, the uninsured and Medicaid beneficiaries with chronic conditions are at the greatest risk of unnecessary disease-related complications and avoidable hospitalizations. THFW data indicates that of the patients readmitted within 30 days for diabetes, about 13% have Medicaid or Managed Care Medicaid, and an additional 6% are self-pay or uninsured. They are without access to the resources and self-management education needed to prevent these hospitalizations and readmissions. Our proposed intervention will help individuals who are traditionally underserved and give them

access to diabetes resources and education so they can better manage their diabetes and break the cycle of avoidable hospitalizations and readmissions.

The identified process milestones will assist our organization in developing and implementing the structure needed to coordinate care for these patients. Process milestones identified in DY2 include (P-1) project planning involving the establishment of a comprehensive care management program and formalization of the multidisciplinary Diabetes CARE team to link these patients to a medical home and resources / self-management education. In DY2, we will also (P-3) develop and test data systems to provide a mechanism for identifying and tracking high risk patients with diabetes and monitoring the effectiveness of interventions to begin analysis of information and determine potential improvement opportunities.

In DY3, conducting Plan Do Study Act (PDSA) cycles (P-4) will allow us to implement performance improvement initiatives based on opportunities identified. In addition, a reporting mechanism will be developed to disseminate information regarding the project.

In DY4 and DY5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Today, THFW has an outpatient diabetes management program for medically managed patients. The improvement target for the readmission rates was decided on using the assumption that we can successfully reduce readmission rates close to the level achieved by the medically managed diabetes population, when we e331stablish the diabetes care management program for the Medicare, Medicaid and unfunded population (~15%)[332].

Outcome Measure Valuation:

- **Approach/333Methodology:** For every inpatient readmission avoided, $8,297 in cost is saved by the health care system[334]. Health care costs are calculated by multiplying $8,297 by the total individuals affected. The average length of stay per admission is multiplied

[331] Jansen, D., Kroll, B., Groothoff, J., & Post, D. (2004). People with intellectual disabilities and their health problems: a review of comparative studies. *Journal of Intellectual Disability Research , 48* (2), 93-102.

[332] Jansen, D., Krol, B., Groothoff, J., & Post, D. (2006). Towards improving medical care for people with intellectual disability living in the community: possitbilities of integrated care. *Journal of Applied Research in Intellectual Disability , 19* (2), 214-218.

[333] Hassiotis, A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disease Management & Health Outcomes , 10* (7), 409-417.

[334] Texas Health and Human Services Commission. (2012, October 01). *Medicaid Transformation Waiver.* Retrieved November 29, 2012, from Tools and Guidelines for Regional Healthcare Partnership Participants: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml

by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.

- **Rationale/Justification:** Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g., aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g., keeping lower acuity patients under observation instead of admitting them).

112677302.3.5	*3.IT-3.3*	*Potentially Preventable Complications – 3.3 Diabetes 30-day readmission rate*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	***Baseline Data:*** *Baseline and outcome improvement targets to be validated in DY2. Preliminary data indicates a 30-day diabetes readmission rate (with diabetes as principal or secondary diagnosis) at approximately 14.6%.* ***Target Population:*** *Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care.* ***Description of Population:*** *Low income, disadvantaged community members with a diagnosis of diabetes identified through the ED, inpatient hospital stay or community partnerships and do not have access to diabetes care and education*		
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]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,492 **Milestone 2** [P- 2]: Establish baseline rates Goal/Baseline: Anticipate approximately 210 meet criteria Data Source: Database including patient administrative and coding/billing information such as Premier Quality Advisor identified and baseline rate confirmed Process Milestone 2 Estimated	**Milestone 4 [**P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Process Milestone 4 Estimated Incentive Payment: $8,682 **Milestone 5 [**P-5]: Disseminate findings, including lessons learned and best practices to stakeholders. Data Source: reports or other communication tools produced to disseminate findings Process Milestone 5 Estimated Incentive Payment: $8,682	**Outcome Improvement Target 2** [IT-3.3]: Diabetes 30-day readmission rate (Stand-alone measure) Goal: 10% reduction from baseline Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $27,862	**Outcome Improvement Target 3** [IT-3.3]: Diabetes 30-day readmission rate (stand-alone measure) Goal: 15% reduction from baseline Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $66,626

112677302.3.5	*3.IT-3.3*	*Potentially Preventable Complications – 3.3 Diabetes 30-day readmission rate*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	***Baseline Data:*** *Baseline and outcome improvement targets to be validated in DY2. Preliminary data indicates a 30-day diabetes readmission rate (with diabetes as principal or secondary diagnosis) at approximately 14.6%.* ***Target Population:*** *Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care.* ***Description of Population:*** *Low income, disadvantaged community members with a diagnosis of diabetes identified through the ED, inpatient hospital stay or community partnerships and do not have access to diabetes care and education*		
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)**
Incentive Payment *(maximum amount):* $5,492 **Process Milestone 3** [P- 3]: Develop and test data systems Data Source: Internally developed database using EMR data to monitor project and produce reports. Process Milestone 3 Estimated Incentive Payment: $ 5,493	**Outcome Improvement Target 1** [IT-3.3]: Diabetes 30-day readmission rate (stand-alone measure): Goal: 4% reduction from baseline Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $8,681		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $16,477	Year 3 Estimated Outcome Amount: $26,045	Year 4 Estimated Outcome Amount: $27,862	Year 5 Estimated Outcome Amount: $66,626
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $137,010			

Title of Outcome Measure (Improvement Target): Potentially Preventable Admissions – IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8 (Stand-alone measure)
Unique RHP outcome identification number(s): 112677302.3.6
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Outcome Measure Description:
IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8 (Stand-alone measure)
By the end of the Waiver, our goal is for congestive heart failure patient admission rates will decrease by 5%.

	DY2	DY3	DY4	DY5
Admissions	953	943	924	905
Total Population	205356	205356	205356	205356
Admission Rate	0.464%	0.459%	0.449%	0.440%

Process Milestones:

- In DY2, Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Baseline rates of admissions will also be established.
- In DY3, Will conduct Plan Do Study Act cycles to improve data collection and intervention activities. Finding will be disseminated to stakeholders regarding lessons learned and best practices. Outcome goal will be to decrease overall population requiring admission due to Heart Failure by 1% from hospital CHF baseline volume.

Outcome Improvement Targets for each year:

- In DY4, to reduce HF patient admissions by 2% more from baseline total community members requiring admission with principal diagnosis of heart failure.
- In DY5 to reduce HF patient admissions by 2 % more from baseline total community members requiring admission with principal diagnosis of heart failure).

Rationale:
The target population includes individuals with heart failure diagnosis who are at risk for hospitalization due to inadequate monitoring or management of their chronic disease, specifically, HF patients within our service area who are underserve335d, unfunded, or underinsured.

- According to a report published in 2011 on readmissions in North Texas[336], patients admitting for congestive heart failure (CHF) had the highest number of readmissions (22.6%). Heart failure was also the number one reason for readmission for both the

[335] Cervical Cancer in Michigan: Screening Saves Lives. Michigan Cancer Consortium. www.michigancancer.org.
[336] See table 4 in referenced article for differences in readmission rates between payer groups. Jiang et al.(September, 2005) Racial/ ethnic disparities in potential preventable readmissions: the case for diabetes, *American Journal of Public Health*, Vol 95, No. 9, 1561-1567

Medicare and uninsured patient demographics. There were 13,272 hospitalizations of North Texas heart failure patients that were followed by a readmission in 2011.

- Tarrant County Public Health Department *Behavioral Risk Factor Surveillance System 2009/2010* notes that among Tarrant County adults in 2007, heart disease ranked as the leading cause of death for both men and women. Also, during the years 2000 to 2005, Tarrant County residents spent about $500 million on preventable hospitalizations due to angina, CHF, and high blood pressure.
- Also noted in "Checkup for Tarrant County-2008", prepared in 2009 from 2008 data: Cardiovascular Disease is identified in Tarrant County as having higher rates than in the state or the U.S. population. This same report noted that the areas in and adjacent to THFW had a significant population337 within the poverty level which leads to underserved populations without a health insurance safety net.[338]
- The Society of Cardiovascular Patient Care notes that Heart Failure is currently the only cardiovascular disease that is increasing in both incidence and prevalence. Being the 339end-stage of all cardiac diseases, heart failure is responsible for 6.5 million hospital days annually.[340]

Outcome Measure Valuation:

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the validation of a baseline rate for measuring our effectiveness in future project years as well supporting and strengthening our recent start-up CHF postdischarge clinic, additionally, strengthening the liaison between inpatient areas/ED and the staff that plan postdischarge services and care. In DY3 – in addition to evaluating the effectiveness of the postdischarge clinic, it is anticipated that the clinic hours will increase to increase the capacity for seeing patients who otherwise might not be seen in a timely manner by a primary or specialist physician postdischarge.

In DY4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

- **Ap341proach/Methodology:** For every CHF admission avoided, $9,203 in cost is saved by the health care system.[342] The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals

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[337] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

[338] *See table 4 in referenced article for differences in readmission rates between payer groups* - Jiang et al.(September, 2005) Racial/ ethnic disparities in potential preventable readmissions: the case for diabetes, American Journal of Public Health, Vol 95, No. 9, 1561-1567

[339] Checkup 2008 Trends and Highlights, 2009 , prepared for Healthy Tarrant County, Parkland.

[340] Readmissions in North Texas. 2011. http://www.dfwhcfoundation.org/wp-content/uploads/2012/09/Readmissions-in-North-Texas-2011final-2.pdf

[341] Checkup 2008 Trends and Highlights, 2009 , prepared for Healthy Tarrant County, Parkland.

[342] Heart Failure, Society of Cardiovascular Patient Care, 2012, http://www.scpcp.org/resources/hf/

affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.

- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).
- Community benefits were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.
- Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

112677302.3.6	*3.IT-2.1*	*THFW – Congestive Heart Failure Admission rate*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.2.1 EXPAND CHRONIC CARE MANAGEMENT MODELS: REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASE*		
Starting Point/Baseline:	*.35% of CHF patients are admitted*		
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**]: Project planning : Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Sources P-1: Provider documents describing and providing evidence of start-up operations, including current capacity. Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,008 **Milestone 2 [P-2]:** P-2 establish baseline rates of admissions Data Source: THR data of CHF-principal diagnosis admissions Milestone 2 Estimated Incentive Payment *(maximum amount):* $12,009	**Milestone 3 [P4]** P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Documents showing evidence of PDSA activities. Milestone 3 Estimated Incentive Payment: $12,654 **Milestone 4 [P5]** P-5 Disseminate findings, including lessons learned and best practices, to stakeholders Milestone 4 Data Source: Reports or other communication tools produced to disseminate findings Milestone 4 Estimated Incentive Payment: $12,654 **Outcome Improvement Target 1 [IT 2.1]** Congestive Heart Failure admission rate (Stand-alone measure): Goal: decrease overall population requiring admission due to HF .459% from hospital CHF baseline	**Outcome Improvement Target 2 [IT-2.1]** Congestive Heart Failure Admission rate (Stand-alone measure) Goal: Decrease overall population requiring admission due to HF by additional .449% from hospital baseline volume. Data Source: Year 4 THR admission rate for CHF principal diagnosis. Outcome Improvement Target 2 Estimated Incentive Payment*:* $40,610	**Outcome Improvement Target 3** [**IT-2.1]** Congestive Heart Failure Admission rate (Stand-alone measure) Goal: Decrease overall population requiring admission due to HF by additional .440% from hospital baseline volume. Data Source: Year 5 THR admission rate for CHF principal diagnosis Outcome Improvement Target 3 Estimated Incentive Payment*:* $97,111

112677302.3.6	*3.IT-2.1*	*THFW – Congestive Heart Failure Admission rate*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.2.1 EXPAND CHRONIC CARE MANAGEMENT MODELS: REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASE*		
Starting Point/Baseline:	*.35% of CHF patients are admitted*		
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)**
	volume. Data Source: Y2 THR data of CHF principal diagnosis admissions. Outcome Improvement Target 1 Estimated Incentive Payment*:* $12,654		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $24,017	Year 3 Estimated Outcome Amount: $37,962	Year 4 Estimated Outcome Amount: $40,610	Year 5 Estimated Outcome Amount: $97,111
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $199,700			

Title of Outcome Measure (Improvement Target): Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs)- IT.3.2 Congestive Heart Failure 30-day readmission rate

Unique RHP outcome identification number(s): 112677302.3.7
Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Outcome Measure Description:
IT.3.2 Congestive Heart Failure 30-day readmission rate

Process Milestones:
In DY2, we will:

- Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
- Develop plans/protocols for HF Clinic managed by nurse practitioners. Obtain necessary supplies and equipment
- Develop and test reporting and monitoring process to evaluate
- Establish the baseline for this rate. An initial data pull from our database shows that the baseline rate may be as high as 22%

Outcome Improvement Targets for each year:

- In DY3, our goal is to reduce this rate by 4%; to conduct performance improvement projects toward further reductions and to disseminate information to key stakeholders regarding our progress
- In DY4 and DY5: In DY4 our goal is to reduce HF patient readmissions by 10% from baseline and in DY5 to reduce HF patient readmissions by 15% from baseline.

Rationale:
The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient nurse-practitioner run heart failure clinic including hiring and training hospital and clinic staff in Wagner's Chronic Care model and processes being implemented to improve care and education of the at risk HF patient. Evaluation of the need for additional CareTransitions coaches and PrimeMedics will also be completed and staff engaged/trained as needed. In DY2, we will also 1) develop a mechanism for identifying and tracking high-risk HF patients, 2) develop a screening tool to assist in identifying needs putting the HF patient at risk for readmission 3) monitor effectiveness of interventions (education, medication reconciliation, ability to meet patients' identified health care need – medication, supplies, primary care provider, transportation to health care appointments, care transitions coach, telemonitoring, postdischarge telephonic case management, home visits, HF Clinic etc.) and begin analysis of our information to determine potential

improvement opportunities 4)collaborate with community health care providers to develop protocols to improve health of HF patients posthospital discharge and along the continuum of care.

In DY3, performance improvement initiatives will be implemented based on opportunities identified from information learned through data collection and analysis. A reporting mechanism will be developed to disseminate information to key partners regarding the project.

In DY4 and 5, the identified outcomes measures will monitor our effectiveness in achieving the desired outcome of preventing HF patient readmissions. We will also continue to evaluate for improvement opportunities and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **A343pproach/Methodology:** For every CHF admission avoided, $8252 in cost is saved by the health care system.[344] The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.
  Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[343] Based on 2011 historical ED visits data for Texas Health Fort Worth
[1] Texas Department of State Health Services with a 30% ccr assumption.
http://www.dshs.state.tx.us/ph/county.shtm

112677302.3.7	*3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.2 EXPAND CHRONIC CARE MANAGEMENT MODELS: REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASE*		
Starting Point/Baseline:	**Baseline Data:** 953 inpatient CHF admissions with a readmission rate of 22%		
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]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,006 **Milestone 2** [P- 2]: Establish baseline rates Data Source: Database including patient administrative and coding/billing information such as Premier Quality Advisor identified and baseline rate confirmed Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 8,006 **Milestone 3 [**P- 3]: Develop and test data systems	**Milestone 4** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $1,2654 **Milestone 5** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment: $1,2654 **Outcome Improvement Target 1** [IT-2.1]: Congestive Heart Failure admission rate (**Stand-alone measure**)	**Outcome Improvement Target 2** [IT-2.1]: Congestive Heart Failure Admission rate (**Stand-alone measure**) Goal: Reduce readmissions by 10% Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $40,610	**Outcome Improvement Target 3** [IT-2.1]: Congestive Heart Failure 30 Admission rate (**Stand-alone measure**) Goal: Reduce readmissions by 15% Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment*:* $97,111

112677302.3.7	*3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.2 EXPAND CHRONIC CARE MANAGEMENT MODELS: REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASE*		
Starting Point/Baseline:	**Baseline Data:** 953 inpatient CHF admissions with a readmission rate of 22%		
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)**
Data Source: Internally developed database using EMR data to monitor project and produce reports. Process Milestone 3 Estimated Incentive Payment: $8,005	Goal: Reduce readmissions by 4% Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,2654		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $24,017	Year 3 Estimated Outcome Amount: $37,962	Year 4 Estimated Outcome Amount: $40,610	Year 5 Estimated Outcome Amount: $97,111
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $199,700			

Title of Outcome Measure (Improvement Target): Right Care, Right Setting IT-9.2 – ED appropriate utilization

Unique RHP outcome identification number(s): 112677302.3.8

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Outcome Measure Description:
The outcome measure is provided in the table below:
By the end of the Waiver, our goal is to improve appropriate ED utilization for the targeted populations by 18%.

Process Milestones:

- In DY2, we will:
    - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
    - Develop and test reporting and monitoring process to evaluate
    - Establish the baseline.

Outcome Improvement Targets for each year:

- In DY4, to reduce ED utilization for the targeted populations by 10% from baseline, and
- in DY5 to reduce ED utilization for the targeted populations by 18% from baseline.

Rationale:

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of a process for hiring and training staff, identifying individuals who are frequent users of the ED or who are utilizing the ED for services that might be provided at a lower level of care, and developing a process to navigate the individuals to more appropriate health care venues. In DY2, we will also develop a mechanism for 1) tracking patients, 2) monitoring the effectiveness of interventions and 3) monitoring impact on compliance with care plan. Analysis of our information will be completed to determine potential improvement opportunities.

In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project.

In DY4 and 5, we will continue to monitor our effectiveness to achieve target outcomes and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology**: For every ED visit avoided, $526 in cost is saved by the health care system.[345] The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** ED visit outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with greater than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.

[1] Texas Department of State Health Services with a 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

112677302.3.8	*3.IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization* *Reduce Emergency Department visits for target conditions*	
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.3 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Specific Number:** Numbers will vary but anticipate 10%-15% of annual ED volume **Description of Population:** Community members with target conditions within Region 10.		
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] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment: $85,080 **Milestone 2** [P-2]: Establish baseline rates (Emergency Department (ED) visits rate for target population: Congestive Heart Failure, Diabetes, End-stage Renal Disease, Cardiovascular Disease/Hypertension, Behavioral Health/Substance Abuse, Chronic Obstructive Pulmonary Disease and Asthma patients) Data Source: Hospital discharge	**Milestone 4** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $201,720 **Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment: $201,720	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization Improvement Target: 9.0% improvement from baseline (total target population). Data Source: Hospital discharge records Outcome Improvement Target 1 Estimated Incentive Payment: $434,545	**Outcome Improvement Target 7** [IT-9.2]: ED Appropriate Utilization Improvement Target: 18% improvement from baseline (total target population). Data Source: Hospital discharge records Outcome Improvement Target 2 Estimated Incentive Payment: $1,109,421

112677302.3.8	*3.IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization* *Reduce Emergency Department visits for target conditions*	
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.3 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Specific Number:** Numbers will vary but anticipate 10%-15% of annual ED volume **Description of Population:** Community members with target conditions within Region 10.		
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)**
records Milestone 2 Estimated Incentive Payment: $85,080 **Milestone 3** [P- 3]: Develop and test data systems Data Source: Internally developed database using EMR, coding and/or case management data to monitor project and produce reports. Milestone 3 Estimated Incentive Payment: $85,079			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $255,239	Year 3 Estimated Outcome Amount: $403,440	Year 4 Estimated Outcome Amount: $434,545	Year 5 Estimated Outcome Amount: $1,109,421
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 2,202,645			

Title of Outcome Measure (Improvement Target): Potentially Preventable Complications and Health Care Acquired Conditions - IT-4.8 Sepsis Mortality

Unique RHP outcome identification number(s): 12677302.3.9

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth Hospital / 12677302

Outcome Measure Description:

IT-4.8 – Sepsis Mortality Rate: The rate of mortality for THFW patients hospitalized for septicemia or sepsis.

Process Milestones:

In DY2 the program plan for the project will include stakeholder engagement, assessing for resources, establishing a timeline, and creating plan implementation protocols (P-1). In addition, we will re-evaluate current baseline sepsis mortality rates for accuracy (P-2) in DY2. In DY3 the Plan-Do-Study-Act Cycle will be implemented and findings will be disseminated to stakeholders (P-3, P-4).

Outcome Improvement Targets for each year:

The outcome measure is to reduce mortality in patient with sepsis through the consistent, timely, implementation of an evidence-based sepsis resuscitation bundle. Estimated current mortality rate is 17.6%. The improvement target will decrease from DY2 to DY5 by a total of 2.1%.Thus, projected improvement targets are 16.9%, 16.2%, and 15.6% in DY3, DY4, and DY5 respectively (0.5% per year).

Rationale:

Establishing a plan is essential to any successful implantation of a plan/project. Determining the current baseline rate will allow for benchmarking in subsequent demonstration years. This information can then be used for decision making, programmatic changes, and assess the program success(P-2)The Plan Do Study Act (P-4) process will be a useful tool to document changes in current practice and ongoing implementation. The diffusion of the results and finding through appropriate communication channels will continue the adaption of the sepsis resuscitation bundle (P-5). The targets established are based on a sample of medical sepsis patient from 2008. Chart reviews were conducted assessing for compliance of the bundle. Initial implementation of a Clinical Nurse Specialist (CNS) was conducted resulting in decreased from 40% mortality to 20%. The CNS model was not sustained which will result in the need for re-education of health care providers.

Outcome Measure Valuation:

- **Approach/Methodology:** Decreased mortality rate does not bring and direct health care cost savings. Lives saved dare utilized to calculate individual and community costs. The total valuation is calculated by summing up individual and community costs.
- **Rationale/Justification:** Community benefits were calculated using lost productivity (net of lost wages), loss in payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

112677302.3.9	*3.IT-4.8*	*Potentially Preventable Complications and Health Care Acquired Conditions – IT-4.8 Sepsis Mortality*	
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.4: Sepsis: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area.*		
Starting Point/Baseline:	*Baseline data to be established in DY2 (estimated current sepsis mortality baseline 17.6%)*		
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 to include stakeholders, assess resources, and establish timeline, document implantation plan. Data Source: Chart review, internal database, EPSI Milestone 1 Estimated Incentive Payment: $57,711 **Process Milestone 2** [P-2]: Establish baseline rates to determine frequency of bundle usage; affecting mortality, Data Source: Chart review of 50 cases in Y1 and internal THR our cost accounting system	**Process Milestone 3** [P-4]: PDSA cycles on targeted opportunities carry over from Year 2 Data Source: Internal database; chart abstraction; quality dashboard Milestone 3 Estimated Incentive Payment: $60,813 **Process Milestone 4** [P-5]: Disseminate findings to stakeholders Data Source: EPIC, EPSi, quality dashboard Milestone 4 Estimated Incentive Payment: $60,813	**Outcome Improvement Target 2** [IT-4.8]: Sepsis mortality rate Goal: Decrease by 0.7% from DY3 Data Source: Premier database and chart abstraction Outcome Improvement Target 2 Estimated Incentive Payment*:* $195,166	**Outcome Improvement Target 3** [IT-4.8]: Sepsis mortality rate Goal: Decrease by 0.7% from DY4 Data Source: Premier database and chart abstraction Outcome Improvement Target 3 Estimated Incentive Payment*:* $466,701

112677302.3.9	*3.IT-4.8*	*Potentially Preventable Complications and Health Care Acquired Conditions – IT-4.8 Sepsis Mortality*	
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.4: Sepsis: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area.*		
Starting Point/Baseline:	*Baseline data to be established in DY2 (estimated current sepsis mortality baseline 17.6%)*		
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 2 Estimated Incentive Payment: $ 57,710	**Outcome Improvement Target** 1 [IT-4.8]: Sepsis mortality rate Goal: Decrease by 0.7% from DY2 Data Source: Premier database (coded encounters); chart abstraction Outcome Improvement Target 1 Estimated Incentive Payment*:* $60,812		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $115,421	Year 3 Estimated Outcome Amount: $182,438	Year 4 Estimated Outcome Amount: $195,166	Year 5 Estimated Outcome Amount: $466,701
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$959,725			

Title of Outcome Measure (Improvement Target): IT-4.9 Average Length of Stay (Sepsis)

Unique RHP outcome identification number(s): 12677302.3.10

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 12677302

Outcome Measure Description:

Outcome Measure IT-4.9 – Average Length of Stay (Sepsis): The average length of hospital stay for THFW patients hospitalized for septicemia or sepsis.

Process Milestones:

In DY2 the program plan the for the project will include stakeholder engagement, assessing for resources, establishing a timeline, and creating a implementation plan (P-1). As well in DY2 we will re-evaluate current baseline sepsis mortality rates for accuracy (P-2). In DY3 Conduct a Plan Do Study Act and disseminate findings to stakeholders (P-4, P-5).

Outcome Improvement Targets for each year:

The outcome measure is to reduce average length of stay (LOS) in patient with sepsis through the consistent, timely, implementation of an evidence-based sepsis resuscitation bundle. Estimated current LOS is 8.4 days. The improvement target will decrease from DY2 to DY5 by a total of 1.8 days (0.6 days per year). Thus, projected improvement targets are 7.8 days, 7.2 days, and 6.6 days in DY3, DY4, and DY5 respectively.

Rationale:

Establishing a plan is essential to any successful implantation of a plan/project. Determining the current baseline rate will allow for benchmarking. This information can then be used for decision making, programmatic changes, and assess the program success(P-2) The Plan Do Study Act (P-4) process will be a useful tool to document changes in current practice and ongoing implementation. The diffusion of the results and finding through appropriate communication channels will continue the adaption of the sepsis resuscitation bundle (P-5). The targets established are based on a sample of medical sepsis patient from 2008. Chart reviews were conducted assessing for compliance of the bundle. Initial implementation of a Clinical Nurse Specialist (CNS) was conducted resulting in decreased LOS from 7.24 day to 6.72 days. The CNS model was not sustained which will result in the need for re-education of health care providers.

Outcome Measure Valuation:

- **Approach/Methodology**: For each day reduced for sepsis admissions, $2,412 in cost is saved by the health care system.[1] The average length of stay per inpatient admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs
- **Rationale/Justification:** Sepsis inpatient admissions outcome improvement targets are dependent on the hospitals current average length of stay per patient, target population being served, size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already reduced length of stay for sepsis inpatients. Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

112677302.3.10	*3.IT-4.9*	*Sepsis: Average length of stay*	
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.4: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area.*		
Starting Point/Baseline:	*Baseline is 2011's THFW's ALOS for Sepsis patients = 8.4*		
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] Project planning to include stakeholders, assess resources, establish timeline, document implantation plan. Data Source: Chart review, internal database, EPSI, EPIC Milestone 1 Estimated Incentive Payment:$57,711 **Milestone 2** [P-2] Re-establish baseline rates to determine frequency of bundle usage affecting , ALOS, Data Source: Chart review of 50 cases in Y1 , EPIC Milestone 2 Estimated Incentive Payment: $57,710	**Milestone 3** [P-4]PDSA cycles on targeted opportunities carry over from Year 2 Data Source: Internal database; chart abstraction; quality dashboard, EPIC Milestone 3 Estimated Incentive Payment: $60,813 **Milestone 4** [P-5]Disseminate findings to stakeholders Data Source: EPIC, quality dashboard Milestone 4 Estimated Incentive Payment: $60,813 **Outcome Improvement Target 1** [IT-4.9] Average length of Stay Goal: Decrease by 0.6 days from Year 2 Data Source: Internal database; chart abstraction; quality dashboard, EPIC	**Outcome Improvement Target 2** [IT-4.9] Average Length of Stay Goal: Decrease by 0.6 days from Year 3 (all sepsis patients) Data Source: Internal database; chart abstraction; quality dashboard, EPIC Outcome Improvement Target 2 Estimated Incentive Payment*:* $195,166	**Outcome Improvement Target 3** [IT-4.9]: Average Length of Stay Goal: Decrease by 0.6 days from Year 4 (all sepsis patients) Data Source: Internal database; chart abstraction; quality dashboard, EPIC Outcome Improvement Target 3 Estimated Incentive Payment*:* $466,701

112677302.3.10	*3.IT-4.9*	*Sepsis: Average length of stay*	
Texas Health Harris Methodist Hospital Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.4: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area.*		
Starting Point/Baseline:	*Baseline is 2011's THFW's ALOS for Sepsis patients = 8.4*		
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 Estimated Incentive Payment*:* $60,812		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $115,421	Year 3 Estimated Outcome Amount: $182,438	Year 4 Estimated Outcome Amount: $195,166	Year 5 Estimated Outcome Amount: $466,701
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$959,725			

Title of Outcome Measure (Improvement Target): Primary Care and Primary Prevention – IT-12.1 Breast Cancer Screening (HEDIS 2012) *(Non-stand-alone measure)*

Unique RHP outcome identification number(s): 112677302.3.11

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth / 112677302

Outcome Measure Description:
By the end of the Waiver, our goal is to increase mobile mammography screenings by 11,298 over baseline to be determined in DY3. Our milestones include the following:

Process Milestones:

- DY2:
    - P- 1 Project planning - Engage stakeholders – renew service contracts with local Texas Breast and Cervical Cancer Program Contractor(s). Identify current capacity- evaluate current processes and capacity with two mobile health teams and validate needed resources (human and equipment) to increase capacity, determine timelines for the acquisition of another fully equipped mobile coach and document implementation plans
    - P- 2 Validate existing baseline rates for screening mammograms with the two existing mobile coaches.
    - P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities- The following components will be evaluated: Administrative Run-up (navigation/tracking system, hire/train staff, collect/enter baseline data, acquire third mobile coach), Community Outreach (enhance community outreach designed to implement community screening activities, engage local schools, businesses, churches and service organizations), Reduce barriers to screening (evaluate language barriers, transportation issues, coordinate use of Federal, State and local resources), Patient Navigation Program (evaluate current navigation process), Internal / External Reporting (develop reporting timeline).

Outcome Improvement Targets for each year:

- DY2: 738 screening mammograms will be performed in RHP 10
- DY3: 3,520 screening mammograms will be performed in RHP 10
- DY4: 3,520 screening mammograms will be performed in RHP 10
- DY5: 3,520 screening mammograms will be performed in RHP 10

Rationale:

There is a need in Region 10 for increased comprehensive mammography services and appropriate follow-up. There is a lack of access to affordable mammograms in the area and access to a systems method of proper follow-up. The continued collaboration with Moncrief Cancer Institute and the Breast and Patient Navigation project will address this need and become a model for the State of Texas and the nation.

Estimates from the 2010 Behavioral Risk Factor Surveillance System indicate that 116,547 (26.5%) screen eligible women in RHP 10 have not had a mammogram within the past two years (Public Health Administration Region 2/3).

- Numerator: 11,298 target number of women ages 40 – 69 that receive a screening mammogram;
- Denominator: 31,942 screen eligible women in RHP 10

Outcome Measure Valuation:

- **Approach/Methodology:** For every patient affec346ted from early detection of breast cancer screening, $6,072 in cost is saved by the health care system.[347] The average length of stay is multiplied by the total affected population to determine the total days saved. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Breast cancer screening outcome improvement targets are dependent on the target population served, size (e.g., if a MHU is at maximum capacity, rates can only decrease), and current processes in place. Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[346] (Lucy K. Ford & Zarate, 2010)
[347] (Steven Belenko, Nicholas Patapis, & Michael T. French, 2005)

112677302.3.11	*3.IT-12.1*	*Breast Cancer Screening (HEDIS 2012)*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.5 Expand Specialty Care Capacity: Expand Wellness for Life Mobile Cancer Screening*		
Starting Point/Baseline:	*Target population is 31,942 focusing only on the rural area. The intervention population in DY2 will be 738, DY3 will be 3520, DY4 will be 3520, and DY5 will be 3520.*		
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 – renew service contracts with local Texas Breast and Cervical Cancer Program Contractor(s). Identify current capacity- evaluate current processes and capacity and validate needed resources (human and equipment) to increase capacity, determine timelines for the acquisition of another fully equipped mobile coach and document implementation plans Data Source: Capital Purchase, Human Resources Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,969 **Process Milestone 2** [P-2]: Validate existing baseline rates for screening mammograms with existing capacity. 738 screening mammograms will be performed in RHP 10 Data Source: EHR	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening Improvement Target: 90% of maximum capacity (max cap 3,520) Numerator: 3,520 target number of women ages 40 – 69 (1.14%) that receive a screening mammogram / Denominator: 31,942 screen eligible women in RHP 10 Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $70,980	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening Improvement Target: 95% of maximum capacity (max cap 3,520) Numerator: 3,520 target number of women ages 40 – 69 (1.14%) that receive a screening mammogram / Denominator: 31,942 screen eligible women in RHP 10 Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $75,932	**Outcome Improvement Target 3** [IT-12.1]: Breast Cancer Screening Improvement Target: 100% of maximum capacity (max cap 3,520) Numerator: 3,520 target number of women ages 40 – 69 (1.14%) that receive a screening mammogram / Denominator: 31,942 screen eligible women in RHP 10 Data Source: EHR, claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $181,577

112677302.3.11	*3.IT-12.1*	*Breast Cancer Screening (HEDIS 2012)*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.5 Expand Specialty Care Capacity: Expand Wellness for Life Mobile Cancer Screening*		
Starting Point/Baseline:	*Target population is 31,942 focusing only on the rural area. The intervention population in DY2 will be 738, DY3 will be 3520, DY4 will be 3520, and DY5 will be 3520.*		
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 2 Estimated Incentive Payment: $14,969 **Process Milestone 3** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities- The following components will be evaluated: Administrative preparation (navigation/tracking system, hire/train staff, collect/enter baseline data, acquire a mobile coach), Community Outreach (enhance community outreach designed to implement community screening activities, engage local schools, businesses, churches and service organizations), Reduce barriers to screening (evaluate language barriers, transportation issues, coordinate use of Federal, State and local resources), Patient Navigation Program (evaluate current navigation process), Internal / External Reporting (develop reporting timeline). Goal: Establish baseline rates Data Source:			

112677302.3.11	*3.IT-12.1*	*Breast Cancer Screening (HEDIS 2012)*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.5 Expand Specialty Care Capacity: Expand Wellness for Life Mobile Cancer Screening*		
Starting Point/Baseline:	*Target population is 31,942 focusing only on the rural area. The intervention population in DY2 will be 738, DY3 will be 3520, DY4 will be 3520, and DY5 will be 3520.*		
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 3 Estimated Incentive Payment: $14,968			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $44,906	Year 3 Estimated Outcome Amount: $70,980	Year 4 Estimated Outcome Amount: $75,932	Year 5 Estimated Outcome Amount: $181,577
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $373,396			

Title of Outcome Measure (Improvement Target): Primary Care and Primary Prevention – IT-12.2 Cervical Cancer Screening (HEDIS 2012) *(Non-stand-alone measure)*

Unique RHP outcome identification number(s): 112677302.3.12

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Fort Worth / 112677302

Outcome Measure Description:
By the end of the Waiver, our goal is to increase mobile cervical cancer screening of 4752 over baseline (to be determined in DY3). Our milestones include the following:

Process Milestones:

- DY2:
    - P- 1 Project planning - Engage stakeholders – renew service contracts with local Texas Breast and Cervical Cancer Program Contractor(s). Identify current capacity- evaluate current processes and capacity with two mobile health teams and validate needed resources (human and equipment) to increase capacity, determine timelines for the acquisition of another fully equipped mobile coach and document implementation plans
    - P- 2 Validate existing baseline rates for screening mammograms with the two existing mobile coaches.
    - P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities- The following components will be evaluated: Administrative Run-up (navigation/tracking system, hire/train staff, collect/enter baseline data, acquire third mobile coach), Community Outreach (enhance community outreach designed to implement community screening activities, engage local schools, businesses, churches and service organizations), Reduce barriers to screening (evaluate language barriers, transportation issues, coordinate use of Federal, State and local resources), Patient Navigation Program (evaluate current navigation process), Internal / External Reporting (develop reporting timeline).

Outcome Improvement Targets for each year:

- DY3: 1,584 cervical cancer screenings will be performed in RHP 10
- DY4: 1,584 cervical cancer screenings will be performed in RHP 10
- DY5: 1,584 cervical cancer screenings will be performed in RHP 10

Rationale:

Cervical cancer and colon cancer are significant health problems in Texas and in Region 10. At least 33,271 of 120,577 women age 21 – 64 in RHP 10 reported that they did not have a Pap smear within the last 3 years. Five of the nine counties in RHP 10 are designated as Medically Underserved Areas or Medically Underserved Populations.

- Numerator: 4,752 cervical cancer screenings women ages 21 to 64
- Denominator: 33,271 cervical cancer screen eligible women in the target population (RHP 10).

Outcome Measure Valuation:

- **Approach/Methodology:** For every patient affected348 from early detection of cervical cancer screening, $16,910 in cost is saved by the health care system.[349] The average length of stay is multiplied by the total affected population to determine the total days saved. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Cervical cancer screening outcome improvement targets are dependent on the target population served, size (e.g., if a MHU is at maximum capacity, rates can only decrease), and current processes in place. Community benefits were calculated lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[348]National Quality Forum. (2010, October). *Quality Connections: Care Coordination.* Retrieved September 22, 2012, from Quality Forum: http://www.qualityforum.org/Publications/2010/10/Quality_Connections__Care_Coordination.aspx

[349]Leonard, M, McGlone, & Boardman, A. (2012) Operation: we care. *CMSA Today*, *12-16*

112677302.3.12	*3.IT-12.2*	*Cervical Cancer Screening (HEDIS 2012)*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.5 Expand Specialty Care Capacity: Expand Wellness for Life Mobile Cancer Screening*		
Starting Point/Baseline:	*Target population for DY3, DY4, and DY5 will be 33,271* cervical cancer screen eligible women. Intervention population will be 1584 for DY3, 1584 for DY4, and 1584 for DY5.		
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 [*RHP PP Process Milestone* – P-1]: Project planning - Engage stakeholders – renew service contracts with local Texas Breast and Cervical Cancer Program Contractor(s). Identify current capacity- evaluate current processes and capacity and validate needed resources (human and equipment) to increase capacity, determine timelines for the acquisition of another fully equipped mobile coach and document implementation plans. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,968 **Process Milestone 2** [P-2]: P- 2 Identify need and determine target baseline rates for cervical cancer screenings. Target: 0 cervical cancer screenings will be performed in RHP 10 Data Source: EHR, claims Process	**Outcome Improvement Target 1** [IT-1.1]: Improvement Target: -90% of maximum capacity (Max cap 1,548) Numerator: 1,584 Number of women ages 21 to 64 (2.9%) that have received a PAP in the measurement year or two prior years. Denominator: 33,271 Women ages 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix excluded. Data Source: EHR Claim Estimated Incentive Payment*:* $70,980	**Outcome Improvement Target 2** [IT-12.2]: Improvement Target: -95% of maximum capacity (Max cap 1,548) Numerator: 1,584 Number of women ages 21 to 64 (2.9%) that have received a PAP in the measurement year or two prior years. Denominator: 33,271 Women ages 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix excluded. Data Source: EHR Claims Estimated Incentive Payment*:* $75,932	**Outcome Improvement Target 3** [IT-12.2]: Improvement Target: -100% of maximum capacity (Max cap 1,548) Numerator: 1,584 Number of women ages 21 to 64 (2.9%) that have received a PAP in the measurement year or two prior years. Denominator: 33,271 Women ages 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix excluded. Data Source: EHR Claims Estimated Incentive Payment*:* $181,577

112677302.3.12	*3.IT-12.2*	*Cervical Cancer Screening (HEDIS 2012)*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.5 Expand Specialty Care Capacity: Expand Wellness for Life Mobile Cancer Screening*		
Starting Point/Baseline:	*Target population for DY3, DY4, and DY5 will be 33,271* cervical cancer screen eligible women. Intervention population will be 1584 for DY3, 1584 for DY4, and 1584 for DY5.		
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 2 Estimated Incentive Payment: $14,969 **Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities- The following components will be evaluated: Administrative Preparation: (navigation/tracking system, hire/train staff, collect/enter baseline data, acquire third mobile coach), Community Outreach (enhance community outreach designed to implement community screening activities, engage local schools, businesses, churches and service organizations), Reduce barriers to screening (evaluate language barriers, transportation issues, coordinate use of Federal, State and local resources), Patient Navigation Program (evaluate current navigation process), Internal / External Reporting (develop reporting timeline). Goal: Establish baseline rates Data Source: EHR, claims process			

112677302.3.12	*3.IT-12.2*	*Cervical Cancer Screening (HEDIS 2012)*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.5 Expand Specialty Care Capacity: Expand Wellness for Life Mobile Cancer Screening*		
Starting Point/Baseline:	*Target population for DY3, DY4, and DY5 will be 33,271* cervical cancer screen eligible women. Intervention population will be 1584 for DY3, 1584 for DY4, and 1584 for DY5.		
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 3 Estimated Incentive Payment: $14,969			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $44,906	Year 3 Estimated Outcome Amount: $70,980	Year 4 Estimated Outcome Amount: $75,932	Year 5 Estimated Outcome Amount: $181,577
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $373,396			

Title of Outcome Measure (Improvement Target): Primary Care and Primary Prevention – IT-12.3 Colorectal Cancer Screening (HEDIS 2012) *(Non-stand-alone measure)*

Unique RHP outcome identification number(s): 112677302.3.13

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Fort Worth / 112677302

Outcome Measure Description:

By the end of the Waiver, our goal is to increase mobile cervical cancer screening by 675 over the baseline to be measured in DY3. Our milestones include the following:

Process Milestones:

- DY2:
  - P- 1 Project planning - Engage stakeholders – renew service contracts with local Texas Breast and Cervical Cancer Program Contractor(s). Identify current capacity- evaluate current processes and capacity with two mobile health teams and validate needed resources (human and equipment) to increase capacity, determine timelines for the acquisition of another fully equipped mobile coach and document implementation plans
  - P- 2 Validate existing baseline rates for screening mammograms with the two existing mobile coaches.
  - P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities- The following components will be evaluated: Administrative Run-up (navigation/tracking system, hire/train staff, collect/enter baseline data, acquire third mobile coach), Community Outreach (enhance community outreach designed to implement community screening activities, engage local schools, businesses, churches and service organizations), Reduce barriers to screening (evaluate language barriers, transportation issues, coordinate use of Federal, State and local resources), Patient Navigation Program (evaluate current navigation process), Internal / External Reporting (develop reporting timeline).

Outcome Improvement Targets for each year:

- DY3: 225 colorectal cancer screenings will be performed in RHP 10
- DY4: 225 colorectal cancer screenings will be performed in RHP 10
- DY5: 225 colorectal cancer screenings will be performed in RHP 10

Rationale:

Colorectal cancer is the third most common cancer diagnosed in men and women and the second leading cause of deaths overall. Blacks have the highest incidence and mortality followed by non-Hispanic whites and Hispanics. There are higher colorectal cancer incidence rates in rural counties.

Out of an estimated 166,853 population of adults age 50 – 75 in RHP 10, 113,595 have reported not having a blood stool test in the past 2 years.

We anticipate a 64% Fecal Occult Blood Test return rate. The return rate for each year of the last two years has been 64%, largely due to individualized teaching by the Family Nurse Practitioner at the time of the visit on the mobile unit compared to return rates of 30% through a direct-mail approach.

- Numerator: 675 adults age 50 – 75 that receive a Fecal Occult Blood Test
- Denominator: 113,595 adults age 50 – 75 in RHP 10.

Outcome Measure Valuation:

- **Approach/Methodology:** For every patient affected f350rom early detection of colorectal cancer screening, $24,756 in cost is saved by the health care system.[351] The average length of stay is multiplied by the total affected population to determine the total days saved. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Colorectal cancer screening outcome improvement targets are dependent on the target population served, size (e.g., if a MHU is at maximum capacity, rates can only decrease), and current processes in place. Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[350] American Nurses Association. (2012, June). *The Value of Nursing Care Coordination: a White Paper of the American Nurses Association.* Retrieved September 29, 2012, from Nursing World: http://nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/Issue-Briefs/Care-Coordination

[351] (Steven Belenko, Nicholas Patapis, & Michael T. French, 2005)

112677302.3.13	*3.IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012)*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.5 Expand Specialty Care Capacity: Expand Wellness for Life Mobile Cancer Screening*		
Starting Point/Baseline:	*Target population is 113,595 people who have reported not having a blood stool test in the past 2 years. Intervention population is 675 adults age 50 – 75 that receive a Fecal Occult Blood Test.*		
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 – renew service contracts with local Texas Breast and Cervical Cancer Program Contractor(s). Identify current capacity- evaluate current processes and capacity and validate needed resources (human and equipment) to increase capacity, determine timelines for the acquisition of another fully equipped mobile coach and document implementation plans Data Source: Capital Purchase, Human Resources Process Milestone 1 Estimated Incentive Payment: $11,226 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: EHR, claims process	**Outcome Improvement Target 1** [IT-1.1]: Improvement Target- 90% of maximum capacity (max cap 225) Numerator: 225 adults age 50 – 75 that receive a Fecal Occult Blood Test / Denominator: 113,595 adults age 50 – 75 in RHP 10. Data Source: EHR Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $70,980	**Outcome Improvement Target 2** [IT-12.3]: Improvement Target: - 95% of maximum capacity (max cap 225) Numerator: 225 adults age 50 – 75 that receive a Fecal Occult Blood Test / Denominator: 113,595 adults age 50 – 75 in RHP 10. Data Source: EHR Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $75,932	**Outcome Improvement Target 3** [IT-12.3]: Improvement Target- 100% of maximum capacity (max cap 225) Numerator: 225 adults age 50 – 75 that receive a Fecal Occult Blood Test / Denominator: 113,595 adults age 50 – 75 in RHP 10. Data Source: EHR Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $181,577

112677302.3.13	*3.IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012)*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.5 Expand Specialty Care Capacity: Expand Wellness for Life Mobile Cancer Screening*		
Starting Point/Baseline:	*Target population is 113,595 people who have reported not having a blood stool test in the past 2 years. Intervention population is 675 adults age 50 – 75 that receive a Fecal Occult Blood Test.*		
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 2 Estimated Incentive Payment *(maximum amount):* $11,227 **Process Milestone 3** [P-2]: Establish baseline rates – number of patients receiving fecal occult blood test Data Source: EHR, claims Process Milestone 3 Estimated Incentive Payment: $11,226 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities- The following components will be evaluated: Administrative Preparation: (navigation/tracking system, hire/train staff, collect/enter baseline data, acquire a mobile coach), Community Outreach (enhance community outreach designed to implement community screening activities, engage local schools, businesses,			

112677302.3.13	*3.IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012)*	
Texas Health Harris Methodist Fort Worth			*112677302*
Related Category 1 or 2 Projects:	*112677302.2.5 Expand Specialty Care Capacity: Expand Wellness for Life Mobile Cancer Screening*		
Starting Point/Baseline:	*Target population is 113,595 people who have reported not having a blood stool test in the past 2 years. Intervention population is 675 adults age 50 – 75 that receive a Fecal Occult Blood Test.*		
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)**
churches and service organizations), Reduce barriers to screening (evaluate language barriers, transportation issues, coordinate use of Federal, State and local resources), Patient Navigation Program (evaluate current navigation process), Internal / External Reporting (develop reporting timeline). Data Source: Provider documents demonstrating completion of performance improvement project Process Milestone 4 Estimated Incentive Payment: $11,227			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $44,906	Year 3 Estimated Outcome Amount: $70,980	Year 4 Estimated Outcome Amount: $75,932	Year 5 Estimated Outcome Amount: $181,577
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $373,396			

Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30-day readmission rate (Stand-alone Measure)

Unique RHP outcome identification number(s): 109574702.3.1
Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702

Outcome Measure Description:
Process Milestones and Outcome Improvement Targets for each year:
Outcome Measure IT-3.2: Congestive heart failure 30-day readmission rate. Reduce 30-day readmission rate for CHF patients by 6% (2.0% points increase each year DY-3, DY-4, and DY-5 over baseline).

- Process Milestone P-1: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

- Process Milestone P-2: Establish baseline rates

- Process Milestone P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities, also allowing for review, analysis, and changes as indicated by the process.

- Process Milestone P-5: Disseminate findings, including lessons learned and best practices, to stakeholders.

- Outcome Milestones 6 through 8 (IT-3.2): Incorporate CQI measure 30-day readmission rate for CHF with a target of 2% incremental improvement from DY3 to DY5

Rationale:

These process milestones were chosen for measurement because they are the innovative approaches within the entire program that we envision. This program will also include the more conventional methods such as transition nurses, case managers and ensuring that patients with limited to no financial resources have the tools they need to self-manage their disease.

As cited in the Category 2 Project Narrative, 30-day readmission rates have become a high-cost, high-focus area for CMS and the importance of putting resources into these milestones and outcomes cannot be underestimated.

Evaluating our current capacity and needed resources will assist in determining process changes that need to be implemented.

Outcome Measure Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $9,203 in cost is saved by the health care system.[352] The average length of stay per admission (5.6 days) is multiplied by the number of avoidable admissions (20.6 admissions avoided over project term) to determine the total days saved by the individuals affected (115.4 days). Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.
- **Individual benefits** were calculated using lost wages, caretaker expense and extension of life (if applicable).
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).

[1] Texas Department of State Health Services with a 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

109574702.3.1	*IT – 3.2*	*Congestive Heart Failure 3- day readmission rate (Stand-alone Measure)*	
Huguley Memorial Medical Center			*109574702*
Related Category 1 or 2 Projects:	*109574702.2.1 Reduction in 30-Day Hospital Readmission Rates (Potentially Preventable Readmissions)*		
Starting Point/Baseline:	**Baseline Data:** Preliminary data indicates approximately 350 patient admissions with principal diagnosis of heart failure annually. Baseline data to be determined in DY2 but preliminary data shows 30-day HF patient readmission rate near 20 - 21% **Target Population:** Low income, disadvantaged community members with a diagnosis of heart failure that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 394 HF patients annually by DY5. **Description of Population:** Individuals with heart failure living within Region 10, particularly those in north Johnson or southern Tarrant Counties		
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]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Performing Provider Data Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,282 **Milestone 2** [P-2]: Establish baseline rates (see note above) Data Source: Performing Provider Data Milestone 2 Estimated Incentive Payment: $3,281 **Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve	**Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Performing provider Process Milestone 4 Estimated Incentive Payment: $5,187 **Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Performing provider Process Milestone 5 Estimated Incentive Payment: $5,187 **Milestone 6** [IT-3.2]: Congestive Heart Failure 30-day readmission rate Numerator: The number of readmissions (for patients 18 years	**Milestone 7** [IT-3.2]: Congestive Heart Failure 30-day readmission rate Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. Improvement Target: 2% points over prior year Data Source: Performing Provider Data	**Milestone 8** [IT-3.2]: Congestive Heart Failure 30-day readmission rate Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. Improvement Target: 2% points over prior year Data Source: Performing Provider Data

109574702.3.1	*IT – 3.2*	*Congestive Heart Failure 3- day readmission rate (Stand-alone Measure)*	
Huguley Memorial Medical Center			*109574702*
Related Category 1 or 2 Projects:	*109574702.2.1 Reduction in 30-Day Hospital Readmission Rates (Potentially Preventable Readmissions)*		
Starting Point/Baseline:	**Baseline Data:** Preliminary data indicates approximately 350 patient admissions with principal diagnosis of heart failure annually. Baseline data to be determined in DY2 but preliminary data shows 30-day HF patient readmission rate near 20 - 21% **Target Population:** Low income, disadvantaged community members with a diagnosis of heart failure that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 394 HF patients annually by DY5. **Description of Population:** Individuals with heart failure living within Region 10, particularly those in north Johnson or southern Tarrant Counties		
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)**
data collection and intervention activities Data Source: Performing provider Milestone 3 Estimated Incentive Payment: $3,281	and older), for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as readmission. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission. Improvement Target: 2% points over the baseline Data Source: Performing Provider Data Milestone 6 Estimated Incentive Payment: $5,186	**Milestone 7** Estimated Incentive Payment: $16,645	**Milestone 8** Estimated Incentive Payment: $39,804

109574702.3.1	*IT – 3.2*	*Congestive Heart Failure 3- day readmission rate (Stand-alone Measure)*	
Huguley Memorial Medical Center			*109574702*
Related Category 1 or 2 Projects:	*109574702.2.1 Reduction in 30-Day Hospital Readmission Rates (Potentially Preventable Readmissions)*		
Starting Point/Baseline:	**Baseline Data:** Preliminary data indicates approximately 350 patient admissions with principal diagnosis of heart failure annually. Baseline data to be determined in DY2 but preliminary data shows 30-day HF patient readmission rate near 20 - 21% **Target Population:** Low income, disadvantaged community members with a diagnosis of heart failure that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 394 HF patients annually by DY5. **Description of Population:** Individuals with heart failure living within Region 10, particularly those in north Johnson or southern Tarrant Counties		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $9,844	Year 3 Estimated Outcome Amount: $15,560	Year 4 Estimated Outcome Amount: $16,645	Year 5 Estimated Outcome Amount: $39,804
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $81,852			

Title of Outcome Measure (Improvement Target): IT-4.8 Sepsis Mortality (Stand-alone Measure)

Unique RHP outcome identification number(s): 109574702.3.2
Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702

Outcome Measure Description:
Process Milestones, and Outcome Improvement Targets for each year:

The measure itself measures the number of patients with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction expiring during a given time period against the same number of patients with the same inclusion criteria who don't expire.

Process milestones include identifying and setting targets for each part of the resuscitation bundle; defining data elements; and developing the internal data base. This is all of the planning process. Other process milestones include developing an internal database which will be utilized in data analysis in order to target opportunities for improvement not only in reducing sepsis mortality. A quality dashboard which can be used for dissemination of data and participation in learning and improvement meetings are the additional process milestones. The goals of each process milestone is to complete the task, i.e., develop a dashboard or internal database. Once a baseline is established in Y2 for the actual implementation rate of the different components of the sepsis resuscitation bundle, then we will determine targets/goals for Y3-5.

Rationale:
Process milestones include identifying and setting targets for each part of the resuscitation bundle; defining data elements; and developing the internal data base. This is all of the planning process. Other process milestones include developing an internal database which will be utilized in data analysis in order to target opportunities for improvement not only in reducing sepsis mortality. A quality dashboard which can be used for dissemination of data and participation in learning and improvement meetings are the additional process milestones and used in communicating process outcomes to key stakeholders. The goals of each process milestone is to complete the task-ie, develop a dashboard or internal database. Once a baseline is established in Y2 for the actual implementation rate of the different components of the sepsis resuscitation bundle, then we will determine targets/goals for Y3-5. Improvement Milestones of progress toward target/goal and improving quality and efficiency were chosen because the first will determine whether or not our process improvement efforts are effective and potential improvement in LOS and cost/case are surrogates of improving efficiency. Again, targets/goals will be set after Y2 when we have established baselines.

Outcome Measure Valuation:

- **Approach/Methodology:** The outcome measure is a stand alone measure and as stated in the project narrative it is very difficult for us to determine what the reduction in mortality will be by implementing the sepsis resuscitation bundle since we have worked on improving our sepsis care and have order sets that have the bundle embedded in them. We also have a mortality rate that is lower than the national average. However, we have never measured that we actually implement the entire bundle; neither have we measured whether or not we complete our interventions in severe sepsis or septic shock within 6

hours. Therefore, our methodology is to ensure that we do consistently implement the entire bundle within 6 hours of identification of sepsis in a patient and then measure the subsequent mortality rate.

- **Rationale/Justification:** Given that our community is aging and elderly patients have a greater risk of infection and then sepsis, it is of community benefit to decrease the morbidity and mortality due to sepsis by ensuring full implementation of evidence-based practices that have clearly been shown to decrease mortality.

109574702.3.2	*IT – 4.8*	*Sepsis Mortality (Stand-alone Measure)*	
Huguley Memorial Medical Center			*109574702*
Related Category 1 or 2 Projects:	*109574702.2.2 Sepsis Resuscitation Bundle*		
Starting Point/Baseline:	*Baseline data to be established in DY2 (estimated current sepsis mortality baseline 13.2%).* .		
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]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Performing provider completed plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,772 **Milestone 2** [P-2]: Establish baseline rates (current patient volume approximately 290 sepsis patients) Data Source: Performing Provider Data Milestone 2 Estimated Incentive Payment: $3,772 **Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Documentation from PDSA Milestone 3 Estimated Incentive	**Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Documentation from PDSA Milestone 4 Estimated Incentive Payment: $5,962 **Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Performing provider Milestone 5 Estimated Incentive Payment*:* $5,962 **Outcome Improvement Target 1** [IT-4.8]: Sepsis Mortality Numerator: Number of patients expiring during the current month hospitalization with Sepsis, Severe Sepsis, or Septic Shock and/or an infection and organ dysfunction Denominator: Number of patients identified that month with Sepsis; Severe Sepsis or Septic Shock and/or	**Outcome Improvement Target 2:** [IT-4.8]: Sepsis Mortality Numerator: Number of patients expiring during the current month hospitalization with Sepsis, Severe Sepsis, or Septic Shock and/or an infection and organ dysfunction Denominator: Number of patients identified that month with Sepsis; Severe Sepsis or Septic Shock and/or an infection and organ dysfunction. Improvement Target: 4% over the prior year Data Source: Performing Provider Data Outcome Improvement Target 2 Estimated Incentive Payment*:* $19,134	**Outcome Improvement Target 3:** [IT-4.8]: Sepsis Mortality Numerator: Number of patients expiring during the current month hospitalization with Sepsis, Severe Sepsis, or Septic Shock and/or an infection and organ dysfunction Denominator: Number of patients identified that month with Sepsis; Severe Sepsis or Septic Shock and/or an infection and organ dysfunction. Improvement Target 4% over the prior year Data Source: Performing Provider Data Outcome Improvement Target 3 Estimated Incentive Payment*:* $45,755

109574702.3.2	*IT – 4.8*	*Sepsis Mortality (Stand-alone Measure)*	
Huguley Memorial Medical Center			*109574702*
Related Category 1 or 2 Projects:	*109574702.2.2 Sepsis Resuscitation Bundle*		
Starting Point/Baseline:	*Baseline data to be established in DY2 (estimated current sepsis mortality baseline 13.2%).* .		
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)**
Payment: $3,772	an infection and organ dysfunction. Improvement Target: 4% over the baseline Data Source: Performing Provider Data Outcome Improvement Target 1 Estimated Incentive Payment: $5,962		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $11,316	Year 3 Estimated Outcome Amount: $17,886	Year 4 Estimated Outcome Amount: $19,134	Year 5 Estimated Outcome Amount: $45,755
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $94,092			

Title of Outcome Measure (Improvement Target): IT- 4.9 Average Length of Stay (Sepsis)

Unique RHP outcome identification number(s): 109574702.3.3
Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702

Outcome Measure Description:
Process Milestones and Outcome Improvement Targets for each year:

- Outcome Measure IT-4.9 – Average Length of Stay (Sepsis): The average length of hospital stay for Huguley's patients hospitalized for septicemia or sepsis.
- Process Milestones: In DY2, the program plan for the project will include stakeholder engagement, assessing for resources, establishing a timeline, and creating an implementation plan (P-1). As well, in DY2, we will re-evaluate current baseline sepsis average length of stay for accuracy (P-2). In DY3, conduct a Plan Do Study Act and disseminate findings to stakeholders (P-4, P-5).
- Improvement Target: The outcome measure is to reduce average length of stay (LOS) in patients with sepsis through the consistent, timely implementation of an evidence-based sepsis resuscitation bundle. Estimated current LOS is 8.9 days. The improvement target will decrease from DY2 to DY5 by a total of .6 days (0.2 days per year). Thus, projected improvement targets are 8.7 days, 8.5 days, and 8.3 days in DY3, DY4, and DY5 respectively.

Rationale:

Establishing a plan is essential to any successful implementation of a plan/project. Determining the current baseline rate will allow for benchmarking. This information can then be used for decision making, programmatic changes and to assess the program success(P-2) The Plan Do Study Act (P-4) process will be a useful tool to document changes in current practice and ongoing implementation. The diffusion of the results and findings through appropriate communication channels will continue the adaption of the sepsis resuscitation bundle (P-5). The targets established are based on a sample of medical sepsis patient from 2011.

Outcome Measure Valuation:
Approach/Methodology: For each day reduced for sepsis admissions, $2,412 in cost is saved by the health care system.[1] The average length of stay per inpatient admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.

Rationale/Justification: Sepsis inpatient admission outcome improvement targets are dependent on the hospital's current average length of stay per patient, target population being served and size (e.g., if a hospital is at maximum capacity, rates can only decrease. Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes and lost sales tax.

Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

109574702.3.3	*3.IT-4.9*	*Sepsis: Average length of stay*	
Huguley Memorial Medical Center			*109574702*
Related Category 1 or 2 Projects:	109574702.2.2		
Starting Point/Baseline:	*Baseline is 2011's Huguley's ALOS for Sepsis patients = 8.9*		
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] Project planning to include stakeholders, assess resources, establish timeline, document implantation plan. Data Source: Chart review, internal database Milestone 1 Estimated Incentive Payment: $5,658 **Milestone 2** [P-2] Establish baseline rates to determine frequency of bundle usage, timing of interventions in the bundle, mortality, ALOS, cost/case (current patient volume approximately 290 sepsis patients) Data Source: Chart review and internal cost accounting system Milestone 2 Estimated Incentive Payment: $5,658	**Milestone 3** [P-4] PDSA cycles on targeted opportunities carry over from Year 2 Data Source: Internal database, chart abstraction, quality dashboard Milestone 3 Estimated Incentive Payment: $5,962 **Milestone 4** [P-5] Disseminate findings to stakeholders Data Source: Reports and dissemination process Milestone 4 Estimated Incentive Payment: $5,962 **Outcome Improvement Target 1** [IT-4.9] Average length of Stay decrease by 0.2 days from Year 2 Data Source: Internal database, chart abstraction, quality dashboard Outcome Improvement Target 1 Estimated Incentive Payment*:* $5,962	**Outcome Improvement Target 2** [IT-4.9] Average Length of Stay decrease by 0.2 days over baseline Data Source: Internal database, chart abstraction, quality dashboard Outcome Improvement Target 2 Estimated Incentive Payment*:* $19,134	**Outcome Improvement Target 3** [IT-4.9]: Average Length of Stay decrease by 0.2 days over prior year Data Source: Internal database, chart abstraction, quality dashboard Outcome Improvement Target 3 Estimated Incentive Payment*:* $45,755

109574702.3.3	*3.IT-4.9*	*Sepsis: Average length of stay*	
Huguley Memorial Medical Center			*109574702*
Related Category 1 or 2 Projects:	109574702.2.2		
Starting Point/Baseline:	*Baseline is 2011's Huguley's ALOS for Sepsis patients = 8.9*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $11,316	Year 3 Estimated Outcome Amount: $17,886	Year 4 Estimated Outcome Amount: $19,134	Year 5 Estimated Outcome Amount: $45,755
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $94,092			

Title of Outcome Measure (Improvement Target): Primary Care and Chronic Disease Management: Diabetes care: HbA1c poor control (>9.0%)

Unique RHP outcome identification number(s): 120726804.3.1

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Southwest Ft. Worth / 120726804

Outcome Measure Description:

By the end of the Waiver, our goal is to decrease the number of outpatient diabetes participants whose HbA1c is > 9.0 by 15%. Our milestones include the following:

Process Milestones:

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient nurse-practitioner run diabetes clinic, expanding on the existing diabetes self-management education service currently provided to our patients. In DY2, we will also develop a mechanism for identifying and tracking high-risk diabetic patients and monitoring effectiveness of interventions (enhanced education, self-management coaching, closer monitoring of medical condition, post discharge telephonic case management,…) to begin analysis of our information and determine potential improvement opportunities.

In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project.

Outcome Improvement Targets for each year:

In DY4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Rationale:

We selected the milestone Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans in order to create a cohesive program based on evidence-based practices. Milestone 2, train staff in the care model, was determined due to the need to train the core staff. In DY3, we will train added staff and current staff on evidence-based protocols and begin the implementation process of those protocols in order to begin to work to improve outcomes. Outcome improvement targets were chosen based on the potential intervention population and that approximately 10% of patients will participate in offered programs. We will strive to push that to 15% in DY5.

Outcome Measure Valuation:

- **Approach/Methodology:** For every inpatient admission avoided, $8,297 in cost is saved by the health care system. Health care costs are calculated by multiplying $9,640 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification**: Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost in payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

120726804.3.1	*3.IT-1.10*	*Primary Care and Chronic Disease Management* *1.10 Diabetes care: HbA1c poor control (>9.0%)*	
Texas Health Harris Methodist Southwest Fort Worth			*120726804*
Related Category 1 or 2 Projects:	*120726804.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	Target is 1113 Baseline: Intervention Population is 167 (15% of target)		
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] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents Incentive Payment: $911 **Milestone 2** [P- 2] Establish baseline rates Data Source: EMR, laboratory data Milestone 2 Estimated Incentive Payment *(maximum amount):* $911	**Milestone 3** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $1440 **Milestone 4** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment: $1440	**Outcome Improvement Target 1** **[IT-1.10]** Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Improvement Target: 10% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $3,081	**Outcome Improvement Target 2** [**IT-1.10]** Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Improvement Target: 15% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment*:* $7,367

120726804.3.1	*3.IT-1.10*	*Primary Care and Chronic Disease Management* *1.10 Diabetes care: HbA1c poor control (>9.0%)*	
Texas Health Harris Methodist Southwest Fort Worth			*120726804*
Related Category 1 or 2 Projects:	*120726804.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	Target is 1113 Baseline: Intervention Population is 167 (15% of target)		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 1,822	Year 3 Estimated Outcome Amount: $ 2,880	Year 4 Estimated Outcome Amount: $ 3,081	Year 5 Estimated Outcome Amount: $ 7,367
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $ 15,150			

Title of Outcome Measure (Improvement Target): Potentially Preventable Readmissions - 30 Day Readmission Rates (PPRs) – IT.3.3 Diabetes 30-day readmission rate

Unique RHP outcome identification number(s): 120726804.3.2

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Southwest Fort Worth / 120726804

Outcome Measure Description:

IT.3.3 Diabetes 30-day readmission rate

By the end of the Waiver, our goal is to decrease 30-day readmission (all-cause) for diabetes patients by 5%. Our milestones include the following:

Process Milestones:

DY2, we will:

- Develop and test reporting and monitoring process to evaluate
- Establish baseline rates for the outcome improvement target

DY3, our goal is to train staff and implement evidence-based protocols and implement evidenced-based protocols

Outcome Improvement Targets for each year:

Beginning in DY3 and continuing on to DY4 and DY5, diabetes patient readmissions will be reduced by 5, 10, and 1%, respectively.

Rationale:

The goal of this program is to establish an outpatient diabetes education and management program to assist all clients identified with diabetes the opportunity to be empowered to make informed decisions and develop self-management skills. Relying on an empirically validated, evidence-based self-management educational and clinical support approach, our goal is to improve the health outcomes and self-management competency of the THSW community. The proposed program will help low income and uninsured clients with diabetes to better self-manage their disease through disease education and provide them with appropriate access to chronic care management support resources.

- Partner with hospitalists to utilize protocols: A1C>8, history of DKA, > one admission in the last 12 months as criteria for referrals to outpatient diabetes education.
- Create the role of an inpatient diabetes educator to identify patients with the same criteria as above, and/or who do not currently have a medical home, and/or have not received diabetes education within the last five years, and any others appropriate for education.
- Develop a comprehensive care management program.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a comprehensive care management program including the program

development and training of staff. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient education program which includes a self-management portion.

In DY3, using the ED Nurse navigator, we will develop a mechanism for identifying and tracking diabetic patients to begin to establish a baseline and begin the implementation of evidence-based protocols.

In DY4, we will begin the implementation of an APN/Care Coordinator role to follow inpatient diabetics through discharge and follow up in the Outpatient Care Management and Education Program. Using the Plan, Do, Study, Act method, we will begin the evaluation of the new program.

In DY5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology:** For every inpatient readmission avoided, $8,297 in cost is saved by the health care system. Health care costs are calculated by multiplying $9,253 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g., aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

120726804.3.2	*3.IT-3.3*	*Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT-3.3 Diabetes 30-day readmission rate*	
Texas Health Harris Methodist Southwest Hospital			*120726804*
Related Category 1 or 2 Projects:	*120726804.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	*Baseline will be established 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)**
Milestone 1 [P-2]: Establish baseline rates Data Source: Database including patient administrative and coding/billing information such as Premier Quality Advisor identified and baseline rate confirmed Estimated Incentive Payment: $911 **Milestone 2** [P-3]: Develop and test data systems Data Source: Internally developed database using EMR data to monitor project and produce reports. Estimated Incentive Payment: $911	**Milestone 3** [P-4]: Train Staff on evidence-based protocols Data Source: Provider documents on number trained Estimated Incentive Payment: $960 **Milestone 4** [P-5]: Implement evidence-based protocols. Data Source: Provider documents describing implementation plan Estimated Incentive Payment: $960 **Outcome Improvement Target 1 [IT-3.2]:** Diabetes 30-day readmission rate (Stand-alone measure) Improvement Target: 5% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment: $960	**Outcome Improvement Target 2 [IT-3.2]:** Diabetes 30-day readmission rate (Stand-alone measure) Improvement Target: 10% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment: $3,081	**Outcome Improvement Target 3 [IT-3.2]:** Diabetes 30-day readmission rate (Stand-alone measure) Improvement Target: 15% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment: $7,367

120726804.3.2	*3.IT-3.3*	*Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT-3.3 Diabetes 30-day readmission rate*	
Texas Health Harris Methodist Southwest Hospital			*120726804*
Related Category 1 or 2 Projects:	*120726804.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	*Baseline will be established 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $1,822	Year 3 Estimated Outcome Amount: $2,880	Year 4 Estimated Outcome Amount: $3,081	Year 5 Estimated Outcome Amount: $7,367
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5)**:** $15,150			

Title of Outcome Measure (Improvement Target): IT-4.8 Sepsis mortality

Unique RHP outcome identification number(s): 120726804.3.3

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest (THSW) / 120726804

Outcome Measure Description:

IT-4.8 – Sepsis Mortality Rate: The rate of mortality for THFW patients hospitalized for septicemia or sepsis. The goal is to reduce mortality by up to 25% by implementation of evidenced-based protocols and processes

Process Milestones:

- P-2: Establish baseline rates– Establish baseline rates consistent with evidenced-based literature and meeting quality goals for appropriate sepsis care to include measurements for door to fluid resuscitation, amount of fluid resuscitation, door to antibiotic and average length of Stay (ALOS).
- P-3: Develop and test data systems – Developing of data systems to track measure and report metrics allowing a reduction manual extraction of data and analysis as well providing ability to rapidly detect changes in practice and trends.
- P-5: Determine findings, including lessons learned and best practices – Analysis and distribution of key indicators to stakeholders to aid in process improvement and better outcomes

Outcome Improvement Targets for each year:

- The outcome measure is to reduce mortality in patients with severe sepsis or septic shock through the consistent, timely, implementation of an evidence-based sepsis resuscitation bundle/protocol.

The measure itself measures the number of patients with diagnosis of sepsis, severe sepsis or septic shock expiring during a given time period against the same number of patients with the same inclusion criteria who don't expire.

Rationale:

According to the Center for Disease Control and Prevention (CDC)[353] 2007 statistics, septicemia is the 10th leading cause of death in the United States. There have been many focused initiatives to decrease mortality and morbidity in the past decade for other top causes of death of influenza and pneumonia. Proving evidence-based initiatives put in place can reduce mortality; implementing initiatives for sepsis follow these plans. Preliminary data for 2009 CDC statistics shows a slight decline of 1.8% in deaths from septicemia. Each year mortality from severe sepsis and septic shock have consistently been reported to be over 20-25% for severe sepsis and as high as 70% for septic shock.

[353] CDC Footnote here

Thus, process milestones include identifying and setting targets for each part of the resuscitation protocol; defining data elements; and developing the internal data base. Other process milestones include developing an internal database which will be utilized in data analysis in order to target opportunities for improvement not only in reducing sepsis mortality but also in looking at the change in ALOS. A quality dashboard which can be used for dissemination of data and participation in learning and improvement meetings are the additional process milestones. The goal of each process milestone is to complete the task (i.e., develop a dashboard, internal database, etc.).

Outcome Measure Valuation:

- **Approach/Methodology:** Decreased mortality rate does not bring any direct health care cost savings. Lives saved are utilized to calculate individual and community costs. The total valuation is calculated by summing up individual and community costs.
- **Rationale/Justification:** Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

120726804.3.3	*IT 4.8*	*Sepsis Mortality*	
Texas Health Harris Methodist Hospital Southwest			*120726804*
Related Category 2 Project:	*120726804.2.2 Sepsis: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area*		
Starting Point/Baseline:	*Baseline population: Inpatients with diagnosis of sepsis, severe sepsis or septic shock (136 in 2011)*		
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] Establish baseline rate of mortality. Baseline/Goal: Currently 13.6% Data Source: Chart review of 50 cases in Y1 and internal database Milestone 1 Estimated Incentive Payment *(maximum amount):* $10,090 **Milestone 2** [P-3] Develop and test data systems-analyze collected data; correlate with above measures; develop a quality dashboard Data Source: Chart review, internal database Milestone 2 Estimated Incentive Payment: $10,090	**Milestone 3** [P-5] Disseminate findings, including lessons learned and best practice to stakeholders Data Source: Internal database; chart abstraction Milestone 3 Estimated Incentive Payment: $31,897	**Improvement Target 1** [IT-4.8] Sepsis mortality Data Source: Premier database and chart abstraction Goal: 4.0% reduction in mortality over Year 2 (approximate mortality rate of 13%) Improvement Target 2 Estimated Incentive Payment*:* $34,123	**Improvement Target 2** [IT-4.8] Sepsis mortality Data Source: Premier database and chart abstraction Goal: 4.0% reduction in mortality over Year 4(approximate mortality rate of 12.5%) Improvement Target 3 Estimated Incentive Payment*:* $81,598

120726804.3.3	*IT 4.8*	*Sepsis Mortality*	
Texas Health Harris Methodist Hospital Southwest			*120726804*
Related Category 2 Project:	*120726804.2.2 Sepsis: Implement an innovative and evidence-based intervention that will lead to reductions in Sepsis Complications (mortality, prevalence and incidence) for providers that have demonstrated need or unsatisfactory performance in this area*		
Starting Point/Baseline:	*Baseline population: Inpatients with diagnosis of sepsis, severe sepsis or septic shock (136 in 2011)*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $20,180	Year 3 Estimated Outcome Amount: $31,897	Year 4 Estimated Outcome Amount: $34,123	Year 5 Estimated Outcome Amount: $81,598
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 167,798			

Title of Outcome Measure (Improvement Target): IT-4.9 Average length of stay (Sepsis)

Unique RHP outcome identification number(s): 120726804.3.4

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest (THSW) / 120726804

Outcome Measure Description:

IT-4.9 Average length of stay (Sepsis)

The measure itself measures the number of patients with diagnosis of sepsis, severe sepsis or septic shock expiring during a given time period against the same number of patients with the same inclusion criteria who don't expire.

Process milestones include identifying and setting targets for each part of the resuscitation protocol; defining data elements; and developing the internal data base. Other process milestones include developing an internal database which will be utilized in data analysis in order to target opportunities for improvement not only in reducing sepsis mortality but also in looking at the change in ALOS. A quality dashboard which can be used for dissemination of data and participation in learning and improvement meetings are the additional process milestones. The goal of each process milestone is to complete the task (i.e., develop a dashboard, internal database, etc.).

Process Milestones:

- **P- 2** Establish baseline rates – Establish baseline rates consistent with evidence-based literature and meeting quality goals for appropriate sepsis care to include measurements for door to IV, door to fluid resuscitation, amount of fluid resuscitation, door to antibiotic and average length of Stay (ALOS).
- **P-3** Develop and test data systems – Developing of data systems to track measure and report metrics allowing a reduction manual extraction of data and analysis as well providing ability to rapidly detect changes in practice and trends.
- **P- 5** Determine findings, including lessons learned and best practices – Analysis and distribution of key indicators to stakeholders to aid in process improvement and better outcomes

Outcome Improvement Targets for each year:

- **IT-4.8** Average length of stay – reduction of average length of stay by 0.6 days each year staring in DY3.

Rationale:

Process milestones were chosen based on previously identified need through internal quality and evidence-based literature review. Creation of data tracking tools, analysis reporting and information dissemination platforms and clinical process improvement goals are all aimed at the goal of reducing bad outcomes for the identified patient population.

Outcome Measure Valuation:

- **Approach/Methodology:** Decreased mortality rate does not bring any direct health care cost savings. Lives saved are utilized to calculate individual and community costs. The total valuation is calculated by summing up individual and community costs.
- **Rationale/Justification:** Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

120726804.3.4	*3.IT 4.9*	*Sepsis: Average length of stay*	
Texas Health Harris Methodist Hospital Southwest Fort Worth			*120726804*
Related Category 2 Project:	*120726804.2.2*		
Starting Point/Baseline:	*Baseline population: Inpatients with sepsis, severe sepsis or septic shock (136 in 2011)*		
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] Establish baseline rates to determine frequency of bundle usage; timing of interventions in the bundle; mortality; ALOS; cost/case Baseline/Goal: 7.4 patient days Data Source: Chart review/Internal database. EPSI, EPIC Milestone 1 Estimated Incentive Payment*:* $10,090 **Milestone 2** [P-3] Develop and test data systems-analyze collected data; correlate with above measures; develop a quality dashboard Baseline/Goal: Monthly extraction, analysis and reporting of sepsis data to stakeholders for CQI Data Source: Chart review, internal database, EPSI Milestone 2 Estimated Incentive Payment: $10,090	**Milestone 3** [P-5] Disseminate findings, including lessons learned and best practices Baseline/Goal: Monthly following analysis and reporting. Data Source: Internal database; chart abstraction; quality dashboard Milestone 3 Estimated Incentive Payment: $15,949 **Milestone 4** [IT-4.9] Average length of stay Data Source: Internal database/ chart abstraction Goal: 0.6 ALOS reduction in Year 3 over Year 2 Milestone 4 Estimated Incentive Payment*:* $15,948	**Improvement Target 1** [IT-4.9] Average length of stay Data Source: Internal database/ chart abstraction Goal: 0.6 ALOS reduction for inpatients in Year 4 over Year 3 Improvement Target 2 Estimated Incentive Payment*:* $34,123	**Improvement Target 1** [IT-4.9] Average length of stay Data Source: Internal database/ chart abstraction Goal: 0.6 ALOS reduction for inpatients in Year 5 over Year 4 Improvement Target 3 Estimated Incentive Payment*:* $81,598

120726804.3.4	*3.IT 4.9*	*Sepsis: Average length of stay*	
Texas Health Harris Methodist Hospital Southwest Fort Worth			*120726804*
Related Category 2 Project:	*120726804.2.2*		
Starting Point/Baseline:	*Baseline population: Inpatients with sepsis, severe sepsis or septic shock (136 in 2011)*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $20,180	Year 3 Estimated Outcome Amount: $31,897	Year 4 Estimated Outcome Amount: $34,123	Year 5 Estimated Outcome Amount: $81,598
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $167,798			

Title of Outcome Measure (Improvement Target): Right Care, Right Setting – IT-9.2 – ED appropriate utilization

Unique RHP outcome identification number(s): 120726804.3.5

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest Hospital / 120726804

Outcome Measure Description:

The outcome measure is provided in the table below:

By the end of the Waiver, our goal is to improve appropriate ED utilization for the targeted populations by 12%. Our milestones include the following:

Process Milestones:

In DY2, we will:

- Complete project planning including identification and hiring/training of necessary staff, development of policies/procedures and processes
- Develop/test reporting and monitoring process to evaluate effectiveness of program
- Develop or identify database for capturing information on targeted populations to understand needs in order to develop interventions to effective meet their needs. This includes creating strategies with other community health care providers (skilled nursing facilities, nursing homes, home health agencies, primary care physicians, outpatient clinics and other resources in the community) to facilitate transition of at-risk populations to a medical home.
- Establish the baseline In DY3, we will conduct performance improvement projects to work toward further reductions and disseminate information to key stakeholders regarding our progress
- Reduce ED utilization for the targeted populations by 5% from baseline

Outcome Improvement Targets for each year:

In DY4 we will:

- Conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress.
- Reduce ED utilization for the targeted populations by 8% from baseline

In DY5 we will:

- Reduce ED utilization for the targeted populations by 12% from baseline

Rationale:

For 2012, an estimated 61,991 THSW ED visits will occur. Of this total, 20% of the ED admissions meet the identified population criteria (unfunded/Medicaid) yielding an estimated total of 12,386 potential EDCM clients for 2012. More than half of identified population had diagnoses that did not require emergency care, including conditions such as chronic back pain, prescription refills, follow-up exams, requesting medical supplies, and seeking narcotics. Additional diagnoses, such as altered mental status, urinary tract infections, and sickle cell pain

could potentially have been managed at a lower level of care. This EDCM program will provide patients utilizing the ED for non-emergent care needs with a trained Navigator to assist them in locating appropriate resources. The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include: In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project.

- Establishment of a baseline rate for measuring effectiveness in future project years and completion of planning for the project key components.
- Finalization of plans and implementation of a process for hiring and training staff, identifying individuals who are frequent users of the ED or who are utilizing the ED for services that might be provided at a lower level of care and developing a process to navigate the individuals to more appropriate health care venues.
- Development of a data base for tracking patients, monitoring the effectiveness of interventions and follow up monitoring to ensure compliance with the plan of care. Analysis of data obtained will be completed to determine potential improvement opportunities.

In DY3 performance improvement initiatives will be implemented based on opportunities identified and the reporting mechanisms developed to disseminate information regarding the project. In DY4 and 5, we will continue to monitor our effectiveness to achieve targeted outcomes and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology:** For every ED visit avoided, $380 in cost is saved by the health care system. The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** ED visit outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with greater than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.
- **Community benefits** were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

120726804.3.5	*3.IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization* *Reduce Emergency Department visits for target conditions*	
Texas Health Harris Methodist Southwest			*120726804*
Related Category 1 or 2 Projects:	*120726804.2.3*		
Starting Point/Baseline:	Baseline Data: The actual baseline data is not known and will be obtained in DY2 year. Target Population: Low income, Medicaid/unfunded, frequent users of the ED that do not have access to a primary care physician or medical home Specific Number: Anticipate 10%-20% of annualized volume of estimated 61,992 ED visits for 2012. Description of Population: Community members with target conditions within Region 10, particularly those living in Fort Worth, Southwest Tarrant County, and Northern Johnson 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)**
Milestone 1[P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment (maximum amount): $16,605 **Milestone** 2 [P-2]: Establish baseline rates (Emergency Department (ED) visits rate for target population Congestive Heart Failure. Data Source: Hospital discharge records Milestone 2 Estimated Incentive	**Milestone** 4 [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $26246 **Milestone** 5 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment: $26245	**Milestone** 7 [IT-9.2]: ED Appropriate Utilization Improvement Target: 8% improvement from baseline of those receving Navigation services. Data Source: Hospital discharge records Milestone 7 Estimated Incentive Payment: $84,229	**Milestone** 8 [IT-9.2]: ED Appropriate Utilization Improvement Target: 12% improvement from baseline baseline of those receving Navigation services. Data Source: Hospital discharge records Milestone 8 Estimated Incentive Payment: $201,416

120726804.3.5	*3.IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization* *Reduce Emergency Department visits for target conditions*	
Texas Health Harris Methodist Southwest			*120726804*
Related Category 1 or 2 Projects:	*120726804.2.3*		
Starting Point/Baseline:	Baseline Data: The actual baseline data is not known and will be obtained in DY2 year. Target Population: Low income, Medicaid/unfunded, frequent users of the ED that do not have access to a primary care physician or medical home Specific Number: Anticipate 10%-20% of annualized volume of estimated 61,992 ED visits for 2012. Description of Population: Community members with target conditions within Region 10, particularly those living in Fort Worth, Southwest Tarrant County, and Northern Johnson 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)**
Payment (maximum amount): $ 16,604 **Milestone** 3:[P- 3]: Develop and test data systems Data Source: Internally developed database using EMR, coding, and case management data to monitor project and produce reports. Milestone 3 Estimated Incentive Payment: $16,604	**Milestone** 6 IT-9.2 ED Appropriate Utilization (Stand-alone measure) Improvement Target: 5% improvement from baseline. Data Source: Identified database determined in DY2 Milestone 6 Estimated Incentive Payment: $26245		
Year 2 Estimated Outcome Amount: : $49,813	Year 3 Estimated Outcome Amount: $78,736	Year 4 Estimated Outcome Amount: $84,229	Year 5 Estimated Outcome Amount: $201,416
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $414,193			

Title of Outcome Measure (Improvement Target): Potentially Preventable Admissions – IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8

Unique RHP outcome identification number(s): 120726804.3.6

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group / 120726804

Outcome Measure Description:
By the end of the Waiver, our goal is to decrease 30-day readmission (all-cause) for heart failure patients by **15**% Our milestones include the following:

Process Milestones:
In DY2, we will:

- Establish the baseline rate for this measure. An initial data pull from our database shows that the baseline rate may be as high as 20%;
- Process milestone 1-Establish baseline rate for this measure.

In DY3, our goal is to reduce this rate by **5**%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress.

- Process milestone 2-Conduct PDSA improvement cycles and document evidence of process improvement; (quantitative and qualitative) description and results.
- Outcome metric 1-Reduce CHF admission rate by 5 % from baseline.

Outcome Improvement Targets for each year:
In DY4, our goal is to reduce HF patient admissions by **10**% from baseline.

- Outcome metric 2-Reduce CHF admission rate by 10% from baseline.

In DY5, our goal is to reduce HF patient admissions by **15**% from baseline.

- Outcome metric 3-Reduce CHF admission rate by 15% from baseline.

Rationale:
The target population includes individuals with heart failure diagnosis who are at risk for hospital admission due to inadequate treatment, monitoring or self-management of their chronic disease, specifically, HF patients within our Extensivist clinics service area who are underserved, unfunded and government-funded insurance populations.

* Tarrant County Public Health Department *Behavioral Risk Factor Surveillance System 2009/2010* notes that among Tarrant County adults in 2007, heart disease ranked as the leading cause of death for both men and women. Also, during the years 2000 to 2005, Tarrant County residents spent about $500 million on preventable hospitalizations due to angina, CHF, and high blood pressure

In DY3, we will conduct PDSA improvement cycles to improve data collection and intervention strategies for target population.

- Process milestone 2-Documents demonstrating completion of the performance improvement activities.
- Outcome improvement target 1: Reduction of CHF admission rate of 5 % from baseline based on PDSA improvements.

In DY4, based on implementation of care management interventions we will achieve:

- Outcomes improvement target 2: 10 % reduction of CHF admission rates from baseline rate in DY2.

In DY5 based on continuous improvements with interventions, we will achieve:

- Outcomes improvement target 3:15% reduction of CHF admission rates from baseline rate in DY2.

Outcome Measure Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $8,252 in cost is saved by the health care system.[354] The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.

[354] Texas Department of State Health Services with a 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

120726804.3.6	*3.IT-2.1*	*Potentially Preventable Admissions: IT-2.1 Congestive Heart Failure Admission rate*	
Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group			*120726804*
Related Category 1 or 2 Projects:	*12072804.2.4 Health e Care NTSP & Texas Health Physician's Group Extensivist Clinics*		
Starting Point/Baseline:	*Estimated heart failure 30-day admission rate is at* **20***%. Baseline will be confirmed 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]: Establish baseline 30-day CHF admission rates. Data Source: Claims data files from CMS for reporting period. Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $32,043	**Process Milestone 2 [**P-4]: Conduct Plan Do Study Act (PDSA) cycles to evaluate effectiveness of model and intervention activities. Data Source: Documentation describing process milestone as evidence PDSA cycles completed. Process Milestone 2 Estimated Incentive Payment: $25,324 **Outcome Improvement Target 1** [IT-2.1]: CHF 30-day admission rate Improvement Target: 5% (25 admits) reduction from baseline. Outcome Improvement Target 1 Estimated Incentive Payment: $25,324	**Outcome Improvement Target 2** [IT-2.1]: Congestive Heart Failure 30-day admission rate Improvement Target: 10 % (50 admits) reduction from baseline. Data Source: Claims data from identified database on DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $54,182	**Outcome Improvement Target 3** [IT-2.1]: Congestive Heart Failure 30-day admission rate Improvement Target: 15 % (76 admits) reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment*:* $129,565

120726804.3.6	*3.IT-2.1*	*Potentially Preventable Admissions: IT-2.1 Congestive Heart Failure Admission rate*	
Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group			*120726804*
Related Category 1 or 2 Projects:	*12072804.2.4 Health e Care NTSP & Texas Health Physician's Group Extensivist Clinics*		
Starting Point/Baseline:	*Estimated heart failure 30-day admission rate is at* **20%**. *Baseline will be confirmed 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $32,043	Year 3 Estimated Outcome Amount: $50,648	Year 4 Estimated Outcome Amount: $54,182	Year 5 Estimated Outcome Amount: $129,565
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $266,438			

Title of Outcome Measure (Improvement Target): Potentially Preventable Complications – IT-3.2 Congestive Heart Failure (CHF) 30-day readmission rate

Unique RHP outcome identification number(s): 120726804.3.7

Performing Provider Name/TPI: Texas Health Harris Methodists Southwest – North Texas Specialty Physicians & Texas Health Physician's Group / 120726804

Outcome Measure Description:
IT-3.2 Congestive Heart Failure (CHF) 30-day readmission rate
By the end of the Waiver, our goal is to decrease 30-day readmission (all-cause) for heart failure patients by 20%. Our milestones include the following:

Process Milestones:
In DY2, we will:

- P-2: Establish the baseline rate for this measure. An initial data pull form CMS claims indicates that the baseline rate may be as high as 20%

In DY3, we will conduct performance improvement strategies using the PDSA cycles to work toward further reductions and disseminate information to key stakeholders regarding our progress.

- P-4: Documentation (qualitative and quantitative) describing process milestone as evidence PDSA cycles completed.
- IT-3.2: Reduce 30-day readmission rate for CHF (<5% from baseline).

Outcome Improvement Targets for each year:
In DY4 our goal is to reduce HF patient readmissions by 10% from baseline.

- IT-3.2: Reduce 30-day readmission rate for CHF

In DY5, our goal is to reduce HF patient readmissions by 20% from baseline.

- IT-3.2: Reduce 30-day readmission rate for CHF.

Rationale:
The target population includes individuals identified for care within our Extensivist Clinics Medical Home with diagnosis of with heart failure who are at risk for readmission to the hospital within 30 days of an index admission. The target population will include HF patients who are underserved, unfunded and/or a beneficiary of government-funded insurance populations.

In DY3, we will conduct PDSA improvement cycles to improve data collection and intervention strategies for target population.

- Process milestone 2-Documents demonstrating completion of the performance improvement activities.
- Outcome improvement target 1: Reduction of CHF readmission rate of 5 % from baseline based on PDSA improvements.

In DY 4, based on implementation of evidence-based care coordination and interventions we will achieve:

- Outcomes improvement target 2: 10 % reduction of CHF readmission rates from baseline rate in DY2.

In DY5 based on continuous improvements with interventions, we will achieve:

- Outcomes improvement target 3:20% reduction of CHF readmission rates from baseline rate in DY2.

Improving care management of chronic conditions requires a coordinated care approach with a focus on primary, secondary and tertiary strategies for reducing disease associated complications and negative health effects. Conducting quality improvement cycles during DY3 will provide organized approach to determining root causes for hospitalization and rehospitalization of patients with diagnosis CHF and AMI and ensure rapid cycle improvements related to care, treatment and interventions.

Outcome Measure Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $8,252 in cost is saved by the health care system.[355] The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.
  Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[355] Texas Department of State Health Services with a 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

120726804.3.7	*3.IT-3.2*	*Potentially Preventable Complications – CHF30-day readmission rate*	
Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group			*120726804*
Related Category 2 Project:	*12072804.2.4 Health e Care NTSP and THPG Extensivist Clinics*		
Starting Point/Baseline:	*Estimated heart failure 30-day readmission rate is at* **20%**. *Baseline will be confirmed 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]: Establish baseline 30-day CHF readmission rates in target population. Data Source: Claims data files from CMS for reporting period. Process Milestone 1 Estimated Incentive Payment: $32,043	**Process Milestone 2** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities in target population. Data Source: Documentation describing process milestone as evidence PDSA cycles completed. Process Milestone 2 Estimated Incentive Payment: $25324 **Outcome Improvement Target 1** [IT-3.2] CHF 30-day readmission rate Improvement Target: 5% (4 admits) reduction from baseline. Data Source: CMS Claims data Outcome Improvement Target 1 Estimated Incentive Payment: $25324	**Outcome Improvement Target 2** [IT-3.2]: CHF 30-day readmission rate Improvement Target: 10% (9 admits) reduction from baseline. Data Source: Claims data from CMS Outcome Improvement Target 2 Estimated Incentive Payment*:* $54,182	**Outcome Improvement Target 3** [IT-3.2]: CHF 30-day readmission rate Improvement Target: 20% (12 admits) reduction from baseline. Data Source: Claims data from CMS Outcome Improvement Target 3 Estimated Incentive Payment*:* $129,565
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $32,043	Year 3 Estimated Outcome Amount: $50,648	Year 4 Estimated Outcome Amount: $54,182	Year 5 Estimated Outcome Amount: $129,565

120726804.3.7	*3.IT-3.2*	*Potentially Preventable Complications – CHF30-day readmission rate*	
Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group			*120726804*
Related Category 2 Project:	*12072804.2.4 Health e Care NTSP and THPG Extensivist Clinics*		
Starting Point/Baseline:	*Estimated heart failure 30-day readmission rate is at* **20**%. *Baseline will be confirmed 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $266,438			

Title of Outcome Measure (Improvement Target): Potentially Preventable Complications – IT-3.5 Acute Myocardial Infarction (AMI) 30-day readmission rate

Unique RHP outcome identification number(s): 120726804.3.8

Performing Provider Name/TPI: Texas Health Harris Methodists Southwest – North Texas Specialty Physicians / 120726804

Outcome Measure Description:

IT-3.5 Acute Myocardial Infarction (AMI) 30-day readmission rate

By the end of the Waiver, our goal is to decrease 30-day readmission (all-cause) for AMI by **20**%. Our milestones include the following:

Process Milestones:

In DY2, we will:

- Establish the baseline for this rate. An initial data pull from our database shows that the baseline rate may be as high as **24.5** %;
- Process milestone 1- Establish the baseline of 30-day AMI readmission rates for at risk population.

In DY3, we will conduct performance improvement projects using the PDSA cycles to work towards further reductions and disseminate information to key stakeholders regarding our progress.

- Process milestone 2 - Conduct PDSA cycles to improve data collection and intervention activities.
- Outcome metric 1 – Reduce baseline rate by **5**% in DY3

Outcome Improvement Targets for each year:

In DY4, our goal is to reduce AMI patient readmissions by **10**% from baseline.

- Outcome metric 2 – Reduce 30-day readmission rate for AMI by 10%.

In DY5, our goal is to reduce AMI patient readmissions by **20**% from baseline.

- Outcome metric 3 – Reduce 30-day readmission rate for AMI by 20%.

Rationale:

In DY2, our process milestone is to establish the baseline AMI Readmission rate to reflect the current state of performance and set targets for the future state.

The target population includes patients in our service area with diagnosis of acute myocardial infarction who are at risk for readmission to the hospital within 30 days of an index admission due to inadequate monitoring or management of their condition. Tarrant County Public Health Department Risk Factor Surveillance System 2009/2010 notes that among Tarrant County adults in 2007, heart disease ranked as one of the leading causes of death for both men and women.

In DY3, we will conduct PDSA improvement cycles to improve data collection and intervention activities for target population.

- Process milestone 2 – Documents demonstrating completion of the performance improvement activities.
- Outcome improvement target 1: Reduction of AMI readmission rate of 5 % from baseline based on PDSA improvements.

In DY4, based on implementation of evidence-based care coordination and interventions, we will achieve:

- Outcomes improvement target 2:10% reduction of AMI readmission rates from baseline rate in DY2.

In DY5, based on continuous improvements with interventions, we will achieve:

- Outcomes improvement target 3: 20% reduction of AMI readmission rates from baseline rate in DY2.

Outcome Measure Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $8,252 in cost is saved by the health care system.[356] The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.
  Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[356] Texas Department of State Health Services with a 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

120726804.3.8	*3.IT-3.5*	*Potentially Preventable Complications – AMI 30-day readmission rate*	
Texas Health Harris Methodist Southwest – North Texas Specialty Physicians & Texas Health Physician's Group			*120726804*
Related Category 1 or 2 Projects:	*12072804.2.4 Health e Care NTSP and THPG Extensivist Clinics*		
Starting Point/Baseline:	*Estimated AMI 30-day readmission rate is at 24%. Baseline will be confirmed 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]: Establish baseline rates Data Source: CMS Claims data Process Milestone 1: Estimated Incentive Payment: $32,043	**Process Milestone 2 [**P-2]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Process Milestone 2 Estimated Incentive Payment: $ 25,324 **Outcome Improvement Target 1** [IT-3.5]: AMI 30-day readmission rate Improvement Target: 5% reduction (2 admits) from baseline. Data Source: CMS Claims data Outcome Improvement Target 1 Estimated Incentive Payment*:* $25,324	**Outcome Improvement Target 2 [**IT-3.5]: AMI 30-day readmission rate (**Stand-alone measure**) Improvement Target: 10 % (3 admits) reduction from baseline. Data Source: CMS Claims data Outcome Improvement Target 2 Estimated Incentive Payment*:* $54,182	**Outcome Improvement Target 3 [**IT-3.5]: AMI 30-day readmission rate (**Stand-alone measure**) Improvement Target: 20 % (4 admits) reduction from baseline. Data Source: CMS Claims data Outcome Improvement Target 3 Estimated Incentive Payment*:* $129,565
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $32,043	Year 3 Estimated Outcome Amount: $50,648	Year 4 Estimated Outcome Amount: $54,182	Year 5 Estimated Outcome Amount: $129,565
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $266,438			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c poor control (> 9.0%)

Unique RHP outcome identification number(s): 121794503.3.1

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Stephenville / 121794503

Outcome Measure Description:

IT-1.10 Diabetes care: HbA1c poor control (> 9.0%)

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
- (P-7) Train appropriate staff on evidence-based clinical protocols

DY3:

- (P-4) Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

Reduce the number of patients with A1C > 9.0% by 10% over the baseline in DY4 and 15% over the baseline in DY5

Rationale:

The identified process milestones will assist our organization in developing and implementing the structure needed to coordinate care for these patients. Process milestones identified in DY2 include (P-1) project planning involving the establishment of a comprehensive care management program and formalization of the multidisciplinary Diabetes CARE team to link these patients to a medical home and resources / self-management education. In DY3, conducting Plan Do Study Act (PDSA) cycles (P-4) will allow us to implement performance improvement initiatives based on opportunities identified. In addition, a reporting mechanism will be developed to disseminate information regarding the project.

89% of medically managed patients who enrolled in a similar outpatient diabetes self-management training program at THFW achieved HbA1c <7% by program completion. Using this comparison for this higher-risk, economically disadvantaged population of people with diabetes, we conservatively project a goal of decreasing by 15% the number of diabetes program participants whose HbA1c is >9% by DY5.

Outcome Measure Valuation:

- **Approach/Methodology:** For every diabetes inpatient admission avoided, $8,297[357] in cost is saved by the health care system. Health care costs are calculated by multiplying $8,297 by the total individuals positively affected. The average length of stay per admission is multiplied by the number of avoided admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** The valuation for each outcome is dependent on the outcome improvement targets. Outcome improvement targets are set, taking into consideration the following factors:
    - Volume capacity of the proposed program, which defines the baseline/ intervention population
    - Clinical literature or historical performance that provide a comparison for expected improvement as a result of the program

The valuation model computes separate values for impacts on the health care system, the individual and the community. Community benefits were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[357] Assumes a cost-to-revenue of 30%. Texas Department of State Health Services. http://www.dshs.state.tx.us/ph/county.shtm.

121794503.3.1	*1.IT-1.10*	*Diabetes Care: HbA1c poor control (>9.0%)*	
Texas Health Harris Methodist Stephenville			*121794503*
Related Category 1 or 2 Projects:	*121794503.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes*		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in DY2. **Target Population:** Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care.		
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 Process Milestone 1 Estimated Incentive Payment*: $472 **Process Milestone 2** [P- 2]: Establish baseline rates Data Source: Patient records Process Milestone 2 Estimated Incentive Payment*: $472 **Process Milestone 3: [P-7]** Train appropriate staff on evidence-based clinical protocols Data source: Documentation in staff records of training on evidence-based protocols Process Milestone 3 Estimated	**Process Milestone 4** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Quality Improvement reports Process Milestone 4 Incentive Payment*: $2,236	**Outcome Improvement Target 1 [IT-1.10]** Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 Outcome Improvement Target 1: Reduce the number of patients with A1C > 9.0% by 10% over the baseline Data Source: Pre- and post-intervention A1C measurements in patient records Outcome Improvement Target 2 Estimated Incentive Payment*: $2,392	**Outcome Improvement Target 2** [IT-1.1]: **IT-1.10** Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 Improvement Target 2: Reduce the number of patients with A1C > 9.0% by 15% over the baseline Data Source: Pre-and post intervention A1C measurements in patient records Outcome Improvement Target 3 Estimated Incentive Payment: $5,720

121794503.3.1	*1.IT-1.10*	*Diabetes Care: HbA1c poor control (>9.0%)*	
Texas Health Harris Methodist Stephenville			*121794503*
Related Category 1 or 2 Projects:	*121794503.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes*		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in DY2. **Target Population:** Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care.		
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)**
Incentive Payment*: $471			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $1,415	Year 3 Estimated Outcome Amount: $2,236	Year 4 Estimated Outcome Amount: $2,392	Year 5 Estimated Outcome Amount: $5,720
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $11,763			

Title of Outcome Measure (Improvement Target): Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT-3.3 Diabetes 30-day readmission

Unique RHP outcome identification number(s): 121794503.3.2

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Stephenville / 121794503

Outcome Measure Description:
IT-3.3 Diabetes 30-day readmission

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
- (P-7) Train appropriate staff on evidence-based clinical protocols

DY3:

- (P-4) Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:
Reduce the number of patients readmitted to the hospital within 30 days by 5% over baseline in year DY3, then by 10% over baseline in DY4 and 15% over the baseline by DY5

Rationale:
The identified process milestones will assist our organization in developing and implementing the structure needed to coordinate care for these patients. Process milestones identified in DY2 include (P-1) project planning involving the establishment of a comprehensive care management program and formalization of the multidisciplinary Diabetes CARE team to link these patients to a medical home and resources / self-management education. In DY3, conducting Plan Do Study Act (PDSA) cycles (P-4) will allow us to implement performance improvement initiatives based on opportunities identified. In addition, a reporting mechanism will be developed to disseminate information regarding the project.
Eighty-nine percent of medically managed patients who enrolled in a similar outpatient diabetes self-management training program at THFW achieved HbA1c <7% by program completion. Using this comparison for this higher-risk, economically disadvantaged population of people with diabetes, we conservatively project a goal of decreasing by 15% the number of diabetes program participants whose HbA1c is >9% by DY5.

Outcome Measure Valuation:

- **Approach/Methodology:** For every diabetes inpatient admission avoided, $8,297 in cost is saved by the health care system. Health care costs are calculated by multiplying $8,297 by the total individuals positively affected. The average length of stay per admission is multiplied by the number of avoided admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** The valuation for each outcome is dependent on the outcome improvement targets. Outcome improvement targets are set, taking into consideration the following factors:
    - Volume capacity of the proposed program, which defines the baseline/ intervention population
    - Clinical literature or historical performance that provide a comparison for expected improvement as a result of the program

The valuation model then computes separate values for program impacts on the health care system, the individual and the community. Community benefits took into account the following factors: lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits considered these factors: lost wages, caretaker expense and extension of life (if applicable).

121794503.3.2	*3.IT-3.3*	*Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT-3.3 Diabetes 30-day readmission rate*	
Texas Health Resources Stephenville			*121794503*
Related Category 1 or 2 Projects:	*121794503.2.1* Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)		
Starting Point/Baseline:	***Baseline Data**: Baseline will be determined in DY2.* ***Target Population**: Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care.*		
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 Process Milestone 1 Estimated Incentive Payment *: $472 **Process Milestone 2** [P- 2] Establish baseline rates Data Source: Program records Process Milestone 2 Estimated Incentive Payment* : $472 **Process Milestone 3** [P-7] Train appropriate staff on evidence-based clinical protocols Data source: Documentation in staff records of	**Process Milestone 4** [P- 4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Quality Improvement reports Process Milestone 4 Incentive Payment* :$1,118 **Outcome Improvement Target 1** [IT-3.3]:Diabetes 30-day readmission rate Improvement target: Reduce the number of patients readmitted to the hospital within 30 days by 5% over baseline in DY3 Data Source: Patient records, hospital admissions/discharges Estimated Incentive Payment*:$1,118	**Outcome Improvement Target 2** [IT-3.3]: Diabetes 30-day readmission rate Improvement target: Reduce the number of patients readmitted to the hospital within 30 days by 10% over the baseline in DY4 Data Source: Patient records, hospital admissions/discharges Estimated Incentive Payment*:$2,392	**Outcome Improvement Target 3** [IT-3.3]: Diabetes 30 day-readmission rate Improvement target: Reduce the number of patients readmitted to the hospital within 30 days by 15% over baseline by DY5 Data Source: Patient records, hospital admissions/discharges Estimated Incentive Payment* : $5,720

121794503.3.2	*3.IT-3.3*	*Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT-3.3 Diabetes 30-day readmission rate*	
Texas Health Resources Stephenville			*121794503*
Related Category 1 or 2 Projects:	*121794503.2.1* Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)		
Starting Point/Baseline:	***Baseline Data**: Baseline will be determined in DY2.* ***Target Population**: Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care.*		
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)**
training on evidence-based protocols Process Milestone 3 Estimated Incentive Payment*: $471			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $1,415	Year 3 Estimated Outcome Amount: $2,236	Year 4 Estimated Outcome Amount: $2,392	Year 5 Estimated Outcome Amount: $5,720
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $11,763			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization (Stand-alone measure)

Unique RHP outcome identification number(s): 121822403.3.1
Performing Provider Name/TPI: Ennis Regional Medical Center/121822403

Outcome Measure Description:

ERMC overall goal is to decrease non-emergent use of ED 15% by DY5. All patients who present to the Emergency Department of the hospital will have a medical necessity screening. The patients who do not meet medical necessity for emergency services will be advised on seeking the appropriate level of care and re-directed for appropriate treatment with a list of available local physician clinics. By DY5, we will decrease the number of low-acuity patients who present in our ED by 10%. To do this, we must implement a Nurse Triage system and develop and test our data systems in DY2-DY4. We will establish a baseline number of low-acuity patients in DY2. ERCM Emergency Department will consistently and proficiently use Emergency Severity Index Triage Screening developed by the Emergency Nurses Association and supported by the Agency of Healthcare Research and Quality to evaluate medical necessity. For all patients discharged rather than treated in the emergency department ERMC will provide written information on location, contact information and hours of operation for all clinics in the Ennis Regional Medical Center Primary Care Service Area. The patients will also receive information verbally and in writing on the importance of having a primary care physician and seeking the appropriate level of care and services.

Rationale:
In 2012, 16, 867 patients presented to the Emergency Department at ERMC. Of these, 9,823 patients, or 58%, were designated as triage level 4 and 5, ERMC Stats, (2012). using the Emergency Severity Index standard for triaging, Emergency Severity Index (ESI) Implementation Handbook, (2012 Edition). Level 4 and 5 patients are considered non-emergent according to this standard. Of the 9,823 patients screened as non-emergent, 3,123 were treated at the lowest charge levels of 1 and 2 (scale range 1-5 plus Critical Care). Level 1 and 2 patients require little to no treatment or diagnostics. Further, of the 3,123 patients, 2,242 were Medicaid, Managed Medicaid or Indigent. This figure represents the baseline used for our ED appropriate utilization improvement Category 3 outcomes. We have targeted a 15% overall improvement in availability of access to primary care in DY4 and DY5 which will impact 112 patients by DY 4 and a total of 336 Medicaid/Managed Medicaid and indigent patients.

The goal of this project is to increase the general population's access to primary care across all payor sources. Increasing the ability for patients to seek and find primary care will improve utilization of primary care services rather than the hospital emergency department for non-emergent services. The expansion approach will include two facets: 1) expanding existing

primary care base through assisting growing practices in recruitment efforts and 2) further expanding relationships (and clinic sites) with existing Federally Qualified Health Clinics and developing new clinics focused on treating Medicare, Medicaid, and Medically Indigent Patients. This project will positively impact quality of life, health outcomes, preventable admissions, and emergency department utilization.

Outcome Measure Valuation:
We propose a community-based expansion of Primary Care capacity in the Ennis Regional Medical Center Primary Service Area (PCSA).

121822403.3.1	*3.IT-9.2*	*ED Appropriate Utilization*	
Ennis Regional Medical Center			121822403
Related Category 1 or 2 Projects:	*1.1.1 Expand Primary Care Capacity*		
Starting Point/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: Project workforce committee meeting minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,670 **Process Milestone 2 [**P-2]: Establish baseline rates Data Source: Survey data from Primary Care Service Area Process Milestone 2 Estimated Incentive Payment: $8,670 **Process Milestone 3 [P-3]** Develop and test systems Data Source: ERMC Project implementation datasheets Process Milestone 3 Estimated Incentive Payment: $8,671	**Process Milestone 4 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: ERMC Project specific Performance Improvement Data Process Milestone 4 Estimated Incentive Payment: $22,613 **Process Milestone 5 [P-5]** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Project workforce committee meeting minutes and archived data from correspondence media Process Milestone 5 Estimated Incentive Payment: $22,613	**Process Milestone 6** [P-6]: Implement a nurse triage software system to assist nurses in determining the acuity of patients. Metric 1 [P-6.1]: Baseline/Goal: Implement Triage System/All staff trained on System and System utilized Data Source: Hospital Emergency Department Data **Milestone 6** Estimated Incentive Payment: $24,190 **Outcome Improvement Target 1** [IT-9.2]:ED Appropriate Utilization Improvement Target: 5% over previous year, 112 Medicaid/Indigent care patients over baseline. Data Source: Emergency Department Data Outcome Improvement Target 1 Estimated Incentive Payment*:* $24,191	**Outcome Improvement Target 2** [IT-9.2]:ED Appropriate Utilization Improvement Target: 10% over previous year for a total of 15%, 336 Medicaid/Indigent care patients over baseline. Data Source: Emergency Department Data Outcome Improvement Target 1 Estimated Incentive Payment*:* $115,693

121822403.3.1	*3.IT-9.2*	*ED Appropriate Utilization*	
Ennis Regional Medical Center			121822403
Related Category 1 or 2 Projects:	*1.1.1 Expand Primary Care Capacity*		
Starting Point/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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $26,011	Year 3 Estimated Outcome Amount: $45,226	Year 4 Estimated Outcome Amount: $48,381	Year 5 Estimated Outcome Amount: $115,693
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $235,311			

Title of Outcome Measure (Improvement Target): Percent improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status. (3.IT-6.1)

Unique RHP outcome identification number(s): 121988304.3.1
Performing Provider Name/TPI: Lakes Regional MHMR Center / 121988304
Outcome Measure Description:
The project will implement outcome measure IT-6.1 to measure improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status.
Process Milestones:

- In DY3, we will establish the baseline for patient satisfaction with overall health status/functional status.

Outcome Improvement Targets for each year:

- In DY4, Improvement Target-6.1 is to achieve 15% improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status. Percentage will be measured by percent improvement in targeted patient satisfaction domain (numerator) over number of patients who were administered the survey (denominator).
- In DY5, Improvement Target-6.1 is to achieve 25% improvement over satisfaction scores in DY4 measuring patient's overall health status/functional status by end of Waiver. Percentage will be measured by percent improvement in targeted patient satisfaction domain (numerator) over number of patients who were administered the survey (denominator).

By the end of the Waiver, our goal is to achieve 40% improvement over baseline of patient satisfaction scores regarding satisfaction with patient's overall health status/functional status.

Rationale:
Research has shown that there is a much greater instance of health problems in the IDD population[358]. The program staff will monitor mental and physical health status and outcomes to facilitate integrated care, improvement of patient satisfaction and outcomes for the target population[359]. Research has shown that the use of Intensive Case Management reduced the number, confidence interval and duration of inpatient admissions, reducing the number of reported needs and increasing patient satisfaction, as well as the cost of care borne by the health sector[360]. The CGCAHPS survey produces ". . . comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers"[361]. Sharing survey results with other agencies and providers in the

[358] Jansen, D., Krol, B., Groothoff, J. and Post, D. (2004). People with intellectual disabilities and their health problems: a review of comparative studies. *Journal of Intellectual Disability Research* 48 (2): 93-102.
[359] Jansen, D., Krol, B., Groothoof, J. and Post D. (2006). Towards improving medical care for people with intellectual disability living in the community: possibilities of integrated care. *Journal of Applied Research in Intellectual Disabilities.* 19: 214-218.
[360] Hassiotis. A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disability Management and Health Outcomes* 10 (7): 409-417.
[361] RHP Planning Protocol, Category 3 Quality Improvements, 398.

Region regarding consumer satisfaction with overall health and functional status will bring about improvements in the overall health system for individuals with IDD/ASD/MH, since "[p]ublic reporting of the survey results is designed to create incentives for institutions to improve their quality of care." [362] Sharing survey results with stakeholders will result in a greater awareness of the efficacy of the crisis respite wraparound model in improving life satisfaction, following better self-management skills and improved follow-up to care.

Lakes Regional has the data to evaluate patient satisfaction with overall health status/functional status at this time. We will establish a baseline to measure satisfaction by implementing the CG-CAHPS, a standardized survey instrument and data collection methodology for measuring patients' perspectives on health care. Working collaboratively with the target population to highlight the importance of implementing evidence-based approaches to care tailored to individual needs will involve the target population in being accountable for participation in consistent self-monitoring. Better control over physical and psychiatric symptoms has shown to lead to greater consumer and family member satisfaction, as noted above.

Additionally, Lakes Regional will collaborate with 39 other MHMR centers across the state 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 data through shared data sources in local communities; centers are currently in the process of engaging a consultant to provide leadership and consultation for the project.

Outcome Measure Valuation:

The valuation for this project was based on an established economic evaluation model and extensive literature review conducted by professionals in the field and at the University of Houston School of Public Health and University of Texas at Austin Center for Social Work Research.

Outcome measures will be valued by assessing community needs identified for Region 10 addressed through the RHP plan, such as the need for more care coordination and overuse of emergency department services. When patients experience a fragmented service system between behavioral health and primary care, as well as a lack of access to coordinated care, they experience lack of satisfaction and inability to self-monitor and manage symptoms effectively as a result. Supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency departments and psychiatric hospitals is a predictor to overall improvement in coordinated care in the community, and greater quality of life satisfaction. [363]

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[362] ibid

[363] Jansen, D., Krol, B., Groothoof, J. and Post D. (2006). Towards improving medical care for people with intellectual disability living in the community: possibilities of integrated care. *Journal of Applied Research in Intellectual Disabilities.* 19: 214-218.

DY2 – There is no process milestone in DY2; the focus of Quality Improvement will be on activities in DY2 in the related project (1.13.1) involving gathering input from stakeholder meetings, conducting mapping and gap analyses regarding Community Need in the project area, and defining project requirements. (Outcome valuation payment/process milestone are not required in DY2 for this project.)
DY3 – Process Milestone (P-6) to establish baseline for improvement in patient satisfaction with overall health/functional status. The need to measure improvement in this domain will be accomplished by hiring part-time Quality Assurance staff to survey the target population to achieve a baseline for outcome measure 3IT-6.1. Participants will be surveyed to assess their experience in the current service system as it relates to meeting their needs.
DY4 – Improvement Target 6.1 to establish 15% improvement over baseline of patient satisfaction scores in selected domain. Nursing staff will administer surveys to measure improvement over baseline in the selected domain. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is expected to lead to a decrease in overuse of emergency department services and other barriers to access to care in the community for the target population, as well as improved ability to successfully and consistently self-manage symptoms in the community.
DY5 – Improvement Target 6.1 to establish 25% improvement over DY4 and 40% improvement over baseline of patient satisfaction scores in selected domain: see approach/methodology for IT-6.1 for DY4.

3IT-6.1 Percent improvement over baseline of patient satisfaction scores. A process milestone in Year 3 will establish baseline for improvement in patient satisfaction with overall health/functional status; Improvement targets in DYs 4 and 5 will establish percent improvement over baseline in patient satisfaction scores, ending Year 5 with a 40% improvement over baseline in patient satisfaction scores.

Size – The project will involve hiring one nursing staff and one part-time Quality Assurance staff to administer surveys, provide monitoring and follow-up and documentation of responses, and collection and maintenance of data on potentially and approximately 250 respondents receiving care at the Crisis Respite/Wraparound program.
Project Scope – The proposed project is projected to measure satisfaction with improvement in overall health status/functional status in approximately 250 individuals (children and adults) who are dually diagnosed in Ellis and Navarro counties.
Population Served – The population targeted to be served are individuals dually diagnosed with IDD/ASD/MH (one or all of those diagnoses).
Community Benefit and Cost Avoidance – As noted above, improved satisfaction with overall health outcomes will lead to improved self-maintenance of physical and psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Research has shown that the use of Intensive Case Management reduced the number, confidence interval and duration of inpatient admissions, reducing the number of reported

needs and increasing patient satisfaction, as well as the cost of care borne by the health sector. [364] Sharing evidence-based data with other providers on patient satisfaction in this area will serve to "enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment" [365]

Addressing Priority Community Need – Currently there is no crisis respite/wraparound program in the targeted area to serve the needs of the target population when in crisis, resulting in the frequent use of more restrictive and expensive settings for care, such as psychiatric hospitals and institutional settings.

Estimated Local Funding – (see table)

[364] Hassiotis. A. (2002). Community mental health services for individuals with intellectual disabilities: issues and approaches to optimizing outcomes. *Disability Management and Health Outcomes* 10 (7): 409-417.

[365] RHP Protocol, Category 3 Quality Improvements, 398.

121988304.3.1	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status*	
Lakes Regional MHMR Center			*TPI#121988304*
Related Category 1 or 2 Projects:	Development of behavioral health crisis stabilization services as alternatives to hospitalization; Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system; (Crisis Respite Behavioral Support Wraparound Services) :121988304.1.1		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will be established in Year 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)**
N/A – during DY-2	**Process Milestone 1 [P-6]:** Establish baseline for improvement in patient satisfaction with overall health status/functional status. Data Source: Patient Survey Process Milestone 1 Estimated Incentive Payment: $**177,138**	**Outcome Improvement Target 1 [IT-6.1]:** Percent improvement over baseline of patient satisfaction scores Improvement Target: 15% improvement over baseline of patient satisfaction scores Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $**189,497**	**Outcome Improvement Target 2 [IT-6.1]:** Percent improvement over baseline of patient satisfaction scores Improvement Target: 25% improvement of patient satisfaction scores from DY4 Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $**411,949**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount**: $**177,138**	**Year 4 Estimated Outcome Amount:$189,497**	**Year 5 Estimated Outcome Amount**: **$411,949**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $778,583**			

Title of Outcome Measure (Improvement Target): Percent improvement over baseline of patient satisfaction scores, measuring patient's overall health status/functional status.

Unique RHP outcome identification number(s): 121988304.3.2
Performing Provider Name/TPI: Lakes Regional MHMR Center / 121988304

Outcome Measure Description:
IT-6.1 Percent improvement over baseline of patient satisfaction scores by (5) patient's overall health status/functional status

Process Milestones:

- In DY3, we will develop and test data systems related to measuring patient satisfaction.

Outcome Improvement Targets for each year:

- In DY4, Improvement Target-6.1 is to achieve 10% improvement over baseline of patient satisfaction scores measuring patient's overall health status/functional status.
- In DY5, Improvement Target-6.1 is to achieve 20% improvement over satisfaction scores in DY4 measuring patient's overall health status/functional status by end of Waiver. Percentage will be measured by percent improvement in targeted patient satisfaction domain (numerator) over number of patients who were administered the survey (denominator).

By the end of the Waiver, our goal is to achieve 20% improvement over baseline of patient satisfaction scores regarding satisfaction with patient's overall health status/functional status.

Rationale:
Our telemedicine/telehealth program will develop and incorporate data systems to provide information and feedback with technical and clinical processes. This data will be used to help us manage the expansion of the program and ensure that we are continuously improving the quality of the services we provide to ensure patient satisfaction. Although this Telemedicine/Telehealth Introduction/Expansion Project will enable services from multiple provider specialties, it will share significant focus with the Lakes Regional Crisis Respite – Behavioral Support Wraparound Program Project. Within the IDD population, research has shown that there is a much greater instance of health problems[366]. With the help of telemedicine/telehealth technology, program staff will monitor mental and physical health status and outcomes to facilitate integrated care, improvement of patient satisfaction and outcomes for the target population[367].
The specific ACT model planned for the program will result in better control of psychiatric symptoms, better quality of life overall, and greater consumer and family member satisfaction[368]. The projected outcomes relate to an improvement in access to care, the quality of care and health

[366] Journal of Intellectual Disability Research 48 (2): 93-102
[367] Journal of Applied Research in Intellectual Disabilities. 19: 214-218
[368] Phillips et al, 2001. . .Teague et al, 1995

outcomes, as well as an overall improvement in health for the target population. The CGCAHPS survey produced comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers[369]. The sharing of consumer satisfaction data (overall health survey results) between agencies (IFF,SDF,MH) and providers in the Region regarding consumer satisfaction, will result in a greater awareness of the efficacy of the crisis respite wraparound model in improving life satisfaction, following better self-management skills and follow-up to care. Identified within the Crisis Respite Project there is significant data analysis planned with encounter based assessments to show and measure improvement in customer satisfaction in health/ functional status.

Lakes Regional has the data to evaluate patient satisfaction with overall health status/functional status at this time. Additionally, Lakes Regional will collaborate with 39 other MHMR centers across the state to develop and 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 data through shared data sources in local communities; centers are currently in the process of engaging a consultant to provide leadership and consultation for the project

Outcome Measure Valuation:

- DY2 – There is no process milestone in DY2; the focus of Quality Improvement will be on activities in DY2 in a related telemedicine project (1.7.1) involving gathering input from stakeholder meetings, conducting mapping and gap analyses regarding Community Need in the project area, and defining project requirements. (Outcome valuation payment/process milestone are not required in DY2 for this project.)
- DY3 – Process Milestone (P-3) will involve developing and testing data systems related to measuring patient satisfaction to establish a methodology for measuring patient satisfaction in Years 4 and 5.
- DY4 – Improvement Target 6.1 will establish 10% improvement over baseline of patient satisfaction scores in the selected domain:
- DY5 – Improvement Target 6.1 will establish 20% improvement over baseline of patient satisfaction scores in the selected domain:

Our telemedicine/telehealth project will provide flexibility for the type of services and where the connections between providers can be established. With the rural nature of Ellis and Navarro counties, the Internet cloud based implementation planned for the project will open up the area for video communication between doctors' offices, schools, hospitals, jails, behavioral health clinics, and just about anywhere that there is broadband access (providers working out of their homes). The possibilities for expansion of this program are numerous and the services provided will result in overall cost reductions for the Region.

This project was valued based on studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: "Valuing Access to Timely Services through Telemedicine." These studies were completed through a contract with Center for Health Care Services. These valuation studies used cost-utility analysis which measure program cost in

[369] RHP Planning Protocol, page 398

dollars and the health consequences in utility-weighted units called quality-adjusted life-years (QALYs). QALYS incorporate costs averted when known (e.g., emergency department visits that are avoided).

Outcome Measure: 3IT-6.1 Percent improvement over baseline of patient satisfaction scores. A process milestone in Year 3 will establish baseline for improvement in patient satisfaction with overall health/functional status; Improvement targets in DYs 4 and 5 will establish percent improvement over baseline in patient satisfaction scores, ending Year 5 with a 20% improvement over baseline in patient satisfaction scores.

Size – In providing the new technology to clinical programs in the Region, the telemedicine program will require all of the needed infrastructure and support operations. This includes the implementation of data line enhancements, Internet-cloud private network connectivity (VPN), and server based audio/video processing and session management. The program will involve collection and maintenance of data on potentially 210 clients over the course of the Waiver period.

Project Scope – The proposed project is projected to measure satisfaction with improvement in overall health status/functional status for those receiving telemedicine/telehealth during the Waiver period. It is estimated the potential client base could reach 210 individuals over the Waiver period in Ellis and Navarro counties.

Population Served – The population targeted to be served are individuals with a primary behavioral health and/or dually diagnosed with IDD/ASD/MH (one or all of those diagnoses).

Community Benefit and Cost Avoidance – Improved satisfaction with overall health outcomes will lead to improved self-maintenance of physical and psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area will serve to "enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment"[370].

Addressing Priority Community Need – Currently there is no telemedicine/ telehealth program to support routine access to specialty care or for crisis respite/wraparound services in these two rural counties. This results in the frequent use of more restrictive and expensive settings for care, such as psychiatric hospitals, emergency departments and institutional settings.

[370] RHP Protocol, page 398

121988304.3.2	*3.IT- 6.1*	Percent improvement over baseline of patient satisfaction scores regarding patient's overall health status/functional status	
Lakes Regional MHMR Center			*TPI-121988304*
Related Category 1 or 2 Projects:	Lakes Regional Telemedicine/Telehealth Project #121304988.1.2 (1.7.1)		
Starting Point/Baseline:	Baseline for improvement of the target population in patient satisfaction with overall health status/functional status will be established in Year 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)**
N/A	**Process Milestone 1 [P-3]:** Develop and test data systems related to measuring patient satisfaction. Data Source: Project documentation and data systems Process Milestone 1 Estimated Incentive Payment: $**48,747**	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores Improvement Target: 10% improvement over baseline of patient satisfaction scores Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* ***$*52,148**	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores Improvement Target: 20% improvement over baseline of patient satisfaction scores Data Source: Patient Survey Outcome Improvement Target 3 Estimated Incentive Payment*:* ***$*113,366**
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount**: **$48,747**	**Year 4 Estimated Outcome Amount: $52,148**	**Year 5 Estimated Outcome Amount**: **$113,366**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $214,261**			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life (Stand-alone Measure

Unique RHP outcome identification number(s): 121988304.3.3 (Pass 2)
Performing Provider Name/TPI: Lakes Regional MHMR Center / 121988304

Outcome Measure Description:

Process Milestones:
In DY3: Process Measure (P-3) Develop and test data systems;

Improvement Target-10.1: Demonstrate 10% improvement in quality of life (QOL) scores measured by evidence-based and validated assessment tools for individuals.

Outcome Improvement Targets:
DY 4: Improvement Target-10.1 – Demonstrate 10% improvement in quality of life (QOL) scores measured by evidence-based and validated assessment tool for individuals.
DY5: Improvement Target-10.1 – Demonstrate 10% improvement in quality of life (QOL) scores as measured by evidence-based and validated assessment tool for individuals.

Rationale:
Process Milestone P-3 DY3 for Lakes Regional Mental Health Mental Retardation Center (LRMHMRC) in Region 10 will involve developing and testing data systems for administration of the QOL validation assessment tool, to ensure accuracy and efficiency in project-related data collection and management. Improvement Targets 10-1 in DYs 4 and 5 will involve administration of the QOL assessment tool to project participants (target population) and determining percentage of improvement in QOL scores. According to the RHP Protocol, two essential components of health-related quality of life are specific to improvement in symptoms and functioning. The RHP Protocol says, ". . .the best way to measure symptoms and functional status is by direct patient survey," and "effective quality improvement requires relentless focus on the patient outcomes" (RHP Protocol, p. 406). Measuring improvement in quality of life will allow project staff to work collaboratively with the target population to highlight the importance of implementing evidence-based approaches to care tailored to individual needs.

In addition, measuring improvement in QOL status will involve the target population in (1) being accountable for participation in consistent self-monitoring, and (2) exhibiting increased ability to manage challenging behaviors and symptoms, leading to greater quality of life satisfaction. Sharing survey results with other agencies and providers in the Region in a semiannual face-to-face learning collaborative regarding improvement in QOL status for the target population will pave the way for other service providers to make improvements in their approaches to the

provision of health care, leading to improved patient outcomes. Other providers in the Region will be made aware of the specialty needs of the target population and of efficacious, research-based approaches to provision of care that avert unnecessary placement in more restrictive settings. As baseline data is established in DY2, refinement of gross estimates of improvement target yearly percentages is expected through the PDSA process.

Outcome Measure Valuation:
The project will implement outcome measure 3-IT-10.1 to measure improvement of Quality of Life (QOL) scores. In keeping with the Waiver Program Funding and Mechanics (PFM) Protocol for the DSRIP pool, the approach to valuation followed the formula prescribed on page 27 of the document for Non-Hospital Performing Providers for Category 3 allowing DY2 5%, DY3 10%, DY4 10%, and DY5 20%. The project coordinator will ensure the protocol as set forth the SF-36 manuals will be followed for administering the QOL measure. This outcome measure will be valued by assessing community needs identified for Region 10 addressed through the RHP Plan, such as the need to address preventable acute care admissions and a need for additional health care providers who can address the specialty needs of the target population in a setting that is accessible. When patients do not have adequate supports and services in the community, they are more likely to utilize the ED and psychiatric hospital settings to manage crises, which escalate due to inability to access the right level of services at the right time. This affects the target populations' overall perception of quality of life factors and leads to a cycle of ineffective coping and inability to manage behaviors in the community. Supporting individuals in the community at a lesser cost than hospital or institutional care, and avoiding costs in emergency departments and psychiatric hospitals is a predictor of overall improvement in coordinated care in the community, and greater QOL satisfaction.

DY3 – Process Milestone (P-3) will involve existing Information Technology and Quality Management staff to select and install data systems for electronic medical record, scheduling and system data collection connected to Lakes Regional MHMR Center (LRMHMRC) parent data system. The pre- and postapplication of the survey and analysis of the data per individual will continue through DY5 to inform PDSA cycles.

DY4 – Improvement Target 10.1 is to establish an aggregate 10% improvement over individual entry baseline in QOL scores. Opening of services in DY3 will see the inclusion of the QOL instrument SF-36 at intake and the close of treatment beyond screening or crisis stabilization services for each individual participant of the Depression Trauma Counseling Center. Pre- and post-scores considered - on the same instrument in the individual's data will provide the outcome for individuals as well as across the services rendered. This QOL measure will be repeated for all treatment clients through FY5. It is expected that service recipients will experience improved overall satisfaction with services due to improved quality of life; improved satisfaction is

expected to lead to a decrease in ED -, as well as improved ability to successfully and consistently self-manage challenging behaviors and symptoms in the community.

DY5 – Improvement Target 10.1 to maintain the aggregate 10% improvement in QOL scores. Since average length of stay is anticipated to be 7-10 weeks- with 70 unique individual participants in the DY3 start-up and the clinic growth at 20% = 84 in DY4 and 30%=109 in DY5, the aggregate pool should grow beyond the minimum 263 unique individuals: See approach/methodology for IT-10.1 for DY4.

Outcome Measures
3IT-10.1 Quality of Life. The quality of life measure SP-36 includes 36 items categorized into eight scales that measure physical health and mental health. It has established validity, and the MH scales have been shown to be useful in screening for psychiatric disorders.

Size: The project staff will administer QOL surveys; provide monitoring, follow-up and documentation of responses, and collection and maintenance of data on minimally 263 respondents - receiving care in the project.

Project Scope: The proposed project is projected to demonstrate 10% improvement in quality of life factors as measured by a validated assessment tool by DY5 in approximately 100 individuals per year utilizing the services in LRMHMRC RHP 10 counties.

Population Served: The population targeted is - individuals who have depression or trauma-related symptoms and do not qualify for State-supported services to the SMI population. This includes individuals referred by hospitals, police and other sources due to lack of ability to afford private care.

Community Benefit and Cost Avoidance: Improved satisfaction with quality of life factors will lead to improved self-management of psychiatric health outcomes, as well as less frequent need for hospital visits and stays that result from crisis/exacerbation of symptoms. Consistently implementing monitoring and follow-up in the approach to care will lead to cost avoidance, in that patients will no longer require the support of more expensive settings for symptom maintenance. Sharing evidence-based data with other providers on patient satisfaction in this area will serve to "enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment" (RHP Protocol, p. 398).

Addressing Priority Community Need: Currently there is no accessible safety net program in the targeted area to serve the needs of the target population when in crisis, resulting in the frequent use of more restrictive and expensive settings for care, such as psychiatric hospitals and

institutional settings. The project relates to the Region 10 CN. 4 Lack of access to mental health services and CN. 10 Overuse of emergency department (ED) services.

121988304.3.3	3.IT-10.1	Quality of Life	
Lakes Regional MHMR Centers			121988304
Related Category 1 or 2 Projects:	**Category 1:** 121988304.1.3 Depression Trauma Counseling Center		
Starting Point/Baseline:	New Project – Build baseline 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)**
N/A (Starts in DY-3)	**Process Milestone 1 [P-3]:** Develop and test data systems Determine and install clinical charting software. Determine screening and intake protocols. **Data Source**: Program records, EMR operational **Process Milestone 1 Estimated Incentive Payment: $75,668**	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life **Improvement Target:** Improvement of 10% in Quality of Life scores as measured by the SP-36 on aggregate treatment participants. **Data Source**: EMR, Project reports **Outcome Improvement Target 1 Estimated Incentive Payment: $81,080**	**Outcome Improvement Target 2** [IT-10.1]: Quality of Life Improvement Target: Improvement of 10% in Quality of Life scores as measured by the SP-36 on aggregate treatment participants. **Data Source**: EMR, Project reports **Outcome Improvement Target 2 Estimated Incentive Payment: $176,262**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $N/A	Year 3 Estimated Outcome Amount: **$75,668**	Year 4 Estimated Outcome Amount: **$81,080**	Year 5 Estimated Outcome Amount: **$176,262**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $333,010			

Title of Outcome Measure (Improvement Target): IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 057620 (Stand-alone measure)

Unique RHP outcome identification number(s): 126675104.3.1
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1 is the percentage of members who received follow-up within 30 days of discharge. Rate 2 is the percentage of members who received follow-up within 7 days of discharge. In DY2, there are 2 process milestones established. The first is for project planning where we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. The second is the development and testing of data systems. In DY3, there are 2 process milestones established. The first is to establish the baseline rates of follow-Up After Hospitalization for Mental Illness. The second milestone is the completion of PDSA cycles to improve data collection and intervention activities. The final process milestone is the establishment of the outcome targets for IT-1.18 Rate 1 and Rate 2. There are two milestones related to managing the data systems to prepare for reporting related to the seven- and 30-day follow-up rates. There are two process milestones related to establishing the current benchmark related to seven and 30-day follow-up rates. In DY4 and DY5 there is one outcome target for each rate in each year. The improvement target is to improve both seven- and 30-day follow-up rates by a percentage to be determined in DY3.

Rationale:

This outcome measure was selected because improved follow-up rates for adherence to outpatient visits for patients discharging from behavioral health hospitals reduces 30-day behavioral health readmission rates. The process milestones in DY2 and DY3 were selected to enable the provider to be able to accurately identify and report the rate of follow-up care. Currently, this is not accurately monitored so process steps are required for successful reporting and documentation of the impact of the project. The target rate of improvement will be selected based on multiple factors. Particularly, the patients' level of engagement and commitment to on-going care is critical. Additionally, many patients hospitalized in Trinity Springs Pavilion will receive follow-up care with MHMR of Tarrant County or other behavioral health providers with whom we cannot guarantee appointment availability. For those who do follow-up within JPS Health Network, their internal commitment to on-going care is further complicated by the high percentage of involuntary psychiatric admissions experienced in our system.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.1	*3.IT- 1.18*	*IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 057620 (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.1: Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the Region where access to care is likely to be limited.		
Starting Point/Baseline:	Target Population: Specific Number: 457 unique patients annually (1,371 unique patients for DY3, DY4, and DY5) Description of Population: Additional patients accessing outpatient behavioral health services in expanded hours/services. Baseline data: No baseline data exists. Baseline rates and improvement targets 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-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Documentation/Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $78748 **Process Milestone 2** [P-3]:Develop and test data systems Data Source: EMR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $78747	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: EMR, Encounter Data, Claims Systems Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $91279 **Process Milestone 4** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Data Reports, PDSA Summaries Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $91279 **Process Milestone 5** [P-7]: Establish outcome targets for IT-1.18 Rate 1	**Outcome Improvement Target 1** [IT-1.18]: Rate 1 – Improve baseline number of patients who received care within 30 days Improvement Target: TBD in DY3 Data Source: Readmission Report, EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $146471 **Outcome Improvement Target 2** [IT-1.18]: Rate 2 – Improve baseline number of patients who received care within 7 days Improvement Target: TBD in DY3 Data Source: Readmission Report, EMR Outcome Improvement Target 2	**Outcome Improvement Target 3** [IT-1.18]: Rate 1 – Improve baseline number of patients who received care within 30 days Improvement Target: TBD in DY3 Data Source: Readmission Report, EMR Outcome Improvement Target 3 Estimated Incentive Payment*:* $350256 **Outcome Improvement Target 4** [IT-1.18]: Rate 2 – Improve baseline number of patients who received care within 7 days Improvement Target: TBD in DY3 Data Source: Readmission Report, EMR Outcome Improvement Target 4

126675104.3.1	*3.IT- 1.18*	*IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 057620 (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.1: Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the Region where access to care is likely to be limited.		
Starting Point/Baseline:	Target Population: Specific Number: 457 unique patients annually (1,371 unique patients for DY3, DY4, and DY5) Description of Population: Additional patients accessing outpatient behavioral health services in expanded hours/services. Baseline data: No baseline data exists. Baseline rates and improvement targets 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)**
	and Rate 2 Data Source: Data Reports, Baseline Process Milestone 5 Estimated Incentive Payment *(maximum amount):* $91279	Estimated Incentive Payment*:* $146470	Estimated Incentive Payment*:* $350256
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $157,495	Year 3 Estimated Outcome Amount: $273,837	Year 4 Estimated Outcome Amount: $292,941	Year 5 Estimated Outcome Amount: $700,512
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,424,786			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization – Reduce Emergency Department visits for behavioral health/substance abuse

Unique RHP outcome identification number(s): 126675104.3.2
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

This measure assesses ED appropriate utilization. Specifically, the reduction in Emergency Department visits for target conditions – Behavioral Health/Substance Abuse.

Process Milestones:

- In DY2, there a milestone is established for project planning where we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- In DY3, there are 2 process milestones established. The first is to establish the baseline rate of PEC utilization after discharge. The second milestone is the completion of the establishment of the outcome targets for IT-9.2.

Outcome Improvement Targets for each year:

- In DY4 and DY5 there is one outcome target for each rate in each year. The improvement target is to reduce the emergency department visits for those discharged from Trinity Springs Pavilion by a percentage to be determined in DY3.

Rationale:

This outcome measure was selected because JPS Health Network experiences over 24,000 Psychiatric Emergency Center (ED) visits per year. The expanded outpatient hours and days of service will ensure patients have greater opportunity to engage in services outside of the emergency system. This measure also directly impacts our identified community needs. There overuse of the emergency department services (CN.10). Additional outpatient services will result in reduced utilization of the emergency services because patients will remain more stable in community-based services.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost

savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.2	*3.IT- 9.2*	*IT 9.2 ED appropriate utilization*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.1: Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the Region where access to care is likely to be limited.		
Starting Point/Baseline:	Target Population: Specific Number: 457 unique patients annually (1,371 unique patients for DY3, DY4, and DY5) Description of Population: Additional patients accessing outpatient behavioral health services in expanded hours/services. Baseline data: No baseline data exists. Baseline rates and improvement targets 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-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR, Encounter Data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $31,499	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: EMR, Encounter Data Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $27384 **Process Milestone 3** [P-7]: Establish outcome targets for IT-9.2 Data Source: EMR, Encounter Data Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $27383	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate utilization – reduce Emergency Department visits for target conditions – Behavioral Health/Substance Abuse Improvement Target: TBD in DY3 Data Source: EMR, Encounter Data Outcome Improvement Target 1 Estimated Incentive Payment*:* $58,588 Report, EMR	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate utilization – reduce Emergency Department visits for target conditions – Behavioral Health/Substance Abuse Improvement Target: TBD in DY3 Data Source: EMR, Encounter Data Outcome Improvement Target 2 Estimated Incentive Payment: $140,102 Report, EMR
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,499	Year 3 Estimated Outcome Amount: $54,767	Year 4 Estimated Outcome Amount: $58,588	Year 5 Estimated Outcome Amount: $140,102

126675104.3.2	*3.IT- 9.2*	*IT 9.2 ED appropriate utilization*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.1: Establish extended operating hours at a select number of local mental health clinics or other community-based settings in areas of the Region where access to care is likely to be limited.		
Starting Point/Baseline:	Target Population: Specific Number: 457 unique patients annually (1,371 unique patients for DY3, DY4, and DY5) Description of Population: Additional patients accessing outpatient behavioral health services in expanded hours/services. Baseline data: No baseline data exists. Baseline rates and improvement targets 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $284,957			

Title of Outcome Measure (Improvement Target): IT-3.1 – All-cause 30-Day Readmission Rate

Unique RHP outcome identification number(s): 126675104.3.3
Performing Provider Name/TPI: JPS Health Network/126675104
Outcome Measure Description:
By the end of the Waiver, our goal is to reduce all-cause 30-day readmission rates by 15% to achieve < 1502 readmissions with a current unverified baseline of 1767 all cause readmissions for FY2011.

Process Milestones:
Our milestones include the following:

- In DY2, the - the baseline will be verified and data systems validated.

Outcome Improvement Targets for each year:

- In DY3, our goal is reduce all cause 30 day readmission rates by 5% with a goal of <1678 readmissions. Ongoing analysis and process improvement efforts will be employed to assist in reaching goals.
- In DY4, our goal is to -reduce all cause readmission rates by 10% with a goal of <1590.

Rationale:

The implementation of a centralized call center with nurse advice available 24/7 will reduce potentially preventable admissions and readmissions by directing patients to the right place for care. The high cost of emergency department care will be reduced as patients are directed back to their medical home for care or other appropriate community resources. The overutilization of the ED has been identified by the Community Needs Assessment as an opportunity for intervention. A nurse advice line has been shown to be an effective strategy in the reduction of preventable ED admissions. [371,372]

Patients who receive regular care in the ED often lack care continuity and use costlier services than those folks who are provided urgent care in their primary medical home. [373]This same study also found that non-emergent ED visits are especially common in low income populations where primary care capacity is limited or not responsive to the needs of the patient population.

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[371] Kempe A, Kempsey C, Whitefiled J, et al. Appropriateness of urgent referrals by nurse at a hospital-based pediatric call center. Archives of Pediatric and Adolescent Medicine. 2000;154:355-360.

[2] Kempe A, Luberti A, Belman S, et.al. Outcomes associated with pediatric after-hours care by call center: a multicenter study. Ambulatory Pediatrics. 2003:3(4),211-217.

373Billings J, Parkih, N, Mijanovich T. Emergency Department Use in New York City: A Substitute for Primary Care. The Commonwealth Fund Issue Brief. November 2000. Reviewed online at www.cmwf.org

4 Minott J. Reducing Hospital Readmissions. Reviewed www.academyhealth.org

Both Health and Human Services (HHS) and the National Quality Forum have endorsed measures that address reducing all-cause readmission rates. Readmission rates have been attributed to many factors but have been shown to impact the low income population with more severity as the availability of social support can be limited in these populations. Additionally, a lack of coordinated care and poor system communication has been shown to impact readmission rates. [4] This same study compilation reported that some health plans had focused on decreasing the inappropriate use of 911 as an effective measure to reduce readmissions. The implementation of the 24/7 nurse advice team will assist with directing patients to appropriate care. The best method to reduce readmission is to prevent the initial admission. Keeping patients connected to their Medical Home is foundational to improving this outcome.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.3	IT-3.1	All-cause 30-day Readmissions	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.1.2: Enhance Urgent Medical Advice		
Starting Point/Baseline:	Target Population: Current and prospective patients seeking medical advice that have had an inpatient stay within 30 days in the JPS Health Network System Specific Number: 1211 patients who had readmissions in FY2011 Description of Population: Patients accessing care in the JPS Network System with one admission all payers Baseline data: 1211 patients had 1767 readmissions in FY2011, data to be verified and validated in DY2 If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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]: Verify and validate 30-day readmission data for all payors Data Source: Claims Data, EMR and Lawson Financial Data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $136982 **Process Milestone 2** [P-2}: Identify and engage stakeholders and determine focus areas. Identify population risk strategies. Include both internal and external resources. Data Source: Meeting Minutes Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $136982 **Process Milestone 3** [P-3]: Analyze and interpret data, develop	**Process Milestone 4** [P-4}: Use lessons learned and PDSA cycles to adjust improvement plan to meet improvement targets established. Data Source: Lessons learned document with improvement strategies Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $357254 **Outcome Improvement Target 1** [5.1]: Reduce all-cause readmission rate by 5% over baseline verified DY2 - <1678 readmissions Improvement Target: 5% improvement over baseline Data Source: Lawson financial data, EMR and claims data Outcome Improvement Target 1 Estimated Incentive Payment*:*	**Outcome Improvement Target 2** [IT-3.1]: Reduce all-cause 30-day readmission rate by 10% over baseline verified in DY2 - < 1590 readmissions Improvement Target:10% over baseline verified in DY2 Data Source: Lawson financial data, EMR and claims data Outcome Improvement Target 2 Estimated Incentive Payment*:* $764,358	**Outcome Improvement Target 3** [IT-3.1]: Reduce all-cause 30-readmission rate by 15% over baseline verified in DY2 - < 1502 readmissions Improvement Target:15% over baseline Data Source: Lawson financial data, EMR and claims data Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,827,812

126675104.3.3	IT-3.1	All-cause 30-day Readmissions	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.1.2: Enhance Urgent Medical Advice		
Starting Point/Baseline:	Target Population: Current and prospective patients seeking medical advice that have had an inpatient stay within 30 days in the JPS Health Network System Specific Number: 1211 patients who had readmissions in FY2011 Description of Population: Patients accessing care in the JPS Network System with one admission all payers Baseline data: 1211 patients had 1767 readmissions in FY2011, data to be verified and validated in DY2 If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
improvement plan to achieve outcome improvement targets Data Source: Documented plan and verification of dissemination Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $136981	$357254		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $410,945	Year 3 Estimated Outcome Amount: $714,508	Year 4 Estimated Outcome Amount: $764,358	Year 5 Estimated Outcome Amount: $1,827,812
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$3,717,623			

Title of Outcome Measure (Improvement Target): IT 9.2 – Reduce Emergency Department Visits for Targeted Conditions in the Medical Home Population

Unique RHP outcome identification number(s): 126675104.3.4

Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

By the end of the Waiver, our goal is to reduce avoidable ED admissions by - 10% or 2100 visits.

Process Milestone:

-;

- In DY2, we will validate and verify our initial data and identify gaps in care.

Outcome Improvement Targets for Each Year:

- In DY3, a system of referral coordination and risk stratification will assist in meeting the goal of reducing admissions by - 2% and reduce avoidable admissions by 420 visits.
- In DY4, our goal is to reduce avoidable admissions by - 5% or 1050 avoidable admissions.
- Ongoing gap analysis and process improvement efforts will be employed throughout the Waiver years to reach improvement targets. Current baseline for the targeted population is 21,000 potentially preventable ED visits. DY5 will see a reduction to <18, 900 potentially preventable ED visits.

Rationale:

The addition of a 24/7 nurse advice team and centralized call center will provide timely medical advice and/or direct access to the appropriate place for care (either medical home, ED, Urgent Care or other community resources). Data will need to be validated in DY2 to determine magnitude of potential preventable admissions, determine level or risk due to care gaps, engage system stakeholders in process changes JPS Health Network will use the NYU ED algorithm to validate potentially preventable admissions.[374] In a briefing released by the Commonwealth Fund based on ED use in New York City, care provided in the ED was determined to be generally costlier than providing the same care in a medical home. [375] Recommendations from the study included expanding primary care capacity and linkages to medical homes. This project is closely tied to the development of the Patient-centered Medical Home project that is also under consideration.

Outcome Measure Valuation:

374http://wagner.nyu.edu/faculty/billings/nyued-background.php

375Billings J, Parikh N, Mijanovich T. Emergency Department use in New York City: A Substitute for Primary Care? The Commonwealth Fund. Issue Brief November 2000.

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.4	IT-9.2	ED Appropriate Utilization	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.1.2: Enhance Urgent Medical Advice		
Starting Point/Baseline:	Target Population: Current and Prospective JPS Medical Home Specific Number: 68,000 Medical Home Patients Description of Population: Potentially preventable care provided in the ED for the JPS Medical Home population Baseline data: 21,000 potentially preventable admissions in FY2011, this data is not validated If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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]: Verify and validate baseline data for current eligible Medical Home patients with the listed conditions that have also had an ED visit, stratify risk by condition and determine gaps in care Data Source: EMR and claims data, Crimson or other stratification systems Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $308,579	**Process Milestone 2** [P-2]: Analyze patient admissions, identify gaps in care and extend training to both providers and patients about the 24/7 medical advice program Data Source: Analysis and documented plan Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $268263 **Outcome Improvement Target 1** [IT-9.2]: Reduction in ED admission rates for targeted population by 2%Targeted population is defined as patients empanelled in the medical home. Improvement Target: Reduce avoidable admissions by 420 from baseline (DY2) or < 20,580 ED admission for the targeted population	**Outcome Improvement Target 2** [IT-9.2]: Reduction in ED admission rates for targeted population by 5% Improvement Target: Reduce avoidable admissions by 1050 admissions from baseline (DY2) or < 19,950 ED admissions for the targeted population Data Source: EMR and claims data Outcome Improvement Target 2 Estimated Incentive Payment*:* $573,957	**Outcome Improvement Target 3** [IT-9.2]: Reduction in ED admission rates for targeted population by 10% Improvement Target: Reduce avoidable admissions by 2100 admissions from baseline (DY2) or <18,900 ED admissions for the targeted population Data Source: EMR and claims data Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,372,506

126675104.3.4	IT-9.2	ED Appropriate Utilization	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.1.2: Enhance Urgent Medical Advice		
Starting Point/Baseline:	Target Population: Current and Prospective JPS Medical Home Specific Number: 68,000 Medical Home Patients Description of Population: Potentially preventable care provided in the ED for the JPS Medical Home population Baseline data: 21,000 potentially preventable admissions in FY2011, this data is not validated If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
	Data Source: EMR and claims data Outcome Improvement Target 1 Estimated Incentive Payment*:* $268262		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $308,579	Year 3 Estimated Outcome Amount: $536,525	Year 4 Estimated Outcome Amount: $573,957	Year 5 Estimated Outcome Amount: $1,372,506
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$2,791,567			

Title of Outcome Measure (Improvement Target): IT-1.12 Diabetes Care: Retinal eye exam

Unique RHP outcome identification number(s): 126675104.3.5
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

By the end of the Waiver, our goal is to improve compliance with retinal eye exam to 60% over baseline of our eligible medical home population (total of 8,597 patients will have received routine eye exam). Our milestones include the following:

Process Milestones:

- In DY2, we will verify and test the baseline rate for this data. An initial pull from our EMR shows a compliance rate of 32% for our eligible population. This data is taken from FY2011.

Outcome Improvement Targets for each year:

- In DY3, our goal is to reach 25% compliance over baseline. This goal will impact the 17,000 diabetic patients in our Medical Home that require an annual eye exam. A 25% improvement rate will mean that 6,716 diabetic patients will have an annual eye exam.
- In DY4, our goal is reach 50% compliance over baseline of the eligible population**.** This goal will impact the 17,000 diabetic patients in our Medical Home that require an annual eye exam. A 50% improvement rate will mean that 8,059 diabetic patients will have an annual eye exam.

Rationale:

The rate of diabetes types 1 and 2 in the JPS Health Network medical home population is 25%, a rate much higher than the county or state. In a sample population of our highest utilizers (users who have been admitted in the ED or inpatient area with potentially preventable diagnoses) diabetes is identified as a predictor of ED utilization. Routine eye exams for diabetic patients can reduce the severity of eye disease and may prevent blindness.

Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome

over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.5	***IT-1.12***	Diabetes Care: Retinal eye exam	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.3: Expand Specialty Care for Ophthalmology and Wound Care		
Starting Point/Baseline:	*32% of Medical Home Population with a diagnosis of diabetes or 5,373 of 17,041 eligible 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]: Verify and validate baseline data Data Source: EMR and claims data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $158,513 **Process Milestone 2** [P-2]: Review data and determine improvement implementation guidelines and resources needed Data Source: Documented improvement plan Process Milestone 2 Estimated Incentive Payment: $158,514	**Process Milestone 3** [P-3]: Conduct PDSA cycles to improve data collection and intervention activities. Target low performers. Data Source: Documented intervention activities, lessons learned and best practice shared Process Milestone 3 Estimated Incentive Payment: $275607 **Outcome Improvement Target 1** [IT-1.1]: Improvement Target: Improve compliance with retinal eye exam by 25% over established baseline (6,716 patients) Data Source: EMR and claims data Outcome Improvement Target 1 Estimated Incentive Payment*:* $275606	**Outcome Improvement Target 2** [IT-1.2]: Improvement Target: Improve compliance with retinal eye exam by 50% over baseline (8,059 patients) Data Source: EMR and claims data Outcome Improvement Target 2 Estimated Incentive Payment*:* $589,670	**Outcome Improvement Target 3** [IT-1.3]: Improvement Target: Improve compliance with retinal eye exam by 60% over baseline (8,597 patients) Data Source: EMR and claims data Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,410,079

126675104.3.5	***IT-1.12***	Diabetes Care: Retinal eye exam	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.3: Expand Specialty Care for Ophthalmology and Wound Care		
Starting Point/Baseline:	*32% of Medical Home Population with a diagnosis of diabetes or 5,373 of 17,041 eligible 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $317,027	Year 3 Estimated Outcome Amount: $551,213	Year 4 Estimated Outcome Amount: $589,670	Year 5 Estimated Outcome Amount: $1,410,079
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,867,988			

Title of Outcome Measure (Improvement Target): IT-5.3 Other: reduce cost of care of patients with a primary or secondary diagnosis of pressure ulcer (707.xx)

Unique RHP outcome identification number(s): 126675104.3.6
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

By the end of the Waiver, our goal is to reduce the cost of inpatient care for patients with a primary or secondary diagnosis of pressure ulcer (707.xx) by 30%.

Process Milestones:

- In DY2, the baseline data will be verified and validated. Data reported for FY2011 shows a baseline of 794 admissions with an average cost per stay of $21, 422.36 based on the overall cost to charge ratio.

Outcome Improvement Targets for each year:

- In DY3, our goal is to reduce the cost of inpatient care for patients with a primary or secondary diagnosis of pressure ulcer (707.xx) by 10%. This measure will impact the approximately 794 annual admissions with the diagnosis.

- In DY4, our goal is to reduce the cost of inpatient care for patients with a primary or secondary diagnosis of pressure ulcer (707.xx) by 20%. This measure will impact the approximately 794 annual admissions with the diagnosis.

Rationale:

A comprehensive wound program will provide many advantages to the JPS Health Network. There is currently no program, only 2 wound care nurses and a tech serving a patient population that has not been quantified as yet. There is some coordination from hospital to home for those patients who are prescribed a wound vacuum but we have not tracked the patients who are readmitted or seen in the ED for care of wounds or postsurgical infections. A program plan will have to be developed, vetted and a medical director hired with expertise in wound care. A multidisciplinary team will be brought together to care for patients across the network.

There have been several studies showing the relationship between pressure ulcers and length of stay. [376,377] In both studies, the median excess length of stay was over 4 days when a patient developed a pressure ulcer. Even when adjusted for admission severity of illness, the cost of care remained significantly greater according to the Allman study.

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[376] Allman, R, Goode, P, Burst N, et al. Pressure ulcers, hospital complications, an disease severity: impact on hospital costs and length of stay. Adv Wound Care. 1999 Jan-Feb;12(1):22-30
[377] Graves N, Birrell F, Whitby M. Effect of pressure ulcers on length of hospital stay. Infect Control Hosp Epidemiol. 2005 Mar;26(3):293-7.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.6	***IT-5.3***	***IT-5.3 Other cost of care – Reduction in cost of care for inpatients with a primary diagnosis or secondary diagnosis of pressure ulcer (707.xx)***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.3: Expand Specialty Care for Ophthalmology and Wound Care		
Starting Point/Baseline:	*Average cost of stay for primary or secondary diagnosis of 707.xx was $21,422.36 in FY2011*		
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]: Engage stakeholders, identify resources needed, document implementation plans Data Source: Documented improvement plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $7599 **Process Milestone 2** [P-2]: Verify and validate data Data Source: EMR and claims data Process Milestone 2 Estimated Incentive Payment: $7599	**Process Milestone 3** [P-3]: Review data, determine gaps and plan focused interventions to meet improvement targets Data Source: Documented improvement plan and goal to meet improvement targets Process Milestone 3 Estimated Incentive Payment: $13213 **Outcome Improvement Target 1** [IT-1.1]: Improvement Target: Reduce cost of stay for inpatients with a primary or secondary diagnosis of pressure ulcer (707.xx) by 10% or $2100 Data Source: EMR and claims data Rationale: For those hospitalized patients with a pressure ulcer, the cost of care was found to be significantly greater even when adjusted for admission for severity of illness. The JPS Network had 794 admissions with pressure ulcers as a primary or secondary diagnosis in FY2011 with an average cost per stay of $21,422.36. Rate of	**Outcome Improvement Target 2** [IT-1.2]: Improvement Target: Reduce cost of stay for inpatients with a primary or secondary diagnosis of pressure ulcer (707.xx) by 20% or $4200. Rate of reduction will be measured by including all admitted patients with diagnosis during the fiscal year. Data Source: EMR and claims data Outcome Improvement Target 2 Estimated Incentive Payment*:* $28,269	**Outcome Improvement Target 3** [IT-1.3]: Improvement Target: Reduce cost of stay for inpatients with a primary or secondary diagnosis of pressure ulcer (707.xx) by 30% or $6400. Rate of reduction will be measured by including all admitted patients with diagnosis during the fiscal year. Data Source: EMR and claims data Outcome Improvement Target 3 Estimated Incentive Payment $67,600

126675104.3.6	***IT-5.3***	***IT-5.3 Other cost of care – Reduction in cost of care for inpatients with a primary diagnosis or secondary diagnosis of pressure ulcer (707.xx)***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.3: Expand Specialty Care for Ophthalmology and Wound Care		
Starting Point/Baseline:	*Average cost of stay for primary or secondary diagnosis of 707.xx was $21,422.36 in FY2011*		
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)**
	reduction will be measured by including all patients with diagnosis. Data Source: EMR and claims data Outcome Improvement Target 1 Estimated Incentive Payment*:* $13212		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $15,198	Year 3 Estimated Outcome Amount: $26,425	Year 4 Estimated Outcome Amount: $28,269	Year 5 Estimated Outcome Amount: $67,600
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $137,493			

Title of Outcome Measure (Improvement Target): IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 057620 (Stand-alone measure)

Unique RHP outcome identification number(s): 126675104.3.7
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1 is the percentage of members who received follow-up within 30 days of discharge. Rate 2 is the percentage of members who received follow-up within 7 days of discharge

Process Milestones:

- In DY2, there are 2 process milestones established. The first is for project planning where we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. The second is the development and testing of data systems.
- In DY3, there are 2 process milestones established. The first is to establish the baseline rates of follow-Up After Hospitalization for Mental Illness. The second milestone is the completion of PDSA cycles to improve data collection and intervention activities. The final process milestone is the establishment of the outcome targets for IT-1.18 Rate 1 and Rate 2. There are two milestones related to managing the data systems to prepare for reporting related to the seven and 30-day follow-up rates. There are two process milestones related to establishing the current benchmark related to seven and 30-day follow-up rates

Outcome Improvement Targets for each year:

- In DY4 and DY5 there is one outcome target for each rate in each year. The improvement target is to improve both seven and 30-day follow-up rates by a percentage to be determined in DY3.

Rationale:

This outcome measure was selected because improved follow-up rates for adherence to outpatient visits for patients discharging from behavioral health hospitals reduces 30-day behavioral health readmission rates. The process milestones in DY2 and DY3 were selected to enable the provider to be able to accurately identify and report the rate of follow-up care. Currently, this is not accurately monitored so process steps are required for successful reporting and documentation of the impact of the project. The target rate of improvement will be selected

based on multiple factors. Particularly, the patients' level of engagement and commitment to on-going care is critical. Additionally, many patients hospitalized in Trinity Springs Pavilion will receive follow-up care with MHMR of Tarrant County or other behavioral health providers with whom we cannot guarantee appointment availability. For those who do follow-up within JPS Health Network, their internal commitment to on-going care is further complicated by the high percentage of involuntary psychiatric admissions experienced in our system.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.7	*3.IT- 1.18*	*IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 057620 (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.4: Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care)		
Starting Point/Baseline:	Target Population: Specific Number: DY2 = 91, DY3 = 618, DY4 = 858, DY5 = 858. Total for DY2-5 is 2,425 patients Description of Population: Patients who will be served in new service locations Baseline data: In FY2011, existing clinics served 8,224 unique 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: Project Documentation/Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $147846 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EMR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $147846	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: EMR, Encounter Data, Claims Systems Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $171373 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Data Reports, PDSA Summaries Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $171373 **Process Milestone 5** [P-7]: Establish outcome targets for IT-1.18 Rate 1	**Outcome Improvement Target 1** [IT-1.18]: Rate 1 – Improve baseline number of patients who received care within 30 days Improvement Target: TBD in DY3 Data Source: Readmission Report, EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $274993 **Outcome Improvement Target 2** [IT-1.18]: Rate 2– Improve baseline number of patients who received care within 7 days Improvement Target: TBD in DY3 Data Source: Readmission Report, EMR Outcome Improvement Target 2	**Outcome Improvement Target 3** [IT-1.18]: Rate 1 – Improve baseline number of patients who received care within 30 days Improvement Target: TBD in DY3 Data Source: Readmission Report, EMR Outcome Improvement Target 3 Estimated Incentive Payment*:* $657593 **Outcome Improvement Target 4** [IT-1.18]: Rate 2 – Improve baseline number of patients who received care within 7 days Improvement Target: TBD in DY3 Data Source: Readmission Report, EMR Outcome Improvement Target 5

126675104.3.7	*3.IT- 1.18*	*IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 057620 (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.4: Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care)		
Starting Point/Baseline:	Target Population: Specific Number: DY2 = 91, DY3 = 618, DY4 = 858, DY5 = 858. Total for DY2-5 is 2,425 patients Description of Population: Patients who will be served in new service locations Baseline data: In FY2011, existing clinics served 8,224 unique 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)**
	and Rate 2 Data Source: Data Reports, Baseline Process Milestone 5 Estimated Incentive Payment *(maximum amount):* $171372	Estimated Incentive Payment*:* $274993	Estimated Incentive Payment*:* $657592
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $295,692	Year 3 Estimated Outcome Amount: $514,118	Year 4 Estimated Outcome Amount: $549,986	Year 5 Estimated Outcome Amount: $1,315,185
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,674,980			

Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure)

Unique RHP outcome identification number(s): 126675104.3.8
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

This measure identifies the behavioral health, all-cause readmission within 30 days of hospital discharge after an index admission for patients ages 18 and older.

Process Milestones:

- In DY2, there are 2 process milestones established. The first is for project planning where we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. The second is the development and testing of data systems.
- In DY3, there are 2 process milestones established. The first is to establish the baseline rates of behavioral health 30-day readmission rate. The second milestone is the completion of PDSA cycles to improve data collection and intervention activities. The final process milestone is the establishment of the outcome targets for IT-3.8.

Outcome Improvement Targets for each year:

- In DY4 and DY5 there is one outcome target for each rate in each year. The improvement target is to improve behavioral health 30-day readmission rates by a percentage to be determined in DY3.

Rationale:

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Given data limitations, only readmissions to the same facility will be included as part of each hospital's rates. The process outcome selected was a required building blocks to accurately identify the baseline rates of patients who readmit within 30 days. The process measure related to identifying the baseline rates is a critical step that must be accomplished before improvement targets for increasing rates of depression remission can be compared. Improvement targets for DY4 and DY5 will result in a total reduction of all-cause psychiatric readmissions by a percentage established in DY3. A reduction amount will be selected with consideration being given to the significant complexity of those who receive services in Trinity Springs Pavilion.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.8	*3.IT-3.8*	*IT-3.8 Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects::	126675104.1.4: Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care)		
Starting Point/Baseline:	Target Population: Specific Number: DY2 = 91, DY3 = 618, DY4 = 858, DY5 = 858. Total for DY2-5 is 2,425 patients Description of Population: Patients who will be served in new service locations Baseline data: In FY2011, existing clinics served 8,224 unique 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: Project Documentation/Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 11806 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EMR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $11805	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: EMR, Encounter Data, Claims Systems Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $13684 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Data Reports, PDSA Summaries Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $13684 **Process Milestone 5** [P-7]: Establish outcome targets for IT-3.8	**Outcome Improvement Target 1** [IT-3.8]: Improve baseline number of behavioral health/substance abuse 30-day readmission rate Improvement Target: TBD in DY3 Data Source: EMR, Encounter Data Outcome Improvement Target 1 Estimated Incentive Payment*:* $43,916	**Outcome Improvement Target 2** [IT-3.8]: Improve baseline number of behavioral health/substance abuse 30-day readmission rate Improvement Target: TBD in DY3 Data Source: EMR, Encounter Data Outcome Improvement Target 2 Estimated Incentive Payment*:* $105,018

126675104.3.8	*3.IT-3.8*	*IT-3.8 Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects::	126675104.1.4: Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care)		
Starting Point/Baseline:	Target Population: Specific Number: DY2 = 91, DY3 = 618, DY4 = 858, DY5 = 858. Total for DY2-5 is 2,425 patients Description of Population: Patients who will be served in new service locations Baseline data: In FY2011, existing clinics served 8,224 unique 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)**
	Data Source: Data Reports, Baseline Process Milestone 5 Estimated Incentive Payment *(maximum amount):* $13684		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $23,611	Year 3 Estimated Outcome Amount: $41,052	Year 4 Estimated Outcome Amount: $43,916	Year 5 Estimated Outcome Amount: $105,018
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $213,597			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization – Reduce Emergency Department visits for behavioral health/substance abuse

Unique RHP outcome identification number(s): 126675104.3.9
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

This measure assesses ED appropriate utilization. Specifically, the reduction in Emergency Department visits for target conditions – Behavioral Health/Substance Abuse.

Process Milestones:

- In DY2, there a milestone is established for project planning where we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
- In DY3, there are 2 process milestones established. The first is to establish the baseline rate of PEC utilization after discharge. The second milestone is the completion of the establishment of the outcome targets for IT-9.2.

Outcome Improvement Targets for each year:

- In DY4 and DY5 there is one outcome target for each rate in each year. The improvement target is to reduce the emergency department visits for those discharged from Trinity Springs Pavilion by a percentage to be determined in DY3.

Rationale:

This outcome measure was selected because JPS Health Network experiences over 24,000 Psychiatric Emergency Center (ED) visits per year. The increased outpatient locations will ensure patients engage in their individualized care plan enhancing stabilization and service utilization outside of the emergency system. This measure also directly impacts our identified community needs. There overuse of the emergency department services (CN.10). Improve transition management will result in reduced utilization of the emergency services because patients will remain more stable in community-based services.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these

metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.9	*3.IT- 9.2*	*IT 9.2 ED appropriate utilization*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.4: Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care)		
Starting Point/Baseline:	Target Population: Specific Number: DY2 = 91, DY3 = 618, DY4 = 858, DY5 = 858. Total for DY2-5 is 2,425 patients Description of Population: Patients who will be served in new service locations Baseline data: In FY2011, existing clinics served 8,224 unique 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: EMR, Encounter Data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $46,228	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: EMR, Encounter Data Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $40188 **Process Milestone3** [P-7]: Establish outcome targets for IT-9.2 Data Source: EMR, Encounter Data Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $40189	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate utilization – reduce Emergency Department visits for target conditions – Behavioral Health/Substance Abuse Improvement Target: TBD in DY3 Data Source: EMR, Encounter Data Outcome Improvement Target 1 Estimated Incentive Payment*:* $85,984 Report, EMR	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate utilization – reduce Emergency Department visits for target conditions – Behavioral Health/Substance Abuse Improvement Target: TBD in DY3 Data Source: EMR, Encounter Data Outcome Improvement Target 2 Estimated Incentive Payment*:* $205,614 Report, EMR
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $46,228	Year 3 Estimated Outcome Amount: $80,377	Year 4 Estimated Outcome Amount: $85,984	Year 5 Estimated Outcome Amount: $205,614

126675104.3.9	*3.IT- 9.2*	*IT 9.2 ED appropriate utilization*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.4: Expand the number of community-based settings where behavioral health services may be delivered in underserved areas (Create PHP and IOP as part of continuum of care)		
Starting Point/Baseline:	Target Population: Specific Number: DY2 = 91, DY3 = 618, DY4 = 858, DY5 = 858. Total for DY2-5 is 2,425 patients Description of Population: Patients who will be served in new service locations Baseline data: In FY2011, existing clinics served 8,224 unique 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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $418,203			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: Hemoglobin A1C poor control (>9.0%) in type 1 and type 2 JPS Health Network Medical Home patients

Unique RHP outcome identification number(s): 126675104.3.10
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

IT-1.10 HbA1c poor control (>9.0)

JPS Health Network has 17,041 diabetic patients who are part of our medical home. 19% of these patients do not have good glycemic control. By the end of the project, we will have reduced the patients with poor glycemic control (HbA1C >9) by 20%.

Process Milestones:

DY2

- Validate baseline data and analyze results
- Plan with stakeholders to determine a process for improvement

DY3

- Develop and test data systems- diabetes registry , EMR
- Conduct Plan Do Study Act cycles in a pilot to improve diabetes data collection of patient interventions, care results and team strategies. Spread the learning to three other clinics
- Disseminate findings to stakeholders

Outcome Improvement Targets for each year:

DY3

- Reduce the number of JPS Health Network Medical Home diabetic patients with poor glycemic control (hemoglobin A1C > 9.0%) 319 patients or 10% from the index number of 3189.

DY4

- Reduce the number of JPS Health Network Medical Home diabetic patients with poor glycemic control (hemoglobin A1C > 9.0%)478 patients or 15% from the index number of 3189.

DY5

- Reduce the number of JPS Health Network Medical Home diabetic patients with poor glycemic control (hemoglobin A1C > 9.0%) by 638 patients or 20% from the index number of 3189.

Rationale:

Because glucose control in diabetes impacts many physiologic systems causing complications, it is important that diabetic patients maintain reasonable control of their glucoses

through self-management skills and pharmaceutical treatment. The hemoglobin A1C also plays a role in feedback for the health care provider and the patient so that plans can be adjusted. A strong chronic disease management program with registry capabilities can impact the patient's glucose control through targeted intervention, education, and multiple touches from the medical home team, thereby reducing the number of patients with poor control of their diabetes.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.10	IT-1.10	Diabetes Care: Hemoglobin A1C poor control (>9.0%) in type 1 and type 2 JPS Health Network Medical Home patients	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.1: JPS Health Network Diabetes Chronic Care Management		
Starting Point/Baseline:	Target Population: Specific Number: 17,041 Description of Population: JPS Health Network Medical Home patients with type 1 or type 2 Diabetes Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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]: Plan with stakeholders Metrics: Plan document Process Milestone 2 [P-2]: Validate and analyze baseline data Numerator: Number of JPS Medical Home patients with type 1 or type 2 Diabetes who had Hemoglobin A1C >9 Denominator: JPS medical home patients with type 1 or type 2 diabetes as of June 15, 2013 Data Source: EMR and lab data Process Milestone 1 Estimated Incentive Payment: $112,464	**Process Milestone 3** [P-3]: Develop and test data systems- diabetes registry , EMR Data Source: Diabetes registry and EMR Process Milestone 2 Estimated Incentive Payment: $48885 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act cycles in a pilot clinic to improve diabetes-related data collection of patient interventions, Hemoglobin A1C results and communication for patient care team. Spread the learning to 3 other clinics and implement plan Documentation of intervention through training documentation and outcomes through pre-and post-implementation A1C results Data Source: Diabetes registry, training sign in sheet and	**Outcome Improvement Target 2** [IT-1.10]: Numerator: Number of JPS Health Network Medical Home patients with type 1 or type 2 Diabetes who had Hemoglobin A1C >9 Denominator: JPS Health Network medical home patients with type 1 or type 2 diabetes Improvement Target: Reduce the number of JPS Health Network Medical Home diabetic patients with poor glycemic control (hemoglobin A1C > 9.0%) by 478 patients or 15% from the index number of 3189. Data source: Diabetes registry and EMR Outcome Improvement Target 2 Estimated Incentive Payment: $209,183	**Outcome Improvement Target 3** [IT 1.10]: Numerator: Number of JPS Health Network Medical Home patients with type 1 or type 2 Diabetes who had Hemoglobin A1C >9 Denominator: JPS Health Network medical home patients with type 1 or type 2 diabetes Improvement Target: Reduce the number of JPS Health Network Medical Home diabetic patients with poor glycemic control (hemoglobin A1C > 9.0%) by 638 patients or 20% from the index number of 3189 Data source: Diabetes registry and EMR Outcome Improvement Target 3 Estimated Incentive Payment: $ 500,220

126675104.3.10	IT-1.10	Diabetes Care: Hemoglobin A1C poor control (>9.0%) in type 1 and type 2 JPS Health Network Medical Home patients	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.1: JPS Health Network Diabetes Chronic Care Management		
Starting Point/Baseline:	Target Population: Specific Number: 17,041 Description of Population: JPS Health Network Medical Home patients with type 1 or type 2 Diabetes Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
	materials. Process Milestone 3 Estimated Incentive Payment: $48885 **Process Milestone** 5[P-5]: Disseminate findings to stakeholders via stakeholder minutes or newsletter Data source: Stakeholder minutes Process Milestone 4 Estimated Incentive Payment: $48885 **Outcome Improvement Target 1** [IT-]: Numerator: Number of JPS Health Network Medical Home patients with rype 1 or rype 2 Diabetes who had Hemoglobin A1C >9 Denominator: JPS Health Network medical home patients with rype 1 or rype 2 diabetes Improvement Target: Reduce the		

126675104.3.10	IT-1.10	Diabetes Care: Hemoglobin A1C poor control (>9.0%) in type 1 and type 2 JPS Health Network Medical Home patients	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.1: JPS Health Network Diabetes Chronic Care Management		
Starting Point/Baseline:	Target Population: Specific Number: 17,041 Description of Population: JPS Health Network Medical Home patients with type 1 or type 2 Diabetes Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
	number of JPS Health Network Medical Home diabetic patients with poor glycemic control (hemoglobin A1C > 9.0%) by 319 patients or 10% from the index number of 3189. Data Source: EMR/diabetes registry Outcome Improvement Target 2 Estimated Incentive Payment*:* $48885		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $112,464	Year 3 Estimated Outcome Amount: $195,540	Year 4 Estimated Outcome Amount: $209,183	Year 5 Estimated Outcome Amount: $500,220
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$1,017,407			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes Care: BP control (<140/80)

Unique RHP outcome identification number(s): 126675104.3.11
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

IT-1.11 Diabetes Care: BP control (<140/80) – JPS Health Network has never been able to evaluate Blood pressure on a population basis and any individual review would be through paper chart audit. Our new electronic medical record now allows us to evaluate our current BP control status. In a recent sample of our diabetic patients who have presented for care in our clinics, we have noted that 17% of the 5373 diabetic patients who we have seen have a blood pressure greater than 140/80. At the end of our 5-year project, we will decrease the number of patients with a BP>140/80 by 60% of the baseline number, 907. This number may change as we validate our numbers in DY2.

Process Milestones:

DY2

- Plan with stakeholders to determine a process for improvement
- Validate and analyze baseline data

DY3

- Develop and test data systems- diabetes registry , EMR
- Conduct Plan Do Study Act cycles in a pilot clinic to improve diabetes-related data collection of patient interventions, BP results and communication between the patient care team. Spread the learning to 3 other clinics and implement the new process
- Disseminate findings to stakeholders

Outcome Improvement Targets for each year:

DY4

- Reduce the number of JPS Health Network Medical Home type 1 and type 2 diabetic patients with BP >140/80 by 20% from the baseline determined in DY2.

DY5

- Reduce the number of JPS Health Network Medical Home type 1 and type 2 diabetic patients with BP >140/80 by 30%from the baseline determined in DY2.

Rationale:

Control of BP in the diabetic patient has been determined to be the strongest risk factor for coronary artery disease in diabetic patients, even a stronger factor than glucose control.

Aggressive management will be needed in many patients to bring the BP down to this goal. Our diabetes registry will help identify patients with further need for BP control intervention.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.11	IT-1.11	Diabetes Care: BP control (<140/80) in type 1 and type 2 JPS Health Network Medical Home patients	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.1: JPS Diabetes Chronic Care Management**Diabetes**		
Starting Point/Baseline:	Target Population: JPS Medical home patients with Diabetes Specific Number: 17,041 Description of Population: JPS Medical Home Patients with diabetes either type 1 or type 2 Baseline data: To be determined 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]: Plan with stakeholders Metrics: Plan document **Process Milestone 2** [P-2]: Validate and analyze baseline data Numerator: Number of JPS Medical Home patients with type 1 and type 2 diabetes who have BP>140/80 Denominator: Number of JPS Medical Home patients with type 1 and type 2 diabetes measured June 15, 2013 Data Source: EMR Process Milestone 1 Estimated Incentive Payment: $ 603,976	**Process Milestone 3** [P-3]: Develop and test data systems- diabetes registry , EMR Data Source: Diabetes registry and EMR Process Milestone 2 Estimated Incentive Payment: $525065 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act cycles in a pilot clinic to improve diabetes-related data collection of patient interventions, BP results and communication for patient care team. Spread the learning to 3 other clinics and implement plan Documentation of intervention through training documentation and outcomes through pre-and post-implementation BP results Data Source: Diabetes registry, training sign in sheet and	**Outcome improvement Target 1** [IT-1.11]: Numerator: Number of JPS Medical Home patients with type 1 and type 2 diabetes who have BP>140/80 Denominator: Number of JPS Medical Home patients with type 1 and type 2 diabetes Improvement Target: Reduce the number of JPS Medical Home type 1 and type 2 diabetic patients with BP >140/80 by 20% from the baseline established in DY2. Data source: Diabetes registry Outcome Improvement Target 1 Estimated Incentive Payment: $1,123,395	**Outcome Improvement Target 2** [IT 1.11]: Numerator: Number of JPS Medical Home patients with type 1 and type 2 diabetes who have BP>140/80 Denominator: Number of JPS Medical Home patients with type 1 and type 2 diabetes Improvement Target: Reduce the number of JPS Medical Home type 1 and type 2 diabetic patients with BP >140/80 by 30% from the baseline determined in DY2. Data source: Diabetes registry Outcome Improvement Target 2 Estimated Incentive Payment: $2,686,379

126675104.3.11	IT-1.11	Diabetes Care: BP control (<140/80) in type 1 and type 2 JPS Health Network Medical Home patients	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.1: JPS Diabetes Chronic Care Management**Diabetes**		
Starting Point/Baseline:	Target Population: JPS Medical home patients with Diabetes Specific Number: 17,041 Description of Population: JPS Medical Home Patients with diabetes either type 1 or type 2 Baseline data: To be determined 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)**
	materials. **Process Milestone 5** [P-5]: Disseminate findings to stakeholders via Stakeholder minutes or newsletter Data Source: Stakeholder minutes Process Milestone 3 Estimated Incentive Payment: $525065		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $603,976	Year 3 Estimated Outcome Amount: $1,050,130	Year 4 Estimated Outcome Amount: $1,123,395	Year 5 Estimated Outcome Amount: $2,686,379
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$5,463,880			

Title of Outcome Measure (Improvement Target): IT-1.13 Diabetes Care: Foot exam in type 1 and type 2 Diabetic JPS Health Network Medical Home patients

Unique RHP outcome identification number(s): 126675104.3.12
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
IT: 1.13 Foot exam: We would like to prevent foot infection and amputation for our diabetes patients. By the end of our 5-year project, we would like to increase foot exams 50% over the baseline documented in DY2.

Process Milestones:
DY2
- Validate baseline data and analyze
- Plan with stakeholders to determine a process for improvement

DY3
- Develop and test data systems- diabetes registry , EMR
- Conduct Plan Do Study Act cycles in a pilot clinic to improve diabetes data collection of patient interventions, registry use, care results and training staff for foot exams and communication with the team for patient care coordination. Spread the learning to 3 more clinics and implement.
- Disseminate findings to stakeholders

Outcome Improvement Targets for each year:
DY3
- Increase the number of JPS Health Network Medical Home diabetic patients with yearly foot exams 20% from baseline determined in DY2

DY4
- Increase the number of JPS Health Network Medical Home diabetic patients with yearly foot exams40% from baseline determined in DY2.

DY5
- Increase the number of JPS Health Network Medical Home diabetic patients with yearly foot exam50% from baseline determined in DY2.

Rationale:
25% of diabetic patients will develop a foot ulcer. The economic cost of a diabetic foot ulcer is thought to be between U.S. $7,000-10,000.and where amputation is required; the cost may increase to as much as U.S. $65,000 per person. Amputation has physical and psychological

implications and impacts quality of life. A yearly foot exam looking for vascular, neurologic and foot abnormalities can result in early intervention to prevent a foot ulcer.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.12	IT-1.13	Diabetes Care: Foot exam JPS Health Network diabetic medical home patients	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.1: JPS Diabetes Chronic Care Management		
Starting Point/Baseline:	Target Population: Specific Number: 17,041 JPS Medical Home patients with diabetes in FY 2011 Description of Population: JPS Medical Home patients with type 1 or type 2 Diabetes Baseline data: There is no broad baseline data for diabetic foot exam If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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] Plan with stakeholders Metrics: Plan document **Process Milestone 2** [P-2]: Validate and analyze baseline data Numerator: Number of JPS Medical Home patients with type 1 and type 2 diabetes who have had a yearly foot exam Denominator: Number of JPS Medical Home patients with type 1 and type 2 diabetes measured June 15, 2013 Data Source: EMR Process Milestone 1 Estimated Incentive Payment: $116,889	**Process Milestone 3** [P-3]: Develop and test data systems- diabetes registry , EMR Data Source: Diabetes registry and EMR Process Milestone 2 Estimated Incentive Payment: $67745 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act cycles in a pilot clinic to improve diabetes-related data collection of patient interventions, foot exam training and confirmation and communication for patient care team. Spread the learning to 3 other clinics and implement plan Documentation of intervention through training documentation and outcomes through pre- and post-implementation completed foot exam Data Source: Diabetes registry, training sign in sheet and	**Outcome Improvement Target 1** [IT-1.13]: Numerator: Number of JPS Medical Home patients with type 1 and type 2 diabetes who have a yearly foot exam Denominator: Number of JPS Medical Home patients with type 1 and type 2 diabetes Improvement Target: Increase the number of JPS Medical Home type 1 and type 2 diabetic patients with yearly foot exams from the baseline to be established in DY2 by 40% Data source: Diabetes registry report for foot exam, EMR Outcome Improvement Target 2 Estimated Incentive Payment: $217,413	**Outcome Improvement Target 2** [IT-1.13]: Numerator: Number of JPS Medical Home patients with type 1 and type 2 diabetes who have a yearly foot exam Denominator: Number of JPS Medical Home patients with type 1 and type 2 diabetes Improvement Target: Increase the number of JPS Medical Home type 1 and type 2 diabetic patients with yearly foot exams from the baseline to be established in DY2 by 50% Data source: Diabetes registry Report for foot exam Outcome Improvement Target 3 Estimated Incentive Payment: $519,901

126675104.3.12	IT-1.13	Diabetes Care: Foot exam JPS Health Network diabetic medical home patients	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.1: JPS Diabetes Chronic Care Management		
Starting Point/Baseline:	Target Population: Specific Number: 17,041 JPS Medical Home patients with diabetes in FY 2011 Description of Population: JPS Medical Home patients with type 1 or type 2 Diabetes Baseline data: There is no broad baseline data for diabetic foot exam If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
	materials, EMR. Process Milestone 2 Estimated Incentive Payment: $67745 **Process Milestone 5** [P-5]: Disseminate findings to stakeholders via Stakeholder minutes or newsletter Data Source: Stakeholder minutes **Outcome Improvement Target 1** [IT-1.13]: Numerator: Number of JPS Medical Home patients with type 1 and type 2 diabetes who have a yearly foot exam Denominator: Number of JPS Medical Home patients with type 1 and type 2 diabetes Improvement Target: Increase the number of JPS Medical Home type 1 and type 2 diabetic patients with yearly foot exams from the baseline to be established in DY2 by 20% Data source: Diabetes registry report for foot exam, EMR		

126675104.3.12	IT-1.13	Diabetes Care: Foot exam JPS Health Network diabetic medical home patients	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.1: JPS Diabetes Chronic Care Management		
Starting Point/Baseline:	Target Population: Specific Number: 17,041 JPS Medical Home patients with diabetes in FY 2011 Description of Population: JPS Medical Home patients with type 1 or type 2 Diabetes Baseline data: There is no broad baseline data for diabetic foot exam If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 2 Estimated Incentive Payment: $67744		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $116,889	Year 3 Estimated Outcome Amount: $203,234	Year 4 Estimated Outcome Amount: $217,413	Year 5 Estimated Outcome Amount: $519,901
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$1,057,437			

Title of Outcome Measure (Improvement Target): IT-2.12 Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions

Unique RHP outcome identification number(s): 126675104.3.13
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

By the end of the Waiver, we expect to reduce PQI admissions rates by 20% for the Medical Home population under 75 years of age. The baseline for our waiver period is currently 1104 admissions. Reducing by 20% will provide a target of < 875 admissions for DY5. Our milestones are as follows:

Process Milestones:

- In DY2, project will begin by engaging stakeholders, developing a project plan and testing our data systems to determine reliability of baseline data. A system for referral to the medical home will be established and implemented.
- In DY3, emphasis will be placed on tracking systems and care coordination to measure time from admission to medical home and link to appropriate resources.

Outcome Improvement Targets for each year:

- In DY3, a targeted improvement of 5% reduction in admissions has been established. The goal will be to have no more than 1049 PQI admissions.
- In DY4, we expect to reduce PQI composite admissions by 15% or reduce admissions to no more than 950 admissions.
- In DY5, we expect to reduce PQI composite admissions by 20% or reduce admissions to no more than 875 admissions.

Rationale:

In a data extraction from FY2011 claims data, JPS Health Network has identified 2291 ambulatory care sensitive admissions based on PQI composite data**.** Of those, 1104 admissions have been attributed to the patients enrolled in our Connection program. Improvement targets have been determined based on this data although the data has not been audited or verified. Data testing and verification is planned for DY2.

Ambulatory Care Sensitive Condition admissions have been correlated to the quality of primary care delivered in the community.[378] The implementation of the PCMH will increase the quality of care received, the timeliness of that care and provide a new focus on coordinated preventive care. As overall health is improved, the ambulatory care sensitive conditions will be reduced.

378 http://www.qualitymeasures.ahrq.gov/content.aspx?id=27275

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.13	IT-2.12	Ambulatory Care Sensitive Conditions Admissions Rate: (Stand-alone measure)	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.2: Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.		
Starting Point/Baseline:	Target Population: Current and prospective medical home members under 75 years Specific Number: Needs to be determined although there were 1104 admissions fY2011 Description of Population: Patients that had at least one ambulatory care visit during the term of the Waiver Baseline data: Baseline data is taken from claims, actual number will need to be verified		
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 Baseline/Goal: Develop and implement plan Data Source: Documented project plan, meeting minutes Process Milestone 1 Estimated Incentive Payment: $26274 **Process milestone 2** [P-2]: Verify and validate baseline rates Baseline/Goal: Verify baseline rates for eligible admissions of 1104 in FY2011 Data Source: EMR and claims data Process Milestone 2 Estimated Incentive Payment: $26274	**Process Milestone 6 [P-6] :** Test tracking systems and care coordination to measure time to medical home after admission; determine reduction in admissions; modify tracking and care coordination plan as necessary to meet the improvement targets; Baseline/Goal: Focused improvement plan with targeted interventions Metric: time to first touch after discharge is 7 days or less Data Source: EMR and claims data Process Milestone 6 Estimated Incentive Payment: $114210 **Outcome improvement Target 1** [IT-2.12]: Numerator: Total number of acute care hospitalizations for ambulatory	**Outcome Improvement Target 2** [IT2.12]: Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years • Exclude all patients over 75 years • Death before discharge Denominator: Total mid-year population under age 75 Improvement Target: Reduce ACSC Admissions rate by 15% over established baseline, < 950 total admissions Data/Source: EMR and claims data Outcome Improvement Target 2 Estimated Incentive Payment: $244356	**Outcome Improvement Target 3** [IT2.12]: Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years • Exclude all patients over 75 years • Death before discharge Denominator: Total mid-year population under age 75 Improvement Target: Reduce ACSC Admissions rate by 20% over established baseline, < 875 total admissions Data/Source: EMR and claims data Outcome Improvement Target 3 Estimated Incentive Payment: $584330

126675104.3.13	IT-2.12	Ambulatory Care Sensitive Conditions Admissions Rate: (Stand-alone measure)	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.2: Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.		
Starting Point/Baseline:	Target Population: Current and prospective medical home members under 75 years Specific Number: Needs to be determined although there were 1104 admissions fY2011 Description of Population: Patients that had at least one ambulatory care visit during the term of the Waiver Baseline data: Baseline data is taken from claims, actual number will need to be verified		
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 3 [P-3]: Test data systems to verify reliability Baseline metrics will be used to demonstrate effective reduction in admissions Baseline/Goal: Develop and disseminate baseline data Data Source: EMR and claims data Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $26,278 **Process Milestone 4** [P-4]: Develop tracking system for care coordination for inpatients with Ambulatory Care Sensitive Condition Admissions back to their Medical Home Baseline/Goal: Coordination plan	care sensitive conditions under age 75 years • Exclude all patients over 75 years • Death before discharge Denominator: Total mid-year population under age 75 Improvement Target: Reduce PQI admissions rate by 5% over established baseline, <1050 total admissions Data Source: EMR and claims data Outcome Improvement Target 1 Estimated Incentive Payment*:* $114,210		

126675104.3.13	IT-2.12	Ambulatory Care Sensitive Conditions Admissions Rate: (Stand-alone measure)	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.2: Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.		
Starting Point/Baseline:	Target Population: Current and prospective medical home members under 75 years Specific Number: Needs to be determined although there were 1104 admissions fY2011 Description of Population: Patients that had at least one ambulatory care visit during the term of the Waiver Baseline data: Baseline data is taken from claims, actual number will need to be verified		
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)**
and flowchart developed Data Source: flowchart, standard workplan, EMR and claims data Process Milestone 4 Estimated Incentive Payment: $26,274 **Process Milestone 5** [P-5]: Develop resources/systems to link with a Medical Home if not already on a panel Baseline/Goal: Develop workflow for all admitted patients without medical home assignment Data Source: EMR and policies/guidelines Process Milestone 5 Estimated Incentive Payment: $26,274			

126675104.3.13	IT-2.12	Ambulatory Care Sensitive Conditions Admissions Rate: (Stand-alone measure)	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.2: Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.		
Starting Point/Baseline:	Target Population: Current and prospective medical home members under 75 years Specific Number: Needs to be determined although there were 1104 admissions fY2011 Description of Population: Patients that had at least one ambulatory care visit during the term of the Waiver Baseline data: Baseline data is taken from claims, actual number will need to be verified		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $131,374	Year 3 Estimated Outcome Amount: $228,420	Year 4 Estimated Outcome Amount: $244,356	Year 5 Estimated Outcome Amount: $584,330
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$1,188,481			

Title of Outcome Measure (Improvement Target): IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-stand-alone measure)

Unique RHP outcome identification number(s): 126675104.3.14
Performing Provider Name/TPI: JPS Health Network/ 126675104

Outcome Measure Description:

By the end of the Waiver, our goal is to increase compliance for breast cancer screening so that the percentage of eligible females with a screening mammogram is at 50%. An initial pull from our EMR shows that 37% of our eligible Medical Home patients have had their breast cancer screening in FY2012. Baseline data shows that 22, 628 eligible females are currently enrolled in our medical homes. Our milestones include the following:

Process Milestones:

- In DY2, we will verify the baseline data the test our reporting system for reliability; data and goals will be shared with clinical care teams to engage these teams in improvement efforts designed to meet the goal;

Outcome Improvement Targets for each year:

- In DY3, our goal is to increase compliance by 10% of the baseline or >9209 eligible females.
- In DY4, our goal is to increase compliance by 20% of the baseline or > 10, 046 eligible females.
- In DY5, our goal is to increase compliance by 40% of the baseline so that the percentage of females 40-69 will be 50% or 11,720 eligible females.

Rationale:

JPS Health Network has implemented an EMR in May of 2012. We have started pulling data for this metric and do have a baseline but would like to spend a year confirming the data for reliability. Improvement targets have been established.

According to the National Cancer Institute (NCI), one in eight women living today will be diagnosed with breast cancer. Age, obesity and lack of physical activity can contribute to the development of breast cancer. Screening mammography can reduce the number of deaths from breast cancer in women from ages 40-70.[379]

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total

379 http://www.cancer.gov

potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.14	IT-12.1	Breast Cancer Screening	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.2: Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.		
Starting Point/Baseline:	Target Population:JPS Medical Home Females Between the Ages of 40 and 69 Specific Number: 22628needs to be validated Description of Population: Patients who had at least one primary care visit in FY2011 Baseline data: Baseline compliance for Medical Home patients with screening mammogram is 37% or 8372 patients in compliance		
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 need resources, determine timelines and document implementation plans Baseline/Goal: Develop project plan and timelines Data Source: Documented project plan, meeting minutes Process Milestone 1 Estimated Incentive Payment: $39,214 **Process Milestone 2** [P-2]: Verify and validate baseline rates Baseline/Goal: 22, 628 eligible females Data Source: EMR/Claims data Process Milestone 2 Estimated Incentive Payment: $39,215 **Process Milestone 3** [P-3]: Test data systems to perform data reliability	**Process Milestone 5** [P-5] : Using data collected in DY2, focus on low performing providers and populations, engage stakeholders such as care managers, RN coaches and providers in process improvement and develop improvement plan and meaningful focus on improving compliance in preparation for measurement years Baseline/Goal: Develop focused improvement plan Data Source: Meeting minutes and written plan Process Milestone 5 Estimated Incentive Payment: $136365 **Outcome Improvement Target** [IT-12.1]: Numerator: Number of women ages 40-69 have received an annual mammogram during the reporting period Denominator: Number of women ages	**Outcome improvement target 2** [I-12.1]: Numerator: Number of women ages 40-69 that have received an annual mammogram during the reporting period. Denominator: Number of women ages 40-69 in the who are empaneled patients in the Medical Home Improvement Target: Increase compliance with breast cancer screening by 20% over baseline, >10,046 Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment: $291757	**Outcome Improvement Target 3** [IT-2.1]: Numerator: Number of women ages 40-69 that have received an annual mammogram during the reporting period. Denominator: Number of women ages 40-69 in the who are empaneled patients in the Medical Home Improvement Target: Increase compliance with breast cancer screening by 40% over baseline, >11,720 Data Source: EMR, Claims Outcome Improvement Target 3 Estimated Incentive Payment: $697679

126675104.3.14	IT-12.1	Breast Cancer Screening	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.2: Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.		
Starting Point/Baseline:	Target Population:JPS Medical Home Females Between the Ages of 40 and 69 Specific Number: 22628needs to be validated Description of Population: Patients who had at least one primary care visit in FY2011 Baseline data: Baseline compliance for Medical Home patients with screening mammogram is 37% or 8372 patients in compliance		
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)**
Baseline metrics will be used to demonstrate improved patient satisfaction Baseline/goal: Verify data systems and create reliable reports Data Source: EMR, Claims Data Process Milestone 3 Estimated Incentive Payment : $39,215 **Process Milestone 4** [P-4]: Share data and baseline metric with clinical care teams to engage teams in focused improvement efforts Baseline/Goal: Create dashboard, teach teams how to find data Data Source: Community Dashboard, LEM goals Process Milestone 4 Estimated Incentive Payment: $39,215	40-69 who are empaneled patients in the Medical Home Improvement Target: Increase compliance with breast cancer screening by 10% over baseline, >9209 Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment: $136364		

126675104.3.14	IT-12.1	Breast Cancer Screening	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.2: Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.		
Starting Point/Baseline:	Target Population:JPS Medical Home Females Between the Ages of 40 and 69 Specific Number: 22628needs to be validated Description of Population: Patients who had at least one primary care visit in FY2011 Baseline data: Baseline compliance for Medical Home patients with screening mammogram is 37% or 8372 patients in compliance		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $156,859	Year 3 Estimated Outcome Amount: $272,729	Year 4 Estimated Outcome Amount: $291,757	Year 5 Estimated Outcome Amount: $697,679
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$1,419,024			

Title of Outcome Measure (Improvement Target): IT-12.2 Cervical Cancer Screening

Unique RHP outcome identification number(s): 126675104.3.15
Performing Provider Name/TPI: JPS Health Network/ 126675104

Outcome Measure Description:

By the end of the Waiver, our goal is to increase compliance with cervical cancer screening to > 30% over baseline of females ages 21-64. An initial pull from our EMR shows that 27% of our eligible Medical Home patients have had their cervical cancer screening in FY2012. The current number of eligible females in this age group is 15, 603.

Process Milestones:

- In DY2, we will verify the baseline data and test our reporting system for reliability; data and goals will be shared with clinical care teams to engage these teams in improvement efforts designed to meet the goal;

Outcome Improvement Targets for each year:

- In DY3, our goal is to increase compliance by 10% of the baseline or >4,637 eligible females will be compliant with this outcome.
- In DY4, our goal is to increase compliance by 25% of the baseline or > 5,266 eligible females will be compliant with this outcome.
- In DY5, our goal is to increase compliance by 50% of the baseline so the percentage of female patients between 21 and 64 years of age will improve to a total of 40% of our eligible population or >6300 eligible females will be compliant with this outcome.

Rationale:

JPS Health Network has implemented an EMR in May of 2012. We have started pulling data for this metric and do have a baseline but would like to spend a year confirming the data for reliability. Improvement targets have been established.

According to the National Cancer Institute, cervical cancer is largely preventable or curable if detected early by routine Pap smears.[380]

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into

380 http://www.cancer.gov/cancertopics/screening/pap-tests-cervical-health

account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction

126675104.3.15	IT-12.2	Cervical Cancer Screening	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.2: Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards.		
Starting Point/Baseline:	Target Population: JPS Medical Home Females Between the Ages of 21 - 64 Specific Number: 15603 Description of Population: Patients that had at least one primary care visit in FY2011 Baseline data: Baseline compliance for Medical Home patients with cervical screening Is 27% or 4,213 If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 Baseline/Goal: Develop and implement project plan Data Source: Documented project plan, meeting minutes Process Milestone 1 Estimated Incentive Payment: $161,838 **Process Milestone 2** [P-2]: Establish baseline rates Baseline/Goal: 15, 603eligible females in DY2011, verify for 2012 Data Source: EMR/Claims Data Process Milestone 2 Estimated Incentive Payment: $161,837	**Process Milestone 5** [P-5]: Using data collected in DY2, focus on low performing providers and populations, engage stakeholders such as care managers, RN coaches and providers in process improvement and develop improvement plan Baseline/Goal: Develop focused project plan Data Source: Meeting minutes and written plan Process Milestone 5 Estimated Incentive Payment *(maximum amount):* $562,772 **Outcome Improvement Target 1** [IT12.2]: Numerator: number of women ages 21-64 that have received a PAP in the measurement year or two prior years Denominator: Women ages 21-64	**Outcome Improvement Target 2** [IT12.2]: Numerator: Number of women ages 21-64 that have received a PAP in the measurement year or two prior years. Denominator: Women ages 21-64 empaneled in a JPS Medical Home Improvement Target: Increase compliance with cervical cancer screening by 25% over baseline metric, >5,266 Data Source: EMR and Claims Data Outcome Improvement Target 2 Estimated Incentive Payment: $1204069	**Outcome Improvement Target 3** [IT12.2]: Numerator: Number of women ages 21-64 that have received a PAP in the measurement year or two prior years. Denominator: Women ages 21-64 empaneled in a JPS Medical Home: Improvement Target: Increase compliance with cervical cancer screening by 50% over baseline metric, 6,300 Data Source: EMR and Claims Data Outcome Improvement Target 3 Estimated Incentive Payment: $2879296

Process Milestone 3 [P-3]: Test data systems to perform data reliability Baseline metrics will be used to demonstrate improved patient satisfaction Baseline/Goal: Verify data reliability using current reports Data Source: EMR, Claims Data Process Milestone 3 Estimated Incentive Payment: $161,837 **Process milestone 4** [P-4]: Share data and baseline metric with clinical care teams to engage teams in focused improvement efforts Baseline/Goal: Develop dashboard for each provider Data Source: Community Dashboard, LEM goals Process Milestone 4 Estimated Incentive Payment: $161,837	empaneled in a JPS Medical Home Improvement Target: Increase compliance with cervical cancer screening by 10% over baseline metric, >4,634 Data Source: EMR and Claims Outcome Improvement Target 1 Estimated Incentive Payment: $562771		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $647,349	Year 3 Estimated Outcome Amount: $1,125,543	Year 4 Estimated Outcome Amount: $1,204,069	Year 5 Estimated Outcome Amount: $2,879,296
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$5,856,256			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c poor control

Unique RHP outcome identification number(s): 126675104.3.16
Performing Provider Name/TPI: JPS Health Network / 126675104

Outcome Measure Description:
IT-1.10 Diabetes Care: HbA1c poor control

Process Milestones:

DY2: Process milestone: Establish baseline rate. JPS Health Network will engage stakeholders such as homeless shelters, supportive housing and primary care clinics serving the homeless to determine volume of diabetic patients and establish baseline HbA1c rates for this target population.

DY3: Process milestone-Plan-Do-Study-Act Cycle will be utilized to identify appropriate frequency of HbA1c monitoring and effective coordination of care.

Outcome Improvement Targets for each year:

DY4: Improvement milestones-Reduce baseline number of homeless individuals identified as diabetic that have HbA1c poor control (>9.0%) by 10%.

DY5: Improvement milestones-Reduce baseline number of homeless individuals identified as diabetic that have HbA1c poor control (>9.0%) by 15%.

Rationale:

The identified population, the homeless, is medically underserved. They have long been identified as insufficiently accessing preventive, primary or secondary medical services, to comply with medication schedules, or to consistently obtain prescribed medications. They are also known to utilize emergency departments at a greater rate than the average population, and require admission to hospitals at higher rates.
The combination of homelessness and diabetes bodes poorly for the health and welfare of individuals affected by both, and presents a formidable toll to each affected person and to society on the whole, in social service demands, medical costs, and in marked increases in disability. Diabetes affects a significant portion of the population. The incidence of diabetes is higher in the south, and particularly within certain subpopulations. The homeless population is inhabited with a disproportional number of these subpopulations: Hispanic, African-Americans, and American Indians.

Race and ethnic differences in prevalence of diagnosed diabetes: After adjusting for population age differences, 2007-2009 national survey data for people diagnosed with diabetes, ages 20 years or older include the following prevalence by race/ethnicity[381]:

- 7.1% of non-Hispanic whites
- 12.6% of non-Hispanic blacks
- 11.8% of Hispanics

Various medical and social interventions for both homelessness and for diabetes have proven to successfully improve outcomes for this targeted population. Medical literature has long established that medical interventions – that includes education, medication compliance, screening for medical complications, and treatments for specific systems (e.g., Cardiovascular, lipids, and renal) – serve to reduce the morbidity, complications, costs and mortality from diabetes.

Since diabetes is a systemic disease and its complications affect many parts of the body, leading to serious complications such as blindness, kidney damage, arterial disease, nerve damage, heart disease, and lower-limb amputations, to name a few. Working together, people with diabetes, their support network, and their health care providers can reduce the occurrence of these and other diabetes complications by controlling the levels of blood glucose, blood pressure, and blood lipids, and by receiving other preventive care practices and social services in a timely manner.

Glucose control

- Studies in the United States and abroad have found that improved glycemic control benefits people with either type 1 or type 2 diabetes. In general, every percentage point drop in A1c blood test results (e.g.,, from 8.0% to 7.0%) can reduce the risk of micro vascular complications (eye, kidney, and nerve diseases) by 40%. The absolute difference in risk may vary for certain subgroups of people.

- In patients with type 1 diabetes, intensive insulin therapy has long-term beneficial effects on the risk of cardiovascular disease.

The 2011 point-in-time count of the homeless was 2,169 and the "annualized" HUD estimate of people experiencing homelessness was 4,847. [382] In FY 2011, JPS Health Network identified 233 homeless who are frequent hospital utilizers, having four or more encounters per year in the emergency department and/or as inpatient admissions. These homeless patients incurred charges totaling $10,174.589. Of this group, 35 patients were identified as having diabetes; this subset incurred charges totally $2,311,858.

[381] American Diabetes Association website: http://www.diabetes.org/diabetes-basics/diabetes-statistics/?loc=DropDownDB-stats

[382] Tarrant County Homeless Coalition, 2011; Annualized estimates are derived by the application of a HUD-proscribed algorithm to point-in-time count data: http://ahomewithhope.org/homeless-facts/homeless-statistics.aspx

Under the Care Connections for the Homeless program, we intend to identify and care for this vulnerable and costly population in an attempt to provide timely and appropriate transitional care that would result in:

- Appropriate identification of medical and social needs,
- Timely provision of vital medications,
- The provision for blood sugar and blood pressure monitoring,
- Timely referral to primary care for establishing a medical home,
- Appropriate referral to specialty care,
- Adequate support for transportation, translation, and for obtaining medications.

Ultimately these initiatives will result in improved diabetic management and care, expanded general medical care, and improved quality of life for homeless patients along with a reduction of preventable readmissions, ED utilization, emergency medical services utilization, and costly secondary medical complications.[383]

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

[383] **Data from the 2011 National Diabetes Fact Sheet (released Jan. 26, 2011):**
Total prevalence of diabetes
Total: 25.8 million children and adults in the United States—8.3% of the population—have diabetes.
Diagnosed: 18.8 million people
Undiagnosed: 7.0 million people
Pre-diabetes: 79 million people*
New Cases: 1.9 million new cases of diabetes are diagnosed in people aged 20 years and older in 2010.

126675104.3.16	*IT-1.10*	*OD-1 Primary Care and Chronic Disease Management- Diabetes Care:HbA1c poor control*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.3: -Implement/Expand Care Transition Programs- Care Connections for the Homeless*		
Starting Point/Baseline:	*Target Population: Diabetic prevalence rates from the American Diabetes Association applied to target population result in an estimated 523 people who are homeless and living with Diabetes in Tarrant County.* *Description of Population: Homeless primary care and support services will be focused on providing services to three homeless populations: those who are unsheltered, emergency sheltered, or tenants are permanent supportive housing throughout Tarrant County.* *Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.*		
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 rate. JPS will engage stakeholders such as homeless shelters, supportive housing and primary care clinics serving the homeless to determine volume of diabetic patients and establish baseline HbA1c rates for this target population. Data source: EMR, Excel spreadsheets, Medical Record data Process Milestone 1 Estimated Incentive Payment: $15,370	**Process Milestone 2** [P-4]: Plan-Do-Study-Act Cycle will be utilized to identify appropriate frequency of HbA1c monitoring and effective coordination of care. Data source: Documentation of PDSA Cycle and evidence of the number of individuals' stakeholders receiving information and lessons learned based on PDSA results Process Milestone 2 Estimated Incentive Payment: $26,724	**Outcome Improvement Target 1** [IT-1.10]: Reduce baseline number of homeless individuals identified as diabetic that have HbA1c poor control (>9.0%) by 10% Improvement Target: Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 1 Estimated Incentive Payment: $28,589	**Outcome Improvement Target 2** [IT-1.10]: Reduce baseline number of homeless individuals identified as diabetic that have HbA1c poor control (>9.0%) by 15% Improvement Target: Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 2 Estimated Incentive Payment: $68,364

126675104.3.16	*IT-1.10*	*OD-1 Primary Care and Chronic Disease Management- Diabetes Care:HbA1c poor control*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.3: -Implement/Expand Care Transition Programs- Care Connections for the Homeless*		
Starting Point/Baseline:	*Target Population: Diabetic prevalence rates from the American Diabetes Association applied to target population result in an estimated 523 people who are homeless and living with Diabetes in Tarrant County.* *Description of Population: Homeless primary care and support services will be focused on providing services to three homeless populations: those who are unsheltered, emergency sheltered, or tenants are permanent supportive housing throughout Tarrant County.* *Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $15,370	Year 3 Estimated Outcome Amount: $26,724	Year 4 Estimated Outcome Amount: $28,589	Year 5 Estimated Outcome Amount: $68,364
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $139,047			

Title of Outcome Measure (Improvement Target): IT-1.18 Follow-Up After Hospitalization for Mental Illness

Unique RHP outcome identification number(s): 126675104.3.17
Performing Provider Name/TPI: JPS Health Network / 126675104

Outcome Measure Description:
IT-1.18 Follow-Up After Hospitalization for Mental Illness

Process Milestones:

- DY-2-
  - Process milestone 1: Partner with identified agencies serving the mental health needs of the homeless community for project planning purposes for – identifying communication plan and resource needs; develop protocols to ensure appropriate access for mental health follow-up services
  - Process milestone 2: Partner with identified agencies serving the mental health needs of the homeless community in order determine baseline rates.

- DY-3:
  - Process Milestone 3 – Plan-Do-Study-Act Cycle will be utilized to identify the optimal location and hours for the effective delivery of mental health crisis intervention.

Outcome Improvement Targets for each year:

- DY4-
  - IT-1.18 – Improvement milestones-Increase access to follow up after hospitalization for mental illness (NQF0576) by 20% from established baseline.
- DY5-
  - IT-1.18 – Improvement milestones-Increase access to follow up after hospitalization for mental illness (NQF0576) by 25% from established baseline

Rationale:

The identified population, the homeless, has long been identified as insufficiently accessing primary or secondary mental health services, to comply with medication schedules, or to consistently obtain prescribed medications. They are also known to utilize emergency departments at a greater rate than the average population.

Homeless persons suffer from mental illnesses and drug or ethanol use problems at a rate disproportional and significantly higher than the average population:

- 38% report alcohol use problems
- 26% report other drug use problems

- 39% report some form of mental health problems (20-25% meet criteria for serious mental illness)
- 66% report either substance use and/or mental health problems.[384]

The 2011 point-in-time count of the homeless was 2,169 and the "annualized" HUD estimate of people experiencing homelessness was 4,847.[385] TCHC has identified in a point of time analysis a percentage of patients who were considered Severely Mentally Ill (15%) and Chronic Substance Abuse (16%).

In FY 2011, JPS Health Network identified 233 homeless who are frequent hospital utilizers, having four or more encounters per year in the emergency department and/or as inpatient admissions. These homeless patients incurred charges totaling $10,174.589. Of this group, 214 were diagnosed with a mental illness (including drug and alcohol abuse) and the charges totaled $9,583,258.

JPS Health Network also collected data and identified patients with mental illness that were homeless and had at least one ED or Inpatient visit during FY 2011, that number totaled 937.

The Care Connections for the Homeless program will identify and contact all partnering mental health agencies serving the homeless community to determine baseline rates and to develop and test data systems to ensure data reliability. Upon establishment of this baseline, the DSRIP project will develop a staffing and implementation plan to provide transitional and on-going mental health services to the homeless population. The homeless populations served will be to those who are emergency sheltered, unsheltered, or tenants in permanent supportive housing. Identification of mental health patients discharged from JPS Health Network Inpatient and ED will be followed and tracked upon discharge to then determine immediate and intermediate follow up needs.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost

[384] National Resource Center on Homelessness and Mental Illness. Who Is Homeless? Newton, MA: U.S. Department of Health and Human Services, Substance Abuse & Mental Health Services Administration; 2003. [Cited 2010 Nov 8]. Available from: http://homeless.samhsa.gov/Resource/View.aspx?id=32511.
[385] Tarrant County Homeless Coalition, 2011; Annualized estimates are derived by the application of a HUD-proscribed algorithm to point-in-time count data: http://ahomewithhope.org/homeless-facts/homeless-statistics.aspx

savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.17	*IT-1.18*	*Follow-Up After Hospitalization for Mental Illness*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.3: -Implement/Expand Care Transition Programs- Care Connections for the Homeless*		
Starting Point/Baseline:	*Target Population:* *Specific Number: It is anticipated that ED/inpatient visits requiring follow-up will be approximately 700 annually* *Description of Population: Mental health services will be focused on providing services to the three homeless populations: those who are unsheltered, emergency sheltered, or tenants are permanent supportive housing.* *Baseline data:* *If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.*		
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]: Partner with identified agencies serving the mental health needs of the homeless community for project planning purposes for –identifying communication plan and resource needs, develop protocols to ensure appropriate access for mental health follow-up services Data source: Written plans. Process Milestone 1 Estimated Incentive Payment: $22,113 **Process Milestone 2** [P-2]: Partner with identified agencies serving the mental health needs of the homeless community in order determine baseline rates. Data source: EMR, Excel spreadsheets, MHMR data Process Milestone 2 Estimated	**Process Milestone 3** [P-4]: Plan-Do-Study-Act Cycle will be utilized to identify the optimal location and hours for the effective delivery of mental health crisis intervention. Data source: Documentation of PDSA Cycle and evidence of the number of individuals' stakeholders receiving information and lessons learned based on PDSA results Process Milestone 3 Estimated Incentive Payment: $76,898	**Outcome Improvement Target 1** [IT-1.18]: Increase access to follow up after hospitalization for mental illness (NQF0576) by 15% from established baseline for both rate 1 and rate 2 as defined below. • 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	**Outcome Improvement Target 2** [IT-1.18]: Increase access to follow up after hospitalization for mental illness (NQF0576) by 20% from established baseline for both rate 1 and rate 2 as defined below. • 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

126675104.3.17	*IT-1.18*	*Follow-Up After Hospitalization for Mental Illness*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.3: -Implement/Expand Care Transition Programs- Care Connections for the Homeless*		
Starting Point/Baseline:	*Target Population:* *Specific Number: It is anticipated that ED/inpatient visits requiring follow-up will be approximately 700 annually* *Description of Population: Mental health services will be focused on providing services to the three homeless populations: those who are unsheltered, emergency sheltered, or tenants are permanent supportive housing.* *Baseline data:* *If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.*		
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)**
Incentive Payment: $22,114		hospitalizations that occur on the date of discharge. Improvement Target: 15% Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $82,263	hospitalizations that occur on the date of discharge. Improvement Target: 20% Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $196,716
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $44,227	Year 3 Estimated Outcome Amount: $76,898	Year 4 Estimated Outcome Amount: $82,263	Year 5 Estimated Outcome Amount: $196,716
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $400,104			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 126675104.3.18
Performing Provider Name/TPI: JPS Health Network / 126675104

Outcome Measure Description:
IT-9.2 ED appropriate utilization

Process Milestones:

DY2-
Process milestone 1: Partner with identified agencies serving the health care needs of the homeless community for project planning purposes for –identifying communication plan, and plans for health information sharing to best serve the health care needs of the homeless with goal of reducing ED visits.

Process milestone 2: Partner with identified agencies serving the homeless community to develop and test data systems (for information sharing) specific to the homeless population.

DY3-
Process Mileston-3: Plan-Do-Study-Act Cycle will be utilized to identify innovative strategies to reduce ED admissions in the homeless population.

Outcome Improvement Targets for each year:

DY4-
Improvement Milestones-Reduce all ED visits form the baseline by 10% for the homeless population.

DY5-
Improvement Milestones-Reduce all ED visits form the baseline by 15% for the homeless population.

Rationale:

The identified population, the homeless, is medically underserved. This group of individuals has long been identified as insufficiently accessing preventive, primary or secondary medical services; poorly adhering to medication schedules or consumption, including the consistent obtaining and retaining of prescribed medications. Often these people have delayed treatment or deferred chronic disease management. Homelessness is also strongly associated with abuse of alcohol and street drugs, and a variety of psychosocial problems and psychiatric symptoms.

- The vulnerability of this population regarding consistent medication and plan of care compliance has been clearly identified in the transition post hospital discharge.
- Many homeless patients do have government insurance under state or federal programs
- Patients who are homeless tend to be readmitted regularly for a number of reasons:
    - homeless patients may visit multiple hospitals in the community as there is typically no tracking from institution to institution
    - homeless patients typically have chronic diseases that require extensive and comprehensive follow-up care
    - being homeless and exposed to the elements, lack of sleep, street crime, and substance abuse from living on the street exacerbates these chronic illnesses
    - Since there is no place for patients to rest, follow-up care is infrequent, if it is obtained at all, for patients who are discharged back to the street. [386]

The homeless are known to utilize EDs[387] and require admissions and readmissions to hospitals at higher rates than the average population.
Various medical and social interventions for both homelessness and for interventions for chronic diseases have proven to successfully improve outcomes for this targeted population. [388] Medical interventions - that includes education, medication compliance, screening for medical complications, and treatments for specific systems (e.g., Cardiovascular, lipids, and renal) – serve to reduce the morbidity, complications, costs and mortality in this vulnerable population.
The 2011 point-in-time count of the homeless was 2,169 and the "annualized" HUD estimate of people experiencing homelessness was 4,847. [389] JPS Health Network has identified a cohort of the homeless who are frequent hospital utilizers (four or more encounters per year). This data is FY 2011. The total number of JPS Connect patients who alone fit into this category was 232 persons at a cost of care for this group totaling $10,174,589.[390]
The Care Connections for the Homeless program, we intend to identify and care for this vulnerable and costly population in an attempt to provide timely and appropriate transitional care that would result in:

- Appropriate identification of medical and social needs,

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[386] Cardarelli, K; Carlson, E; Jackson, R; Ward, K; *A Plan for the Delivery of Health Care to the Homeless: A report prepared for Tarrant County Commissioner Roy Brooks by The Blue Ribbon Task Force on Health Care for the Homeless*; Center for Community Health University of North Texas Health Science Center, 2008.
[387] Homeless adults visit emergency departments (EDs) nearly four times more often than the general population and are among the highest repeat visitors.(Readmission Strategies for Homeless Patients" January 12, 2012, http://www.pepperlaw.com/publications_update.aspx?ArticleKey=2274
[388] In a cohort of supportive housing tenants, post-housing service reductions "were largest for urgent care (64%), psychiatric ER (50%), and medical ER (45%)." Petrovich, J. and Spence-Almaguer, E., *Evaluation of Directions Home Supportive Housing and the Use of Critical Service Systems: Preliminary Results;* August 10, 2010; http://www.DirectionsHome.org
[389] Tarrant County Homeless Coalition, 2011; Annualized estimates are derived by the application of a HUD-proscribed algorithm to point-in-time count data: http://ahomewithhope.org/homeless-facts/homeless-statistics.aspx
[390] Tarrant County Hospital District, internal data base

- Timely provision or support in obtaining vital medications upon discharge and for an interim,
- The provision for blood sugar and blood pressure monitoring and other possible DME,
- Timely referral to primary care for establishing a medical home,
- Appropriate referral to specialty care,
- Patient support for transportation, translation, and other social services.

Ultimately these measures will result in improved post hospital medical management and care, general medical care, and a reduction of preventable rehospitalizations and ED utilization.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.18	*IT-9.2*	*OD-9 Right Care, Right Setting* *ED Appropriate Utilization*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.3: -Implement/Expand Care Transition Programs- Care Connections for the Homeless*		
Starting Point/Baseline:	*Target Population:* *Specific Number: 2,100* *Description of Population: This project will be focused on providing primary care, supportive services, and behavioral services to three homeless populations: those who are unsheltered, emergency sheltered, or tenants are in permanent supportive housing throughout Tarrant County. The primary objective is to decrease all ED visits in this identified homeless population.* *Baseline data:* *If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target*		
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]: Partner with identified agencies serving the health care needs of the homeless community for project planning purposes for –identifying communication plan, and plans for health information sharing to best serve the health care needs of the homeless with goal of reducing ED visits. Data source: Written plans. Process Milestone 1 Estimated Incentive Payment: $4,937 **Process Milestone 2** [P-3]: Partner with identified agencies serving the	**Process Milestone 3** [P-4]: Plan-Do-Study-Act Cycle will be utilized to identify the innovative strategies to reduce ED admissions in the homeless population. Data source: Documentation of PDSA Cycle and evidence of the number of individuals' stakeholders receiving information and lessons learned based on PDSA results Process Milestone 3 Estimated Incentive Payment: $17,169	**Outcome Improvement Target 1** [IT-9.2]: Reduce all ED visits from baseline by 10% for the homeless population. Improvement Target: Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 1 Estimated Incentive Payment: $9,184 **Outcome Improvement Target 2** [IT-9.2]: Reduce Emergency Department visits for target conditions from baseline by 10% in the homeless population. Improvement Target:	**Outcome Improvement Target 3** [IT 9-2]: Reduce all ED visits from baseline by 15% for the homeless population. Improvement Target: Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 3 Estimated Incentive Payment: $21,960 **Outcome Improvement Target 4** [IT-9.2]: Reduce Emergency Department visits for target conditions from baseline by 15% in the homeless population.

126675104.3.18	*IT-9.2*	*OD-9 Right Care, Right Setting* *ED Appropriate Utilization*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.3: -Implement/Expand Care Transition Programs- Care Connections for the Homeless*		
Starting Point/Baseline:	*<u>Target Population:</u>* *Specific Number: 2,100* *Description of Population: This project will be focused on providing primary care, supportive services, and behavioral services to three homeless populations: those who are unsheltered, emergency sheltered, or tenants are in permanent supportive housing throughout Tarrant County. The primary objective is to decrease all ED visits in this identified homeless population.* *<u>Baseline data:</u>* *If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target*		
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)**
homeless community to develop and test data systems (for information sharing) specific to the homeless population. Data source: EMR, Excel spreadsheets, Medical Record data, HIE Process Milestone 2 Estimated Incentive Payment: $4,938		Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 2 Estimated Incentive Payment*:* $9,183	Improvement Target: Data Source: EMR, Spreadsheets, and Claims data Outcome Improvement Target 4 Estimated Incentive Payment*:* $21,960
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $9,875	Year 3 Estimated Outcome Amount: $17,169	Year 4 Estimated Outcome Amount: $18,367	Year 5 Estimated Outcome Amount: $43,920
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $89,330			

Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30-Day readmission rate

Unique RHP outcome identification number(s): 126675104.3.19

Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
By the end of the Waiver, our goal is to reduce CHF readmissions for all patients to the hospital district by 5%.

Process Milestones:

- In DY2, we will establish the baseline for this rate. An initial data pull from our financial records indicate that the baseline may be as high as 18%.

Outcome Improvement Targets for each year:

- In DY3, our goal is to reduce this rate by 2%.
- In DY4, our goal is to reduce this rate by 5%.
- In DY5, our goal is to reduce this rate by 7%.

Rationale:

Our rationale for this outcome improvement target is that CHF is a major health epidemic and a large portion of CHF expenditure is due to readmissions. In addition to the cost of readmission which can be reduced and prevented in some cases, CHF admissions increase the risk of survival as symptomatic patients have a 20% mortality rate at one year. In 2010, CHF was approximately 2% of all health care expenditures at a total cost of over $39 billion dollars. We feel that our facility can impact our CHF patient population with a focused well developed plan that includes our primary care physicians, our partners in the community and our emergency department.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome

over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.19	IT- 3.2	Congestive Heart Failure 30-day readmission rate	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.4: Coordinated CHF Program		
Starting Point/Baseline:	Target population: 263 annual visits		
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 data Data Source: Facility financial system Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $27,284	**Outcome Improvement Target 1** [IT-3.2]:Congestive Heart Failure 30-day readmission rate Improvement Target: Baseline as of September 2012 all payors observed = 26.6% Reduce readmission for CHF patients by 2% of baseline Data Source: Facility financial system Outcome Improvement Target 1 Estimated Incentive Payment*:* $47,439	**Outcome Improvement Target 2** [IT-3.2]:Congestive Heart Failure 30-day readmission rate Improvement Target: : Baseline as of September 2012 all payors observed = 26.6% Reduce readmission for CHF patients by 5% of baseline Data Source: Facility financial system Outcome Improvement Target 2 Estimated Incentive Payment*:* $50,749	**Outcome Improvement Target 3** [IT-3.2]: Congestive Heart Failure 30-day readmission rate Improvement Target: Baseline as of September 2012 all payors observed = 26.6% Reduce readmission for CHF patients by 7% of baseline Data Source: Facility financial system Outcome Improvement Target 3 Estimated Incentive Payment*:* $121,355
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $27,284	Year 3 Estimated Outcome Amount: $47,439	Year 4 Estimated Outcome Amount: $50,749	Year 5 Estimated Outcome Amount: $121,355
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $246,827			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 126675104.3.20
Performing Provider Name/TPI: JPS Health Network/126675104
Outcome Measure Description:
By the end of the Waiver, we expect to improve our patient satisfaction for our CHF population by 15%.
Process Milestones:

- In DY2, we will establish a baseline. We are not certain of our current rate.
- In DY3, we will implement the patient satisfaction program.

Outcome Improvement Targets for each year:

- In DY4, we will continue to monitor and establish action plans as needed to improve our rates.
- In DY5, we will continue to monitor and refine action plans.

Rationale:

Our rationale for selecting this outcome improvement target is that we believe patient satisfaction directly impacts patient compliance for the CHF regimen including medication management. Patients who have an opportunity to discuss issues and concerns with their medical team along with the ability to understand their disease (including their families) have a better chance for their personal outcomes. We will not know how effective our program will be unless we monitor patient satisfaction and actively develop action plans that meet the needs of our patients.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.20	3.IT- 6.1	Percent improvement over baseline of patient satisfaction scores	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.4: Coordinated CHF Program		
Starting Point/Baseline:	**Target population:** CHF population		
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 data Data Source: Patient satisfaction survey tool Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $4,096	**Outcome Improvement Target 1** [IT-6.1]:Percent improvement over baseline of patient satisfaction scores. This is a new measure based on the baseline of the cardiology clinic patient satisfaction results for 12 months ending December 2012. Improvement Target: Improve patient satisfaction by 5% over baseline of 80% Data Source: Patient satisfaction survey tool Outcome Improvement Target 1 Estimated Incentive Payment*:* $7,122	**Outcome Improvement Target 2** [IT-6.1]:Percent improvement over baseline of patient satisfaction scores Improvement Target: Improve patient satisfaction10% over baseline of 80% Data Source: Patient satisfaction survey tool Outcome Improvement Target 2 Estimated Incentive Payment*:* $7,619	**Outcome Improvement Target 3** [IT-6.1]:Percent improvement over baseline of patient satisfaction scores Improvement Target: Improve patient satisfaction15% over baseline of 80% Data Source: Patient satisfaction survey tool Outcome Improvement Target 3 Estimated Incentive Payment*:* $18,219
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $4,096	Year 3 Estimated Outcome Amount: $7,122	Year 4 Estimated Outcome Amount: $7,619	Year 5 Estimated Outcome Amount: $18,219
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $37,055			

Title of Outcome Measure (Improvement Target): IT-3.1 All-cause 30-day readmission rate

Unique RHP outcome identification number(s): 126675104.3.21
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

Process Milestones:
Outcome measure description: All-cause 30-day readmission rate

By the end of the five-year period, we will reduce the rate of all-cause 30-day readmission by 15%. The milestones for the project include the following:

In DY2, project planning will be completed. We will validate the baseline and include stakeholders for program input.

In DY3, we will develop and test data systems (EMR reports, registries) and conduct plan-do-study act cycles to improve data collection and to implement effective change of interventions and continuously move toward goal attainment. Information and lessons learned will be shared through meetings and electronic communication with interdisciplinary teams within the organization and with community-linked partners.

Outcome Improvement Targets for each year:
In DY4, the goal is to reduce the all-cause 30-day re-admission by 10%.

Rationale:
Readmission rates for hospitals have been brought to the forefront recently. Patient-centeredness also compels us to improve our management of transitions from the hospital, care coordination, and outside support for the patient in their community setting. But complex community/hospital relationships and financial implications for hospitals make this issue demand thoughtful intervention. This outcome measure was chosen because JPS Health Network does not have a systematic process to reduce the risk for potentially preventable hospital readmissions. The readmission rate in 2011 for JPS Connection patients was 13%. The chosen milestones and improvement targets will afford us the opportunity to plan and subsequently report progress within the project. Engaging internal and external stakeholders will help us to develop a cross-continuum team to work together to improve care. Our improvement targets were chosen that reflect the organizational commitment to providing health care that will lead to a safe discharge, provide coordination of care and communication within and across health care settings to avoid readmissions.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.21	IT-3.1	All-cause 30-day readmission rate	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.5: Implement/Expand Care Transitions Programs – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions		
Starting Point/Baseline:	Target Population: 25,488 Specific Number: 1500 Description of Population: JPS discharged patients Baseline data: Plan to validate baseline data in DY2 If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 The Care Transitions Program using Coleman model-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: stakeholder interviews and meetings , EMR, registries, project plans and timelines, reports Process Milestone 1 Estimated Incentive Payment: $91,729 **Process Milestone 2 [P-2]:** Establish baseline data for all-cause 30-day readmission rate. Data Source: EMR, registries, This project will validate baseline	**Process Milestone 3** [P-3]**:** Develop and test data systems Data Source: EPIC EMR, registries, risk stratification reports Process Milestone 2 Estimated Incentive Payment: $106,326 **Process Milestone 4** [P-4]**:** Conduct Plan Do Study Act cycles to improve data collection , patient interventions and hand off communication for patient care transitions Data Source: PI meeting minutes, reports, observation tools, etc. Process Milestone 3 Estimated Incentive Payment: $106,325 **Process Milestone 5** [P-5]**:** Disseminate findings, including lessons learned internally and to	**Outcome Improvement Target 1** [IT-3.1]**:** Reduce readmissions , for any cause within 30 days of discharge from the index admission Improvement Target: 10% reduction over baseline in all-case 30-day readmission rate. Goal: < 1850 admission encounters Data Source: EMR, claims data Outcome Improvement Target 1 Estimated Incentive Payment*:* $341,231	**Outcome Improvement Target 2** [IT-3.1]: Reduce readmissions for any cause within 30 days of discharge from the index admission Improvement Target: 15% reduction over baseline in all-cause 30-day readmission rate. Goal: <1750 admission encounters Data Source: EMR, claims data Outcome Improvement Target 2 Estimated Incentive Payment*:* $815,987

126675104.3.21	IT-3.1	All-cause 30-day readmission rate	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.5: Implement/Expand Care Transitions Programs – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions		
Starting Point/Baseline:	Target Population: 25,488 Specific Number: 1500 Description of Population: JPS discharged patients Baseline data: Plan to validate baseline data in DY2 If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
data. Process Milestone 1 Estimated Incentive Payment: $91,729	community linked partners (MedStar Mobile Health Care, Homeless Care Transitions Program, home care agencies, hospices, nursing homes, etc.) Data Source: **electronic communications, community agency meetings, etc.** Process Milestone 4 Estimated Incentive Payment: $106,326		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $183,458	Year 3 Estimated Outcome Amount: $318,977	Year 4 Estimated Outcome Amount: $341,231	Year 5 Estimated Outcome Amount: $815,987
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,659,653			

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization

Unique RHP outcome identification number(s): 126675104.3.22
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

Process Milestones:
Outcome measure description: ED Appropriate Utilization

By the end of the 5-year period, we will have reduced ED inappropriate utilization/increase appropriate ED utilization by 10% over baseline. The milestones for the project include the following:

In DY2, project planning will be completed. We will determine the baseline and include stakeholders for program input.

In DY3, we will develop and test data systems (EMR reports, registries) and conduct plan-do-study act cycles to improve data collection and to implement effective change of interventions and continuously move toward goal attainment. Information and lessons learned will be shared through meetings and electronic communication with interdisciplinary teams within the organization and with community-linked partners.

Outcome Improvement Targets for each year:
In DY4, ED appropriate utilization will have increased by 5% over baseline.

In DY5, ED appropriate utilization will have increased by 10% over baseline.

Rationale:
Inappropriate utilization for hospital emergency departments have been brought to the forefront recently. Patient-centeredness also compels us to improve our management of transitions from the hospital, care coordination, and outside support for the patient in their community setting. But complex community/hospital relationships and financial implications for hospitals make this issue demand thoughtful intervention. This outcome measure was chosen because JPS Health Network does not have a systematic process to ensure that their patients are utilizing the ED appropriately and effectively. The chosen milestones and improvement targets will afford us the opportunity to plan and subsequently report progress within the project. Engaging internal and external stakeholders will help us to develop a cross-continuum team to work together to improve care. Our improvement targets were chosen that reflect the organizational commitment to providing health care that will lead to a safe discharge, provide coordination of care and communication within and across health care settings to reduce inappropriate ED usage.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.22	IT-9.2	ED Appropriate Utilization	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.5: Implement/Expand Care Transitions Programs – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions		
Starting Point/Baseline:	Target Population: 10,000 Specific Number: - 4,000 Description of Population: JPS Connection patients in the ED Baseline data: Plan to validate baseline data in DY2 If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 The Care Transitions Program using Coleman model-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: stakeholder interviews and meetings , EMR, registries, project plans and timelines, reports Process Milestone 1 Estimated Incentive Payment: $31,397 **Process Milestone 2 [P-2]:** Establish baseline data for inappropriate ED utilization Data Source: EMR, registries, This project will validate baseline	**Process Milestone 3** [P-3]**:** Develop and test data systems Data Source: EPIC EMR, registries, risk stratification reports Process Milestone 3 Estimated Incentive Payment: $36,393 **Process Milestone 4** [P-4]**:** Conduct Plan Do Study Act cycles to improve data collection , patient interventions and hand off communication for patient care transitions Data Source: PI meeting minutes, reports, observation tools, etc. Process Milestone 4 Estimated Incentive Payment: $36,393 **Process Milestone 5** [P-5]**:** Disseminate findings, including lessons learned internally and to	**Outcome Improvement Target 1** [IT-9.2]**:** ED Appropriate Utilization Improvement Target: 5% -decrease in ED utilization- over baseline. Data Source: EMR, claims data Outcome Improvement Target 1 Estimated Incentive Payment*:* $116,796	**Outcome Improvement Target 2** [IT-9.2]: Reduce inappropriate ED utilization Improvement Target: 10% decrease in ED utilization - over baseline. Data Source: EMR, claims data Outcome Improvement Target 2 Estimated Incentive Payment*:* $279,294

126675104.3.22	IT-9.2	ED Appropriate Utilization	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.5: Implement/Expand Care Transitions Programs – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions		
Starting Point/Baseline:	Target Population: 10,000 Specific Number: - 4,000 Description of Population: JPS Connection patients in the ED Baseline data: Plan to validate baseline data in DY2 If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
data. Process Milestone 1 Estimated Incentive Payment: $31,396	community linked partners (MedStar Mobile Health Care, Homeless Care Transitions Program, home care agencies, hospices, nursing homes, etc.) Data Source: **electronic communications, community agency meetings, etc.** Process Milestone 5 Estimated Incentive Payment: $36,393		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $62,793	Year 3 Estimated Outcome Amount: $109,179	Year 4 Estimated Outcome Amount: $116,796	Year 5 Estimated Outcome Amount: $279,294
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $568,062			

Title of Outcome Measure (Improvement Target): IT-1.8 – Depression management: Screening and Treatment Plan for Clinical Depression

Unique RHP outcome identification number(s): 126675104.3.23
Performing Provider Name/TPI: JPS Health Network / 126675104

Outcome Measure Description:
IT-1.8 – Depression management: Screening and Treatment Plan for Clinical Depression

This measure assesses the percentage of patients receiving treatment from the integrated care project who have been screened for clinical depression using a standardized tool and a follow-up plan is documented.

Process Milestones:
In DY2, there are 2 process milestones established. The first is related to Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. The second is related to develop and testing data systems necessary to establish baseline and improvement targets. In DY3, there is three process milestones established. One is related to conducting Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

Outcome Improvement Targets for each year:
The other two are related to establishing the baseline and improvement rates for DY4 and DY5 of patients screened for depression with a follow-up plan. In DY4 and 5 there is one outcome target for each year to improve baseline number of patients who are screened and have a follow-up plan for clinical depression by a percentage to be established in DY3.

Rationale:
The process outcomes selected were required building blocks to accurately identify the baseline rates of depression screening and treatment plans. The process measure related to identifying the baseline rates is a critical step that must be accomplished before improvement targets can be established. Improvement targets will be established in DY3 for implement in DY4 and DY5.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these

metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.23	3.IT-1.8	Depression management: Screening and Treatment Plan for Clinical Depression	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.6: Design, implement, and evaluate projects that provide integrated primary and behavioral health care services		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** *5,567* (DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670) ***Description of Population:*** *The population who will be served by both primary and behavioral health care in an integrated fashion.* ***Baseline data:*** *4,273*		
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/Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,073,891 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: *EMR* Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $207,391	**Process Milestone 3** [P-2]: Establish baseline rate of patients who have depression remission at 12 months Data Source: EMR Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $240,394 **Process Milestone 4** [P-4]**:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Data Reports, PDSA Summaries Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $240,393 **Process Milestone 5** [P-7]: Establish outcome targets for IT-1.8 Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented Data Source: Data Reports,	**Outcome Improvement target 1** [IT-1.8]: Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented Improvement Target: TBD in DY3 Data Source: EMR, Paper Medical Records, Provider Data, Utilization Report, Project Data Outcome Improvement Target 1 Estimated Incentive Payment*:* $771,495	**Outcome Improvement target 2** [IT-1.8]: Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented Improvement Target: TBD in DY3 Data Source: EMR, Paper Medical Records, Provider Data, Utilization Report, Project Data Outcome Improvement Target 2 Estimated Incentive Payment*:* $184,4879

126675104.3.23	3.IT-1.8	Depression management: Screening and Treatment Plan for Clinical Depression	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.6: Design, implement, and evaluate projects that provide integrated primary and behavioral health care services		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** *5,567* (DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670) ***Description of Population:*** *The population who will be served by both primary and behavioral health care in an integrated fashion.* ***Baseline data:*** *4,273*		
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)**
	Baseline Report Process Milestone 5 Estimated Incentive Payment *(maximum amount):* $240,393		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $414,782	Year 3 Estimated Outcome Amount: $721,180	Year 4 Estimated Outcome Amount: $771,495	Year 5 Estimated Outcome Amount: $1,844,879
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $3,752,336			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)17- NQF 0059* (Stand-alone measure)

Unique RHP outcome identification number(s): 126675104.3.24
Performing Provider Name/TPI: JPS Health Network / 126675104

Outcome Measure Description:
IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)17- NQF 0059*

This measure identifies the percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

Process Milestones:

- In DY2, there is one process milestones related to project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. A second process milestone is related to developing and testing data systems to prepare report indicating baseline percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- In DY3, there are three process milestones. The first is to establish the baseline percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. The second milestone is to conduct PDSA cycles to improve data collection and intervention activities.

Outcome Improvement Targets for each year:
DY4 and DY5 have an outcome Improvement target to improve the baseline percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0% by a percentage by determined in DY3
Rationale:
The process milestone selected for DY2 is a required building block to accurately identify the baseline rates of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. The DY3 process milestone related to identifying the baseline rates is a critical step that must be accomplished before improvement targets can be established for increasing the percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%. Outcome improvement targets will be established in DY3 for DY4 and DY5.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus

received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.24	*3.IT.1.10*	**IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)17- NQF 0059* (Stand-alone measure)**	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.6: Design, implement, and evaluate projects that provide integrated primary and behavioral health care services		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** *5,567*(DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670) ***Description of Population:*** *The population who will be served by both primary and behavioral health care in an integrated fashion.* ***Baseline data:*** *4,273*		
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/Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,154 **Process Milestone 2** [P-3]**:** Develop and test data systems Data Source: EMR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3,153	**Process Milestone 4** [P-2]**:** Establish baseline percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0% Data Source: EMR, Encounter Data, Claims Systems Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $5,483 **Process Milestone 5** [P-4]**:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Data Reports, PDSA Summaries Process Milestone 5 Estimated Incentive Payment *(maximum amount):* $5,483	**Outcome Improvement target 1** [IT-1.10]**:** Diabetes care: *HbA1c poor control (>9.0%)17* Improvement Target: Improve baseline percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0% by XX%. Target will be linked to organizational target for overall diabetes management program improvement. Data Source: EMR, Encounter Data, Claims Systems Outcome Improvement Target 1 Estimated Incentive Payment*:* $17,596	**Outcome Improvement target 2** [IT-1.10]**:** Diabetes care: *HbA1c poor control (>9.0%)17* Improvement Target: Improve baseline percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0% by XX%. Target will be linked to organizational target for overall diabetes management program improvement. Data Source: EMR, Encounter Data, Claims Systems Outcome Improvement Target 2 Estimated Incentive Payment*:* $42,077

126675104.3.24	*3.IT.1.10*	**IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)17- NQF 0059* (Stand-alone measure)**	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.6: Design, implement, and evaluate projects that provide integrated primary and behavioral health care services		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** *5,567*(DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670) ***Description of Population:*** *The population who will be served by both primary and behavioral health care in an integrated fashion.* ***Baseline data:*** *4,273*		
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 3 [P-7]**:** Manage data systems to prepare report indicating baseline percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0% Data Source: Data reports, Electronic Health Record Process Milestone 3 Estimated Incentive Payment: $3,153	**Process Milestone 6** [P-7]**:** Establish outcome improvement target for IT-1.10 – improvement in percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0% Data Source: Data Reports, Baseline Process Milestone 6 Estimated Incentive Payment *(maximum amount):* $5,482		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $9,460	Year 3 Estimated Outcome Amount: $16,448	Year 4 Estimated Outcome Amount: $17,596	Year 5 Estimated Outcome Amount: $42,077

126675104.3.24	*3.IT.1.10*	**IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)17- NQF 0059* (Stand-alone measure)**	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.6: Design, implement, and evaluate projects that provide integrated primary and behavioral health care services		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** *5,567*(DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670) ***Description of Population:*** *The population who will be served by both primary and behavioral health care in an integrated fashion.* ***Baseline data:*** *4,273*		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $85,581			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes care: BP control (<140/80mm Hg) – NQF 0061 (Stand-alone measure)

Unique RHP outcome identification number(s): 126675104.3.25
Performing Provider Name/TPI: JPS Health Network / 126675104

Outcome Measure Description:
IT-1.11 Diabetes care: BP control (<140/80mm Hg)
This measure identifies the percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg.

Process Milestones:
In DY2, there is one process milestones established to manage data systems to prepare report indicating baseline percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg. In DY3, there are two process milestones. The first is to establish the baseline percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg.

Outcome Improvement Targets for each year:
The second is to establish outcome improvement targets for DY4 and DY5 related to the improvement in percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg. DY4 and DY5 have an outcome Improvement target (determined in DY3) to improve the baseline percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg by a percentage to be determined in DY3.

Rationale:
The process milestone selected for DY2 is a required building block to accurately identify the baseline rates of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg. The DY3 process milestone related to identifying the baseline rates is a critical step that must be accomplished before improvement targets can be established for increasing the percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg. Outcome improvement targets will be established in DY3 for DY4 and DY5.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus

received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.25	*.IT-1.11*	**Diabetes care: *BP control (<140/80mm Hg) – NQF 0061 (Stand-alone measure*)**	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.6: Design, implement, and evaluate projects that provide integrated primary and behavioral health care services		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** *5,567*(DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670) ***Description of Population:*** *The percentage of population who will be served by both primary and behavioral health care in an integrated fashion.* ***Baseline data:*** *4,273*		
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 Baseline/Goal: Project plan to establish baseline and improvement targets in DY3 Data Source: Project Plan Process Milestone 1 Estimated Incentive Payment: $27,878	**Process Milestone 2** [P-2]**:** Establish baseline percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg Baseline/Goal: Establish Baseline Report for percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg Data Source: EMR Process Milestone 2 Estimated Incentive Payment: $24,236 **Process Milestone 3** [P-7]**:** Establish outcome improvement target for improvement in percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg Baseline/Goal: Establish Baseline Report for percentage of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg	**Outcome Improvement target 1** [IT-1.11]**:** Diabetes care: BP control (<140/80mm Hg) – NQF 0061 Improvement target: Improve baseline percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg by XX%. Target will be linked to organizational target for overall diabetes management program improvement. TBD in DY3 Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $51,853	**Outcome Improvement target 2** [IT-1.11]**:** Diabetes care: BP control (<140/80mm Hg) – NQF 0061 Improvement target: Improve baseline percent of behavioral health patients 18-75 years of age with diabetes (type 1 or type 2) who had BP less than 140/90 mm Hg by XX%. Target will be linked to organizational target for overall diabetes management program improvement. TBD in DY3 Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $123,997

126675104.3.25	*.IT-1.11*	**Diabetes care: *BP control (<140/80mm Hg) – NQF 0061 (Stand-alone measure*)**	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.6: Design, implement, and evaluate projects that provide integrated primary and behavioral health care services		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** *5,567*(DY2 = 557, DY3 = 1670, DY4 = 1670, and DY5 = 1670) ***Description of Population:*** *The percentage of population who will be served by both primary and behavioral health care in an integrated fashion.* ***Baseline data:*** *4,273*		
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)**
	Data Source: EMR Process Milestone 3 Estimated Incentive Payment: $24,236		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $27,878	Year 3 Estimated Outcome Amount: $48,472	Year 4 Estimated Outcome Amount: $51,853	Year 5 Estimated Outcome Amount: $123,997
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $252,200			

Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health / Substance Abuse 30-day readmission rate (Stand-alone measure)

Unique RHP outcome identification number(s): 126675104.3.26
Performing Provider Name/TPI: JPS Health Network / 126675104

Outcome Measure Description:
IT-3.8 Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure)
This measure identifies the behavioral health, all-cause readmission within 30 days of hospital discharge after an index admission for patients ages 18 and older.

Process Milestones:
In DY2, there are 2 process milestones established. The first is for project planning where we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. The second is the development and testing of data systems. In DY3, there are 2 process milestones established. The first is to establish the baseline rates of behavioral health 30-day readmission rate. The second milestone is the completion of PDSA cycles to improve data collection and intervention activities. The final process milestone is the establishment of the outcome targets for IT-3.8.

Outcome Improvement Targets for each year:
The final process milestone is the establishment of the outcome targets for IT-3.8. In DY4 and DY5 there is one outcome target for each rate in each year. The improvement target is to improve behavioral health 30-day readmission rates by a percentage to be determined in DY3.

Rationale:
The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Given data limitations, only readmissions to the same facility will be included as part of each hospital's rates. The process outcome selected was a required building blocks to accurately identify the baseline rates of patients who readmit within 30 days. The process measure related to identifying the baseline rates is a critical step that must be accomplished before improvement targets for increasing rates of depression remission can be compared. Improvement targets for DY4 and DY5 will result in a total reduction of all-cause psychiatric readmissions by a percentage established in DY3. A reduction amount will be selected with consideration being given to the significant complexity of those who receive services in Trinity Springs Pavilion.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of

milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.26	*3.IT-3.8*	*IT-3.8 Behavioral Health /Substance Abuse 30- day readmission rate (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.7: Behavioral Health Discharge Management Program		
Starting Point/Baseline:	Target Population: Specific Number: 4,923 inpatient discharges annually (14,769 for DY3, DY4, and DY5) Description of Population: All patients discharging from Trinity Springs Pavilion (96 bed inpatient psychiatric hospital) Baseline data: No baseline data exists. Baseline rates and improvement targets 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-1]: Project planning and engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Documentation/Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $47,811 **Process Milestone 2** [P-3 -]: Develop and test data systems Data Source: EMR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $47,811	**Process Milestone 3** [P-2 -]: Establish baseline rates Data Source: EMR, Encounter Data, Claims Systems Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $55,419 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Data Reports, PDSA Summaries Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $55,419 **Process Milestone 5** [P-7 -]: Establish outcome targets for IT-3.8 Data Source: Data Reports, Baseline	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Improvement Target: Improve baseline number of behavioral health/substance abuse 30-day readmission rate Data Source: EMR, Encounter Data Numerator: The number of readmissions, for patients 18 years and older, for any cause, within 30 days of discharge from the index behavioral health and substance abuse admission is indicated as either the primary or secondary diagnosis. If an index admission has more than 1 readmission, only the first is counted as a readmission. Denominator: The number of admissions, for patients 18 years and older, for patients discharged from the hospital with a principal or secondary diagnosis of	**Outcome Improvement Target 2** [IT-3.8]: Behavioral Health /Substance Abuse 30-day readmission rate (Stand-alone measure) Improvement Target: Improve baseline number of behavioral health/substance abuse 30-day readmission rate Data Source: EMR, Encounter Data Outcome Improvement Target 2 Estimated Incentive Payment*:* $425,309

126675104.3.26	*3.IT-3.8*	*IT-3.8 Behavioral Health /Substance Abuse 30- day readmission rate (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.7: Behavioral Health Discharge Management Program		
Starting Point/Baseline:	Target Population: Specific Number: 4,923 inpatient discharges annually (14,769 for DY3, DY4, and DY5) Description of Population: All patients discharging from Trinity Springs Pavilion (96 bed inpatient psychiatric hospital) Baseline data: No baseline data exists. Baseline rates and improvement targets 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 5 Estimated Incentive Payment *(maximum amount):* $55,419	behavioral health and substance abuse and with a complete claims history for the 12 months prior to admission Outcome Improvement Target 1 Estimated Incentive Payment*:* $177,856	
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $95,622	Year 3 Estimated Outcome Amount: $166,257	Year 4 Estimated Outcome Amount: $177,856	Year 5 Estimated Outcome Amount: $425,309
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $865,044			

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(s): 126675104.3.27
Performing Provider Name/TPI: JPS Health Network / 126675104

Outcome Measure Description:
This measure assesses the decrease admission and readmission to criminal justice settings such as jails and prisons.

Process Milestones:
In DY2, there a milestone is established for project planning where we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. In DY3, there are 2 process milestones established. The first is to establish the baseline rate of admissions and readmissions to criminal justice settings such as jails and prisons. The second milestone is the completion of the establishment of the outcome targets for IT-9.1.

Outcome Improvement Targets for each year:
In DY4 and DY5 there is one outcome target for each rate in each year. The improvement target is to reduce the rates of admission and readmission to criminal justice settings by a percentage to be determined in DY3.

Rationale:
This outcome measure was selected because admission and readmission to criminal justice settings such as jails and prisons is disruptive and deleterious to recovery from behavioral health disorders. Studies of recidivistic criminal justice patients in Texas and other states have demonstrated poorer physical health status, increased incidence of homelessness, increased propensity to use emergency department, and inpatient services. Interventions that can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning. Currently, there is no determination of the criminal justice system involvement following treatment nor is there a transition management focus on intentionally reducing the rate of criminal justice involvement. The target rate of improvement will be selected based on the unique factors of this patient population and the current rates of criminal justice involvement after discharge.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total

potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.27	*3.IT- 9.1*	*IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.7: Behavioral Health Discharge Management Program		
Starting Point/Baseline:	Target Population: Specific Number: 4,923 inpatient discharges annually (14,769 for DY3, DY4, and DY5) Description of Population: All patients discharging from Trinity Springs Pavilion (96 bed inpatient psychiatric hospital) Baseline data: No baseline data exists. Baseline rates and improvement targets 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-1]: Project planning and engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR, Jail Public Records, Jail MH Contractor (MHMR) Data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $197,330	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: EMR, Jail Public Records, Jail MH Contractor (MHMR) Data Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $171,548 **Process Milestone 3** [P-7 -]: Establish outcome targets for IT-9.1 Data Source: EMR, Jail Public Records, Jail MH Contractor (MHMR) Data Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $171,549	**Outcome Improvement Target 1** [IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons *(Standalone measure)* Improvement Target: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Data Source: EMR, Jail Public Records, Jail MH Contractor (MHMR) Data Report, EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $367,034	**Outcome Improvement Target 2** [IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons *(Standalone measure)* Improvement Target: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Data Source: EMR, Jail Public Records, Jail MH Contractor (MHMR) Data Report, EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $877,689

126675104.3.27	*3.IT- 9.1*	*IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.7: Behavioral Health Discharge Management Program		
Starting Point/Baseline:	Target Population: Specific Number: 4,923 inpatient discharges annually (14,769 for DY3, DY4, and DY5) Description of Population: All patients discharging from Trinity Springs Pavilion (96 bed inpatient psychiatric hospital) Baseline data: No baseline data exists. Baseline rates and improvement targets 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $197,330	Year 3 Estimated Outcome Amount: $343,097	Year 4 Estimated Outcome Amount: $367,034	Year 5 Estimated Outcome Amount: $877,689
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,785,150			

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization – Reduce Emergency Department visits for behavioral health/substance abuse

Unique RHP outcome identification number(s): 126675104.3.28
Performing Provider Name/TPI: JPS Health Network / 126675104

Outcome Measure Description:
IT-9.2 ED appropriate utilization – Reduce Emergency Department visits for behavioral health/substance abuse
This measure assesses ED appropriate utilization. Specifically, the reduction in Emergency Department visits for target conditions – Behavioral Health/Substance Abuse.

Process Milestones:
In DY2, there a milestone is established for project planning where we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. In DY3, there are 2 process milestones established. The first is to establish the baseline rate of PEC utilization after discharge. The second milestone is the completion of the establishment of the outcome targets for IT-9.2.

Outcome Improvement Targets for each year:
In DY4 and DY5 there is one outcome target for each rate in each year. The improvement target is to reduce the emergency department visits for those discharged from Trinity Springs Pavilion by a percentage to be determined in DY3.

Rationale:
This outcome measure was selected because JPS Health Network experiences over 24,000 Psychiatric Emergency Center (ED) visits per year. The transition management program will ensure patients engage in their individualized care plan enhancing stabilization and service utilization outside of the emergency system. This measure also directly impacts our identified community needs. There overuse of the emergency department services (CN.10). Improve transition management will result in reduced utilization of the emergency services because patients will remain more stable in community-based services.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these

metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.28	*3.IT- 9.2*	*IT-9.2 ED appropriate utilization (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.2.7: Behavioral Health Discharge Management Program		
Starting Point/Baseline:	Target Population: Specific Number: 4,923 inpatient discharges annually (14,769 for DY3, DY4, and DY5) Description of Population: All patients discharging from Trinity Springs Pavilion (96 bed inpatient psychiatric hospital) Baseline data: No baseline data exists. Baseline rates and improvement targets 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-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EMR, Encounter Data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $16,976	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: EMR, Encounter Data Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $14,758 **Process Milestone 3** [P-7 -]: Establish outcome targets for IT-9.2 Data Source: EMR, Encounter Data Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $14,758	**Outcome Improvement Target 1** [IT-9.2]: Reduce Emergency Department visits for target conditions -Improvement Target: ED Appropriate utilization – reduce Emergency Department visits for target conditions – Behavioral Health/Substance Abuse Data Source: EMR, Encounter Data Report, EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $31,575	**Outcome Improvement Target 2** [IT-9.2]: Reduce Emergency Department visits for target conditions Improvement Target: ED Appropriate utilization – reduce Emergency Department visits for target conditions – Behavioral Health/Substance Abuse Data Source: EMR, Encounter Data Report, EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $75,505
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $16,976	Year 3 Estimated Outcome Amount: $29,516	Year 4 Estimated Outcome Amount: $31,575	Year 5 Estimated Outcome Amount: $75,505
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $153,571			

Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30-day readmission rate

Unique RHP outcome identification number(s): 126675104.3.29
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

Process Milestones:
DY2:
Process Milestones 1:
P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
Partner with JPS Health Network Cardiology and Case Management staff to develop process for identification of patients at risk for a 30-day PPR and assess the capacity of CHF treatment resources in the community.
Process Milestone 2-
P-2: Establish Baseline Rates – Work with stakeholder group above to establish baseline rates of PPR for CHF.
Process Milestone 3:
P-3: Develop and test data systems –
Review process for tracking enrolled patients and EMR linkages for sharing patient assessment and treatment data.
DY3:
Process milestones 4:
P-4: Conduct Plan-Do-Study-Act (PDSA) cycles to improve data collection and intervention activities.
A Plan-Do-Study-Act Cycle will be utilized to identify the innovative strategies to reduce PPR for CHF patients and disseminate findings to internal and external stakeholders.

Outcome Improvement Targets for each year:

Outcome Improvement Target 1:
IT-3.2: 25 of these patients (50% of the 50 enrollees) will experience no PPR during the 30-day post discharge time frame.
DY4:
Outcome Improvement Target 2:
IT-3.2: 38 of these patients (50% of the 75 enrollees) will experience no PPR during the 30-day post discharge time frame.
DY5:

Outcome Improvement Target 3:
IT-3.2: 50 of these patients (50% of the 100 enrollees) will experience no PPR during the 30-day post discharge time frame.

Rationale:
Congestive Heart Failure Program:
The average charge for a CHF admission is $54,000 and the community readmission rate for CHF is 17%. Under this DSRIP program, patients at risk for a CHF readmission are referred to MedStar for in-home education and non-emergent care during the 30-day readmission risk corridor. In a limited pilot project started in June 2012, 10 CHF patients at risk for readmission have been referred to the program with no CHF-related readmissions. The program expansion proposed here will allow an additional 225 patients to be referred to the program at significant improvement in health status and reduction in costs.
During DY2, we will determine the use data for CHF readmit patients, and the costs associated with this use.

We will then determine the processes necessary to achieve the Improvement Milestones, implement the programs and measure the change in use patterns of the target population. The baseline costs of prior use will then be compared to the actual costs of the target population's use of health care services, along with a tool to measure the patient's perception of their health status.

Once established, we will apply currently measured data metric to the expanded population as described above.

The milestones and metrics for this program has been based on actual experiences of JPS Health Network and MedStar conducting limited enrollment pilot projects in each of these areas, tracking the actual data as described and measuring results.

This CHF program significantly expands already operating, proven programs the impact larger number of patients. This increase in patient populations will allow for a more robust analysis of the impact to the patient and the costs of care for possible replication in other areas.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources,

time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.29	IT-3.2 CHF 30-day Readmission Rate	**OD-9 Right Care, Right Setting** JPS-Category 3.[unique identifying number]	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.8: Establish/Expand a Patient Care Navigation Program- MedStar Patient Navigation		
Starting Point/Baseline:	**Target Population:** **Specific Number:** All identified CHF patients at risk for PPA/PPR-225 enrollees **Description of Population:** This project will be focused on providing in-home management of CHF patients at-risk for PPR for CHF Dx. The goals will be achieved by providing in-home patient and patient family education on disease process, medication compliance, weight monitoring compliance, 3 times a week home visits by community health paramedics, non-emergency access to a 24/7 community paramedic for episodic issues, and coordination with patient's PCP for in-home diuresis if necessary to prevent PPR for 30 days post discharge. **Baseline data:** If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 Milestones 1: P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Partner with JPS Cardiology and Case Management staff to develop process for identification of patients at risk for a 30-day PPR and assess the capacity of CHF treatment resources in the community. Data Source: Information on established baseline metrics EMR, Excel spreadsheets, JPS Cardiology data, MedStar 911 use data.	**Process milestones 4:** P-4: Conduct Plan-Do-Study-Act (PDSA) cycles (rapid cycle improvement) to improve data collection and intervention activities. A Plan-Do-Study-Act Cycle will be utilized to identify the innovative strategies to reduce PPR for CHF patients and disseminate findings to internal and external stakeholders. Data Source: Information on PDSA outcomes, EMR, Excel spreadsheets, JPS Cardiology data, MedStar 911 use data.	**Outcome Improvement Target 2 (IT-3.2):** 38 of these patients (50% of the 75 enrollees) will experience no PPR during the 30-day post discharge time frame. CHF In-Home Management – Enroll 75 patients at risk for PPR for CHF are referred to the MedStar program. Data Source: JPS and MedStar EMRs. Data Source: EMR, Spreadsheets, and Claims data.	**Outcome Improvement Target 3 (IT-3.2):** 50 of these patients (50% of the 100 enrollees) will experience no PPR during the 30-day post discharge time frame. CHF In-Home Management – Enroll 100 patients at risk for PPR for CHF are referred to the MedStar program. Data Source: JPS and MedStar EMRs. Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 3

126675104.3.29	IT-3.2 CHF 30-day Readmission Rate	**OD-9 Right Care, Right Setting** JPS-Category 3.[unique identifying number]	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.8: Establish/Expand a Patient Care Navigation Program- MedStar Patient Navigation		
Starting Point/Baseline:	**<u>Target Population:</u>** **<u>Specific Number:</u>** All identified CHF patients at risk for PPA/PPR-225 enrollees **<u>Description of Population:</u>** This project will be focused on providing in-home management of CHF patients at-risk for PPR for CHF Dx. The goals will be achieved by providing in-home patient and patient family education on disease process, medication compliance, weight monitoring compliance, 3 times a week home visits by community health paramedics, non-emergency access to a 24/7 community paramedic for episodic issues, and coordination with patient's PCP for in-home diuresis if necessary to prevent PPR for 30 days post discharge**.** **<u>Baseline data:</u>** If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 Milestone1 Estimated Incentive Payment: $22,455 **<u>Process Milestone 2-</u>** P-2: Establish Baseline Rates – Work with stakeholder group above to establish baseline rates of PPR for CHF. <u>Data Source</u>: Information on established baseline metrics EMR, Excel spreadsheets, JPS Cardiology data, MedStar 9-1-1 use data. Process Milestone 2 Estimated Incentive Payment *(maximum*	Process Milestone 4 Estimated Incentive Payment: $58,564 **<u>Outcome Improvement Target 1</u>** <u>(IT-3.2):</u> 25 of these patients (50% of the 50 enrollees) will experience no PPR during the 30-day post discharge timeframe <u>Data Source</u>: Information on established baseline metrics EMR, Excel spreadsheets, JPS Cardiology data, MedStar 9-1-1 use data.	Outcome Improvement Target 2 Estimated Incentive Payment: $125,299	Estimated Incentive Payment: $299,627

126675104.3.29	IT-3.2 CHF 30-day Readmission Rate	**OD-9 Right Care, Right Setting** JPS-Category 3.[unique identifying number]	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.8: Establish/Expand a Patient Care Navigation Program- MedStar Patient Navigation		
Starting Point/Baseline:	**<u>Target Population:</u>** **<u>Specific Number:</u>** All identified CHF patients at risk for PPA/PPR-225 enrollees **<u>Description of Population:</u>** This project will be focused on providing in-home management of CHF patients at-risk for PPR for CHF Dx. The goals will be achieved by providing in-home patient and patient family education on disease process, medication compliance, weight monitoring compliance, 3 times a week home visits by community health paramedics, non-emergency access to a 24/7 community paramedic for episodic issues, and coordination with patient's PCP for in-home diuresis if necessary to prevent PPR for 30 days post discharge**.** **<u>Baseline data:</u>** If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
amount): $22,455 **<u>Process Milestone 3:</u>** P-3: Develop and test data systems – Review process for tracking enrolled patients and EMR linkages for sharing patient assessment and treatment data. <u>Data Source</u>: Information on established baseline metrics EMR, Excel spreadsheets, JPS Cardiology data, MedStar 9-1-1 use data.	Outcome Improvement Target 1 Estimated Incentive Payment: $58,563		

126675104.3.29	IT-3.2 CHF 30-day Readmission Rate	**OD-9 Right Care, Right Setting** JPS-Category 3.[unique identifying number]	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.8: Establish/Expand a Patient Care Navigation Program- MedStar Patient Navigation		
Starting Point/Baseline:	**Target Population:** **Specific Number:** All identified CHF patients at risk for PPA/PPR-225 enrollees **Description of Population:** This project will be focused on providing in-home management of CHF patients at-risk for PPR for CHF Dx. The goals will be achieved by providing in-home patient and patient family education on disease process, medication compliance, weight monitoring compliance, 3 times a week home visits by community health paramedics, non-emergency access to a 24/7 community paramedic for episodic issues, and coordination with patient's PCP for in-home diuresis if necessary to prevent PPR for 30 days post discharge. **Baseline data:** If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 3 Estimated Incentive Payment *(maximum amount):* $22,455			

126675104.3.29	IT-3.2 CHF 30-day Readmission Rate	**OD-9 Right Care, Right Setting** JPS-Category 3.[unique identifying number]	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.8: Establish/Expand a Patient Care Navigation Program- MedStar Patient Navigation		
Starting Point/Baseline:	**Target Population:** **Specific Number:** All identified CHF patients at risk for PPA/PPR-225 enrollees **Description of Population:** This project will be focused on providing in-home management of CHF patients at-risk for PPR for CHF Dx. The goals will be achieved by providing in-home patient and patient family education on disease process, medication compliance, weight monitoring compliance, 3 times a week home visits by community health paramedics, non-emergency access to a 24/7 community paramedic for episodic issues, and coordination with patient's PCP for in-home diuresis if necessary to prevent PPR for 30 days post discharge. **Baseline data:** If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $67,365	Year 3 Estimated Outcome Amount: $117,127	Year 4 Estimated Outcome Amount: $125,299	Year 5 Estimated Outcome Amount: $299,627
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $609,418			

Title of Outcome Measure (Improvement Target): IT-1.8 - Depression management: Screening and Treatment Plan for Clinical Depression

Unique RHP outcome identification number(s): 126675104.3.31
Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
This measure assesses the percentage of patients receiving treatment from participating primary care providers within the virtual psychiatric and clinical guidance project who have been screened for clinical depression using a standardized tool and a follow-up plan is documented. In DY2, there are 2 process milestones established. The first is related to Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. The second is related to develop and testing data systems necessary to establish baseline and improvement targets. In DY 3, there is three process milestones established. One is related to conducting Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. The other two are related to establishing the baseline and improvement rates for DY4 and DY5 of patients screened for depression with a follow-up plan. In DY 4 and 5 there is one outcome target for each year to improve baseline number of patients who are screened and have a follow-up plan for clinical depression by a percentage to be established in DY 3.

Rationale:
The process outcomes selected were required building blocks to accurately identify the baseline rates of depression screening and treatment plans. The process measure related to identifying the baseline rates is a critical step that must be accomplished before improvement targets can be established. Improvement targets will be established in DY 3 for implement in DY 4 and DY5.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

126675104.3.31	.IT-1.8	Depression management: Screening and Treatment Plan for Clinical Depression	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.9		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** 1,802 primary care physicians in Region 10 who will potentially address behavioral health issues in primary care settings for 489,000 patients who will see assistance with behavioral health problems from their primary care physician. Primary care physicians in Region 10 who will address behavioral health issues in primary care settings for 9,047 patients (DY2 = 452, DY3 = 1810, DY4 = 2940, DY5 = 3845) ***Description of Population:*** This project targets the 489,000 people in Region 10 who have a diagnosable mental disorder but do not seek services in the mental health system. It is reported 28% of the population have a diagnosable mental disorder in any year. Only 8% of the population have a diagnosable mental disorder and receive services in the mental health system each year.[391] The target population includes those who have a diagnosable mental illness who do not receive care in the mental health system. The number was calculated as: (Region 10 population of 2,444,642 x 28%) – (Region 10 population of 2,444,642 x 8%) = 489,000. ***Baseline data:*** *No baseline – This is a new initiative*		
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)**

[391] National Institute of Mental Health, 1999. "Mental Health: A Report of the Surgeon General"

Process Milestone 1 [P-1]:: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Baseline/Goal: Project Plan Data Source: Project Documentation/Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $405,299 **Process Milestone 2 [P-3]:** Develop and test data systems Baseline/Goal: Test Data Reports *Data Source: EMR* Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $405,299	**Process Milestone 3 [P-2]:** Establish baseline rate of patients who have depression remission at 12 months Baseline/Goal: Baseline Report Data Source: EMR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $469,794 **Process Milestone 4 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Data Reports, PDSA Summaries Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $469,794 **Process Milestone 5 [P-7]:** Establish outcome targets for IT-1.8 Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented Baseline/Goal: Outcome Target for DY4 and DY5 Data Source: Data Reports, Baseline Report Process Milestone 7 Estimated Incentive Payment *(maximum amount):* $469,796	**Outcome improvement target 1 [IT-1.8]:** Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented Improvement Target: TBD in DY3 Data Source: EMR, Paper Medical Records, Provider Data, Utilization Report, Project Data Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,507,713	**Outcome improvement target 2 [IT-1.8]:** Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented Improvement Target: TBD in DY3 Data Source: EMR, Paper Medical Records, Provider Data, Utilization Report, Project Data Outcome Improvement Target 2 Estimated Incentive Payment*:* $3,605,400

Outcome Improvement target: Establish base line of patients screened for depression by partnering providers

Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $810,598	Year 3 Estimated Outcome Amount: $1,409,384	Year 4 Estimated Outcome Amount: $1,507,713	Year 5 Estimated Outcome Amount: $3,605,400
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $7,333,094			

Title of Outcome Measure (Improvement Target): IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (Stand-alone measure)

Unique RHP outcome identification number(s): 126675104.3.X (NEW- not in workbook)

Outcome Measure Description:
This outcome measures adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. In DY2, there are 2 process milestones established. The first is for project planning where we will engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. The second is the development and testing of data systems. In DY3, there are 3 process milestones established. The first is to establish the baseline rates of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. The second milestone is the completion of PDSA cycles to improve data collection and intervention activities. The final process milestone is the establishment of the outcome targets for IT-1.9. In DY4 and DY5 there is one outcome target in each year. The improvement target is to improve adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5 by a percentage to be determined in DY3.

Rationale:
The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator. The process outcomes selected were required building blocks to accurately identify the baseline rates of patients who have depression remission at 12 months. The process measure related to identifying the baseline rates is a critical step that must be accomplished before improvement targets for increasing rates of depression remission can be established. Improvement targets will be established in DY 3 for implement in DY 4 and DY5.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension or diabetes related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost

savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.X (NEW – Not in workbook)	*IT- 1.9*	*IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.9*		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** 1,802 primary care physicians in Region 10 who will potentially address behavioral health issues in primary care settings for 489,000 patients who will see assistance with behavioral health problems from their primary care physician. Primary care physicians in Region 10 who will address behavioral health issues in primary care settings for 9,047 patients (DY2 = 452, DY3 = 1810, DY4 = 2940, DY5 = 3845) ***Description of Population:*** This project targets the 489,000 people in Region 10 who have a diagnosable mental disorder but do not seek services in the mental health system. It is reported 28% of the population have a diagnosable mental disorder in any year. Only 8% of the population have a diagnosable mental disorder and receive services in the mental health system each year.[392] The target population includes those who have a diagnosable mental illness who do not receive care in the mental health system. The number was calculated as: (Region 10 population of 2,444,642 x 28%) – (Region 10 population of 2,444,642 x 8%) = 489,000. ***Baseline data:*** *No baseline – This is a new initiative*		
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)**

[392] National Institute of Mental Health, 1999. "Mental Health: A Report of the Surgeon General"

126675104.3.X (NEW – Not in workbook)	*IT- 1.9*	*IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.9*		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** 1,802 primary care physicians in Region 10 who will potentially address behavioral health issues in primary care settings for 489,000 patients who will see assistance with behavioral health problems from their primary care physician. Primary care physicians in Region 10 who will address behavioral health issues in primary care settings for 9,047 patients (DY2 = 452, DY3 = 1810, DY4 = 2940, DY5 = 3845) ***Description of Population:*** This project targets the 489,000 people in Region 10 who have a diagnosable mental disorder but do not seek services in the mental health system. It is reported 28% of the population have a diagnosable mental disorder in any year. Only 8% of the population have a diagnosable mental disorder and receive services in the mental health system each year.[392] The target population includes those who have a diagnosable mental illness who do not receive care in the mental health system. The number was calculated as: (Region 10 population of 2,444,642 x 28%) – (Region 10 population of 2,444,642 x 8%) = 489,000. ***Baseline data:*** *No baseline – This is a new initiative*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-1 Process Milestone: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Baseline/Goal: Project Plan Data Source: Project Documentation/Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**P-2 Process Milestone:** Establish baseline rate of patients who have depression remission at 12 months Baseline/Goal: Baseline Report Data Source: EMR Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $0 **P- 4 Process Milestone:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and	**IT-1.9 Outcome Improvement target:** Improve baseline percentage of patients who have depression remission at 12 months by XX% Baseline/Goal: TBD in DY3 Data Source: EMR **Payment: $0**	**IT-1.9Outcome Improvement target:** Improve baseline percentage of patients who have depression remission at 12 months by XX% Baseline/Goal: TBD in DY3 Data Source: EMR **Payment: $0**

126675104.3.X (NEW – Not in workbook)	*IT- 1.9*	*IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.9*		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** 1,802 primary care physicians in Region 10 who will potentially address behavioral health issues in primary care settings for 489,000 patients who will see assistance with behavioral health problems from their primary care physician. Primary care physicians in Region 10 who will address behavioral health issues in primary care settings for 9,047 patients (DY2 = 452, DY3 = 1810, DY4 = 2940, DY5 = 3845) ***Description of Population:*** This project targets the 489,000 people in Region 10 who have a diagnosable mental disorder but do not seek services in the mental health system. It is reported 28% of the population have a diagnosable mental disorder in any year. Only 8% of the population have a diagnosable mental disorder and receive services in the mental health system each year.[392] The target population includes those who have a diagnosable mental illness who do not receive care in the mental health system. The number was calculated as: (Region 10 population of 2,444,642 x 28%) – (Region 10 population of 2,444,642 x 8%) = 489,000. ***Baseline data:*** *No baseline – This is a new initiative*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-3 Process Milestone: Develop and test data systems Baseline/Goal: Test Data Reports *Data Source: EMR* Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $0	intervention activities Data Source: Data Reports, PDSA Summaries Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $0 **P-7 Process Milestone:** Establish outcome targets for IT-1.19 Baseline/Goal: Outcome Target Data Source: Data Reports, Baseline Report		

126675104.3.X (NEW – Not in workbook)	*IT- 1.9*	*IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.9*		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** 1,802 primary care physicians in Region 10 who will potentially address behavioral health issues in primary care settings for 489,000 patients who will see assistance with behavioral health problems from their primary care physician. Primary care physicians in Region 10 who will address behavioral health issues in primary care settings for 9,047 patients (DY2 = 452, DY3 = 1810, DY4 = 2940, DY5 = 3845) ***Description of Population:*** This project targets the 489,000 people in Region 10 who have a diagnosable mental disorder but do not seek services in the mental health system. It is reported 28% of the population have a diagnosable mental disorder in any year. Only 8% of the population have a diagnosable mental disorder and receive services in the mental health system each year.[392] The target population includes those who have a diagnosable mental illness who do not receive care in the mental health system. The number was calculated as: (Region 10 population of 2,444,642 x 28%) – (Region 10 population of 2,444,642 x 8%) = 489,000. ***Baseline data:*** *No baseline – This is a new initiative*		
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 7 Estimated Incentive Payment *(maximum amount):* $0		

126675104.3.X (NEW – Not in workbook)	*IT- 1.9*	*IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (Stand-alone measure)*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.9*		
Starting Point/Baseline:	***Target Population:*** ***Specific Number:*** 1,802 primary care physicians in Region 10 who will potentially address behavioral health issues in primary care settings for 489,000 patients who will see assistance with behavioral health problems from their primary care physician. Primary care physicians in Region 10 who will address behavioral health issues in primary care settings for 9,047 patients (DY2 = 452, DY3 = 1810, DY4 = 2940, DY5 = 3845) ***Description of Population:*** This project targets the 489,000 people in Region 10 who have a diagnosable mental disorder but do not seek services in the mental health system. It is reported 28% of the population have a diagnosable mental disorder in any year. Only 8% of the population have a diagnosable mental disorder and receive services in the mental health system each year.[392] The target population includes those who have a diagnosable mental illness who do not receive care in the mental health system. The number was calculated as: (Region 10 population of 2,444,642 x 28%) – (Region 10 population of 2,444,642 x 8%) = 489,000. ***Baseline data:*** *No baseline – This is a new initiative*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $0	Year 4 Estimated Outcome Amount: $0	Year 5 Estimated Outcome Amount: $0
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $0			

Title of Outcome Measure (Improvement Target): IT 1.10 Diabetes Care: HbA1c poor control

Unique RHP outcome identification number(s): 126675104.3.32
Performing Provider Name/TPI: JPS Health Network/ 126675104
Outcome Measure Description:
Process Milestones:

- DY2-Process milestones: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans for reducing patients with HbA1c >9.%
- DY2-Process Milestones: Establish baseline rates
- DY3- Process milestone: Plan-Do-Study-Act Cycle will be utilized to identify appropriate frequency of HbA1c monitoring and effective coordination of care, the PDSA cycle will be performed to evaluate changes

Outcome Improvement Targets for each year:

- DY4-5-Improvement milestones-Reduce baseline number of low income, uninsured individuals identified as diabetic that have HbA1c >9.0% by 10% in DY4 and 15% in DY5.

Rationale:

Our ultimate goal is to improve the health of the low income, uninsured through patient engagement, acute interventions and posthospitalization encounters, and care that is coordinated and focused on prevention, primary and secondary care, and social and community-based services. This project has adopted HEDIS, AHRQ Quality indicators and PQI as guiding criteria to measure the outcome of diabetic follow-up: HbA1c Poor Control: "Percentage of patients 18-75 years of age with diabetes whose most recent HbA1c level during the measurement year is >9.0%. Patient-centered Medical Home to care for their chronic conditions such as HbA1c (listed as top contributors for frequent emergency department visits and admissions which can be preventable when managed by a primary care physician on a regular basis) will lead to improved quality outcomes reducing frequent emergency department visits and preventable admissions to the hospital, therefore, reducing the overall health care costs to the community.
There are various organizations, including JPS Health Network, dedicated to serving the uninsured population in Tarrant County. However, our limited resources contribute to fragmented care and a lack of patient follow-up care. Improving chronic care for the low income, uninsured population will contribute to a reduction in ED visits and admission to JPS Health Network.

In DY2, the baseline and improvement targets will be determined based on information from the FQHC and identified agencies serving the targeted. JPS Health Network will also develop and test data systems to ensure data reliability. In DY3, JPS Health Network will

develop and implement a plan to provide primary and specialty care, along with supportive health services, to the underserved population.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.32	IT-1.10	Diabetes care: HbA1c-poor control	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.10 Implement/Expand Care Transitions Programs: Community Connect-Transitioning Care/Continuity of Care with non-JPS Clinics		
Starting Point/Baseline:	Target Population: Specific Number: Anticipated to manage 500 Diabetic unduplicated patients during the reporting period. Description of Population: Low income, uninsured primary care and support services will be focused on providing services to the low income, uninsured populations with goal of reducing ED visits and potentially preventable admissions throughout Tarrant County. Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 for reducing patients with HbA1c >9.% Data source: EMR, Excel spreadsheets, and information data sources for shared information. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,674 **Process Milestone 2** [P-2]: Establish baseline rates- Baseline rates will be established for HbA1c appropriate utilization specific to the low income individuals not receiving services at JPS.	**Process milestone 3** [P-4]: Plan-Do-Study-Act Cycle (PDSA) will be utilized to identify appropriate frequency of HbA1c monitoring and effective coordination of care. Data source: Documentation of PDSA Cycle and evidence of the number of individuals' stakeholders receiving information and lessons learned based on PDSA results Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $12,774	**Outcome Improvement Target 1** [I-1.10]: Documentation of those low income, uninsured individuals 18-75 years of age that have HbA1c poor control (>9.0%) Improvement Target: Reduce baseline number of low income, uninsured individuals identified as diabetic that have HbA1c poor control (>9.0%) by 10% (Anticipated impact 22 patients) Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 1 Estimated Incentive Payment*:* $13,666	**Outcome Improvement Target 2** [I-1.10]: Documentation of those low income, uninsured individuals 18-75 years of age that have HbA1c poor control (>9.0%) Improvement Target: Reduce baseline number of low income, uninsured individuals identified as diabetic that have HbA1c poor control (>9.0%) by 15% (Anticipated impact 32 patients) Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 2 Estimated Incentive Payment: $32,679

126675104.3.32	IT-1.10	Diabetes care: HbA1c-poor control	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.10 Implement/Expand Care Transitions Programs: Community Connect-Transitioning Care/Continuity of Care with non-JPS Clinics		
Starting Point/Baseline:	Target Population: Specific Number: Anticipated to manage 500 Diabetic unduplicated patients during the reporting period. Description of Population: Low income, uninsured primary care and support services will be focused on providing services to the low income, uninsured populations with goal of reducing ED visits and potentially preventable admissions throughout Tarrant County. Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
System and written process will be developed on how to establish tracking of baseline data. Data Source: EPIC, NexGen, HIE. Process Milestone 2 Estimated Incentive Payment: $3,673			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $7,347	Year 3 Estimated Outcome Amount: $12,774	Year 4 Estimated Outcome Amount: $13,666	Year 5 Estimated Outcome Amount: $32,679
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$66,466			

Title of Outcome Measure (Improvement Target): IT 9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 126675104.3.33

Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

Process Milestones:

- DY2-Process Milestone 1: (P-1) Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans)
- Process Milestone 2 (P-2)-Establish baseline rates for ED appropriate utilization for this target population.
- DY3-Process milestones (P-4): Conduct Plan Do Study Act (PDSA) cycles to improve data collection intervention activities (Plan-Do-Study-Act will be utilized to identify the innovative strategies to reduce ED admissions in the low income, uninsured population

Outcome Improvement Targets for each year:

- DY4-5 Improvement milestones (IT 9.2): Reduce all ED visits for the underserved population from the baseline by 10% (DY4) and 15% (DY5).

Rationale:

JPS Health Network and their collaborative partners are dedicated to serving the uninsured population in Tarrant County. However, our limited resources contribute to fragmented and uncoordinated care, adding unnecessary risks and costs, and duplicating services. JPS and the FQHC will partner with Project Access to identify patients who will benefit the most from care coordination to intervene and help reduce frequent visits to the costly ED. With the projected growth in the underserved population of Tarrant County and current capacity issues, the FQHC is planning to adding 2 physicians and 3 mid-levels by DY5. The additional providers will be able to serve more patients through coordinated primary and specialty care.

The baseline will be established in DY2 from information provided by Project Access of Tarrant County on their transitional management for patients seeking primary and specialty care at the FQHC. Improvement can be determined through data provided by Project Access and the FQHC to establish and validate the baseline for underserved patients requiring transitional management to navigate through their health care needs.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into

account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.33	IT-9.2	ED appropriate utilization	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.10 Implement/Expand Care Transitions Programs: Community Connect-Transitioning Care/Continuity of Care with non-JPS Clinics		
Starting Point/Baseline:	Target Population: Specific Number: 5,000 unduplicated patient lives will be served through this project.(1,000 unduplicated patients by DY3, 2,000 additional unduplicated patients by DY-4, and 2,000 additional unduplicated patients by DY-5) Description of Population: This project will be focused on providing improved coordination of transitional care to the underserved patients who utilize the emergency department on a frequent basis. The primary objective is to decrease all ED visits in the low income, uninsured population for this targeted low income population currently not receiving primary care services at JPS. Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 [P-1]:Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data source: EMR, Excel spreadsheets, and information data sources for shared information. Process Milestone 1 Estimated Incentive Payment: $55,104 **Process Milestone 2** [P-2]: Establish baseline rates Baseline rates will be established for ED appropriate utilization specific to the low income individuals not receiving services at JPS. System and written process will be developed on how to establish tracking of baseline data. Data Source: EPIC, NextGen, HIE. Process Milestone 2 Estimated Incentive Payment: $55,103	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities (Plan-Do-Study-Act Cycle will be utilized to identify the innovative strategies to reduce ED admissions in the low income, uninsured population). Metric: Documentation of completed PDSA Cycle. Data source: Documentation of PDSA Cycle and evidence of the number of individuals' stakeholders receiving information and lessons learned based on PDSA results Process Milestone 3 Estimated Incentive Payment: $191,616	**Outcome improvement Target 1** [IT-9.2]: Reduce all ED visits Documentation of all ED visits for those identified as low income, uninsured population. Improvement Target: Reduction of all ED visits from established baseline by 10% for the target population. (Anticipated ED reduction impact of 144 visits) Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 1 Estimated Incentive Payment: $204,985	**Outcome Improvement Target 2** [IT-9.2]:Reduce all ED visits Documentation of all ED visits for those identified as low income, uninsured population. Improvement Target: Reduction of all ED visits from established baseline by 15% (Anticipated ED reduction impact of 356 visits). for the target population Data Source: EMR, Spreadsheets, and Claims data. Outcome Improvement Target 2 Estimated Incentive Payment: $490,181

Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $110,207	Year 3 Estimated Outcome Amount: $191,616	Year 4 Estimated Outcome Amount: $204,985	Year 5 Estimated Outcome Amount: $490,181
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$996,988			

Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction

Unique RHP outcome identification number(s): 126675104.3.34
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

Process Milestones:
By the end of the Waiver, our goal to increase our top box patient perception of care percentage points by 10% over the baseline determined in DY2.

In DY2, a nationally recognized CAHPS vendor will be selected and the CAHPS tool implemented across the organization as appropriate. There is currently no data for the CGCAHPS tool as it only been piloted in our larger clinics. Our current patient satisfaction tool is showing overall perception of patient care < the 10th percentile across our ambulatory clinics. Additionally, a patient experience plan will be developed and disseminated throughout the district to align patient experience goals and projects.

In DY3, Patient Experience Teams will be deployed to areas of low performance in a targeted effort to increase patient satisfaction scores with implementation of process improvement initiatives using LEAN tools, methods and assessment principles. All initiatives will use the Plan-Do-Study-Act (PDSA) model of improvement to verify that changes are appropriate and sustainable.

Outcome Improvement Targets for each year:

In DY4, the organization expects a 5% improvement over topbox baseline for the domains selected.

In DY5, the organization expects a 10% improvement over topbox baseline for the domains selected.

Rationale:
With overall patient perception lingering at less than the 10th percentile for patients visiting our outpatient clinics, JPS Health Network will take a more strategic approach to improving patient satisfaction across our network. More than half of the unique patients visiting JPS Health Network in the hospital fiscal year 2011 had a visit to one of our outpatient clinics. The clinic is a significant entry point to the JPS Health Network for our community. There are many case studies published about transformational improvement in both operational and patient experience using LEAN and PDSA as tools to leverage cooperation and collaboration.[3931] In a report of health care CEO surveys produced by the Beryl Institute, it is noted that organizations having a

393 BisognanoM, Kenney C. Pursuing the Triple Aim. Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs. San Francisco: Jossey-Bas Publishers; 2012.

distinct patient experience leader with definitive time commitment will have more success with improving patient experience scores.[394] The report also notes that competing priorities is ranked as the third most prevalent reason for reducing emphasis on the patient experience. The greatest difficulty for most institutions in redesigning the patient experience is an inability to spread or execute strategic improvement initiatives across the organization.[395,396] In designing the improvement approach for JPS Health Network, the lessons learned and reported by these recognized health care leaders have been incorporated into the plan.

The achievement of the goal to increase patient satisfaction over the Waiver period is tied to several other projects including the implementation of the patient and family centered medical, enhancing urgent medical advice and improving care transitions. By starting with the appointment of a patient experience leader, aligning disconnected projects and committees and developing a strategic plan, JPS Health Network expects to meet or exceed our project goals for this category.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

394 Wole, J. The State of Patient Experience in American Hospitals. The Beryl Institute. Spring 2011 (available on www.berylinstitute.org)

395 Nolan T. Execution of Strategic Improvement Initiatives to Produce System-Level Results.IHI Innovation Series whie paper. Cambridge, Massachusetts: Institute for Health care Improvement; 2007. (available on www.IHI.org)

396 Reinertsen J, Bisognano M, Pugh M. Seven Leverage Points for Organization-Level Improvement in Health Care (Second Edition). Cambridge, Massachusetts: Institute for Health care Improvement; 2008. (Available on www.ihi.org)

126675104.34	IT-6.1	IT 6.1 Percent improvement over baseline of patient satisfaction scores	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.11 Redesign to Improve Patient Experience (JPS Cares)		
Starting Point/Baseline:	Target Population: All patients and the family members that participate in care in the outpatient areas Specific Number:124,000 unique patients per year Description of Population: Patients receiving care in the JPS Health Network Baseline data: Will be developed in DY2 after selection of vendor tool If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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] Engage stakeholders, identify current capacity and resources needed, determine timelines, develop and document patient experience plan Process Milestone 1 Estimated Incentive Payment: $82,288 **Process Milestone 2** [P-2]: Select a CGCAHPS vendor and implement the survey tool across the medical practice sites. Data Source: CAHPS tool Process Milestone 2 Estimated Incentive Payment: $-$82,288 **Process Milestone 3** [P-3] Disseminate baseline patient experience plan data to stakeholders. Implement baseline dashboard Data Source: Dashboard	**Process Milestone 4** [P-1]: Determine areas of improvement and develop improvement plan. Communicate plan and align with performance measures. Data Source: Action plans, dashboards and verification of patient experience goals aligned in performance measures Process Milestone 4 Estimated Incentive Payment: $429,225	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline for selected questions. Improvement Target: 5% of top box percentage points over baseline established in DY2 Data Source: CAHPS survey results Outcome Improvement Target 1 Estimated Incentive Payment: $459,170	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline for selected questions.. Improvement Target:10%of top box percentage points over baseline established in DY2 Data Source: CAHPS survey results Outcome Improvement Target 2 Estimated Incentive Payment: $1,098,016

126675104.34	IT-6.1	IT 6.1 Percent improvement over baseline of patient satisfaction scores	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.11 Redesign to Improve Patient Experience (JPS Cares)		
Starting Point/Baseline:	Target Population: All patients and the family members that participate in care in the outpatient areas Specific Number:124,000 unique patients per year Description of Population: Patients receiving care in the JPS Health Network Baseline data: Will be developed in DY2 after selection of vendor tool If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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 3 Estimated Incentive Payment: $- $82,288			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $246,866	Year 3 Estimated Outcome Amount: $429,225	Year 4 Estimated Outcome Amount: $459,170	Year 5 Estimated Outcome Amount: $1,098,016
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,233,277			

Title of Outcome Measure (Improvement Target): IT-4.9 Sepsis Resuscitation and Management : Reduce Length of Stay(ICU)

Unique RHP outcome identification number(s): 126675104.3.35
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
Length of stay reductions will occur as a result of early identification and intervention encompassed within the sepsis resuscitation and management bundles. Early intervention will circumvent the development of organ failure and other complications which are the result of poorly managed sepsis. By avoiding these complications, treatment intensity, resources, and LOS in the ICU- are reduced.

Process Milestones:
Year 2 Process milestones: - Reactivating the Sepsis Response team for the purpose of project planning; . - establishing baseline rates, developing data systems, redesigning processes and communicating results; Continuous quality improvement e.g., rapid cycle PDSA, Six Sigma, and Lean will be utilized to drive improvement and sustain the gains;
- hiring the sepsis coordinator, a clinical analyst and 2.5 additional FTEs tol expand the existing Medical Emergency Team and provide 24/7 Sepsis Response Team coverage. Expected achievements are achieving compliance with diagnosis to 50%(173 patients) and sepsis management to 50%(173 patients). Improvement Milestones associated with length of stay and mortality will be - limited because of process standardization immaturity and re-calibration of baselines.

Year 3 Process Milestones- The - team's - utilization of the tools for the rapid response to -and the management of sepsis -le will improve - compliance with diagnosis to 65%(224 of 345patients) and sepsis management to 65%(224 of 345). Rapid cycle improvement and other process improvement tools will drive continued improvement in the management of these patients. -Better management of sepsis and the avoidance of complications is expected to result in a reduction in ICU LOS.

Outcome Improvement Targets for each year:
Year 4 Process Milestones include the continuation of rapid cycle improvements will continue to refine the processes for identification and management, achieving compliance with diagnosis to 75%(259 patients) and sepsis management to 85%(293 patients) and ICU LOS reduction to 5% of the baseline or 4.2 days

Year 5 Process Milestones include achieving compliance with diagnosis to 85%(210 patients)and sepsis management at 95%(327 patients), and reducing ICU LOS to 10% of the baseline or 3.7 days.

JPS Health Network is proposing the erection of an Innovation and Transformation Center (Category 2) which will increase competencies in performance improvement and also support the

Network's Measurement System. Secondly we also reactivating our Harm Avoidance teams for reducing Health Acquired Infections (CAUTI, CLABSI, SSI) which could result in reducing Sepsis acquired after admission.

Rationale:

By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate - appropriate treatment early, which -will decrease the patient's development of complications and comorbid conditions which contribute to more intense treatment, and longer ICU length of stay.

The refinement of the data bases, dashboards and methods of disseminating reports along with, participation in - performance improvement (PI) meetings will provide feedback and further engage clinicians.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.35	***3.IT-4.9***	***Improvement in risk adjusted PPC Length of Stay- ICU IT 4.9***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.12: Sepsis*		
Starting Point/Baseline:	*Target Population: Patients who present to the ED with suspected infection.* *Intervention Population: Patients presenting in ED with a diagnosis of severe sepsis, septic shock, and/or lactate>4mmol/L(36mg/dl) (Calendar Year 2011)* *Impact Population: Patients with confirmed sepsis/septic shock diagnosis with initiation and completion of bundles.* *Baseline data: 20%(To be validated)*		
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 (Code Sepsis Improvement Team), identify current capacity and needed resources, determine timelines and document implementation team. Data Source: At least monthly meeting minutes documenting resources Process Milestone 1 Estimated Incentive Payment: $233,895 **Process Milestone 2** [P-2]: Perform a deep dive review of the cases in the SSC database to validate presence of sepsis for inclusion in the baseline. Establish baseline acute and ICU LOS. Data Source: EPIC and Surviving Sepsis Campaign (SSC) Data base Process Milestone 2 Estimated Incentive Payment *(maximum*	**Process Milestone 5** [P-4] Target opportunities for improvement based on results of baseline and plan for PDSA cycles Targeted interventions could include additional education, implementation of a sepsis resuscitation bundle checklist, timing of interventions; and ensuring all portions of bundle are implemented. Data source: SSC data based info Process Milestone 5 Estimated Incentive Payment: $813,346 **Outcome Improvement Target** [IT-4.9]**:** **Improvement target:** ICU LOS:4.7 days Outcome Improvement Target 1 Estimated Incentive Payment:	**Process Milestone 6** [P-4]: Target opportunities for improvement based on results of continuous measurement and reporting and plan for PDSA cycles Targeted interventions could include additional education, implementation of a sepsis resuscitation bundle checklist, timing of interventions; and ensuring all portions of bundle are implemented. Data source: SSC data based info Process Milestone 6 Estimated Incentive Payment: $870,091 **Outcome Improvement Target 2** [IT-4.9]: **Improvement target:** ICU LOS:4.2 days Outcome Improvement Target 2 Estimated Incentive Payment:	**Outcome Measure Goal** [IT-4.9]**:** **Improvement target:** **ICU LOS 3.7 days** Outcome Improvement Target 3 Estimated Incentive Payment: $4,161,305

126675104.3.35	***3.IT-4.9***	***Improvement in risk adjusted PPC Length of Stay- ICU IT 4.9***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.12: Sepsis*		
Starting Point/Baseline:	*Target Population: Patients who present to the ED with suspected infection.* *Intervention Population: Patients presenting in ED with a diagnosis of severe sepsis, septic shock, and/or lactate>4mmol/L(36mg/dl) (Calendar Year 2011)* *Impact Population: Patients with confirmed sepsis/septic shock diagnosis with initiation and completion of bundles.* *Baseline data: 20%(To be validated)*		
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)**
*amount): $*233,895 **Process Milestone 3** [P-3]: Compare and analyze data to identify variation in treatment in ICU Data Source: Chart review – EPIC Process Milestone 3 Estimated Incentive Payment: $233,896 **Process Milestone 4** [P-5]: Implement patient-centered PI project Data Source: Chart review – EPIC Process Milestone 4 Estimated Incentive Payment: $233,896	$813,346	$870,091	
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $935,582	Year 3 Estimated Outcome Amount: $1,626,692	Year 4 Estimated Outcome Amount: $1,740,182	Year 5 Estimated Outcome Amount: $4,161,305

126675104.3.35	***3.IT-4.9***	***Improvement in risk adjusted PPC Length of Stay- ICU IT 4.9***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.12: Sepsis*		
Starting Point/Baseline:	*Target Population: Patients who present to the ED with suspected infection.* *Intervention Population: Patients presenting in ED with a diagnosis of severe sepsis, septic shock, and/or lactate>4mmol/L(36mg/dl) (Calendar Year 2011)* *Impact Population: Patients with confirmed sepsis/septic shock diagnosis with initiation and completion of bundles.* *Baseline data: 20%(To be validated)*		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $8,463,761			

Title of Outcome Measure (Improvement Target): IT-4.2 Central Line-Associated Bloodstream Infection Prevention

Unique Project ID: 126675104.3.36 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
DY2/DY3 P-1[P-2] Identify/target metric to measure impact of process improvement methodology and establish CLABSI baseline. PI teams facilitated by individuals with advanced skill set in Lean, Six Sigma and rapid-cycle improvement will focus on CLABSI prevention processes/opportunities and related workflow in the inpatient hospital settings in a post EPIC-EMR implementation environment. The teams will redesign disrupted workflows, optimize documentation, validate central line numbers, enhance reporting capabilities and align with NHSN's methodology to capture a valid CLABSI rate. The focus of improvement initiatives will include compliance with Central Line Insertion Practices (CLIP).

DY3: P-2 Develop a quality dashboard for sharing of results

Through the work of the Innovation and Transformation Center's Decision Support infrastructure, the quality dashboard will be developed and include process and outcome measures which will link board measures through process level measures. This dashboard will provide near real-time feedback to physicians and other clinicians in order to impact CLABSI improvement.

The CLABSI team will participate in Hospital P-3[P-15] Engagement Network (HEN) for purposes of shared learning; gaining technical assistance; and validating adoption of evidence-based guidelines.

DY4: Outcome Improvement Target 1: IT 4.2 Central Line-Associated Blood Stream Infections (CLABSI) Rate reduction 50% of the DY2 Baseline. Measure progress toward NHSN benchmark. CLIP Practices at 90%; CLABSI hospital-wide rate at benchmark or p-value that is not significantly different.

DY5: Outcome Improvement Target 2: IT 4.2 Central Line-Associated Blood Stream Infections (CLABSI) Rate Goal is to achieve NHSN rate for at least six months within DY5.

Rationale:
JPS conversion in May 2012 to EPIC_EMR disrupted many of the CLABSI Surveillance Program and electronic protocols. The conversion impacted JPS' ability to optimize documentation; validate central line numbers; generate reports and align with National Health and Safety Network's(NHSN) methodology for effectively capturing CLABSI rates.

The process milestones will assist us in gaining an understanding the variation in practices associated with line insertion, maintenance and discontinuation. With this knowledge the team will be positioned to design, implement and test new workflows with the EPIC-EMR,

which will in-turn serve as the foundation for the JPS House-wide CLABSI Surveillance Program.

Outcome Measure Valuation:

The approach to valuation is first to establish the true baseline for housewide CLABSI surveillance and apply the avoided CLABSI cost of $3,700 to $29,000 to the number of CLABSIs identified post-EPIC workflow changes. The value is the avoided cost difference of the baseline CLABSI when compared to DY5 CLABSI rates.

An estimated 41,000 central line-associated bloodstream infections (CLABSI) occur in U.S. hospitals each year. These infections are usually serious infections typically causing a prolongation of hospital stay and increased cost and risk of mortality.
CLABSI can be prevented through proper management of the central line. The CDC's Healthcare Infection Control Practices Advisory Committee (CDC/HIPAC) Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011, addresses these preventive techniques. The NHSN CLIP practices align with these guidelines. The estimated cost of a central line infection ranges from $3,700 to $29,000 per episode. This project's objectives enhance patient safety and promote better patient outcomes.

126675104.3.36	*3.IT-4.2*	***Central Line-Associated Infection Reduction***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.1.5: Innovation and Transformation Center*		
Starting Point/Baseline:	***Baseline data:*** *37 infections* ***Target Population:*** *Hospital-wide Inpatients with Central line: 2,251* ***Specific Number:*** ***Description of Population:*** *Adults and Neonates*		
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]: Identify/target metric to measure impact of process improvement methodology and establish baseline: Data Source: NHSN Process Milestone 1 Estimated Incentive Payment: $96,511	**Process Milestone 2** [P-2]: Develop a quality dashboard that will quantify and determine the quality of care provided. Data Source: Program records Process Milestone 2 Estimated Incentive Payment: $83,912 **Process Milestone 3** [P-3] 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. Data Source: Program records. Process Milestone 3 Estimated Incentive Payment: $83,912	**Outcome Improvement Target 1** [IT-4.2]: Central Line-Associated Infection Reduction Improvement target: 25% reduction in CLABSIs over baseline Data Source: NHSN Estimated Incentive Payment*:* $179,829	**Outcome Improvement Target 2** [IT-4.2]: Central Line-Associated Infection Reduction Improvement target: 50% reduction in CLABSIs over baseline; achieve NHSN benchmark and hold for 6 months Data Source: NHSN Estimated Incentive Payment*:* $430,025
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $96,511	**Year 3 Estimated Outcome Amount: $167,824**	**Year 4 Estimated Outcome Amount: $179,829**	**Year 5 Estimated Outcome Amount: $430,025**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $874,189			

Title of Outcome Measure (Improvement Target): IT-4.3 Catheter Associated Urinary Tract Infection Prevention

Unique Project ID: 126675104.3.37 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/**126675104**

Outcome Measure Description:
DY2/DY3 P-1 Identify/target metric to measure impact of process improvement methodology and establish CAUTI baseline. PI teams facilitated by individuals with advanced skill set in Lean, Six Sigma and rapid-cycle improvement will focus on CAUTI prevention processes/opportunities and related workflow opportunities in the inpatient hospital settings in a post-EPIC-EMR implementation environment. The team's focus will be to build/verify electronic nurse-driven protocols in EPIC EMR to provide guidelines for insertion and removal of Foley catheters to decrease unnecessary utilization. Surgical protocols are evidence-based.

Success in this area will create the capability to transition from targeted to housewide CAUTI surveillance which will require a recalibration of the CAUTI baseline. The process will also provide the capabilities to monitor compliance with the integrated Foley catheter protocols, e.g., improve SCIP INF-9 compliance data (Foley catheter removal POD1 or POD 2 postoperative procedure) from 85% to 95%.

DY3: P-2 Develop a quality dashboard for sharing results

Through the work of the Innovation and Transformation Center's Decision Support infrastructure, the quality dashboard will be developed and include process and outcome measures which will link board measures through process-level measures. This dashboard will provide near real-time feedback to physicians and other clinicians in order to impact CAUTI improvement. The CAUTI team will participate in Hospital P-3[P-15] Engagement Network (HEN) for purposes of shared learning; gaining technical assistance; and validating adoption of evidence-based guidelines.

DY4: Outcome Improvement Target 1: IT 4.3 Catheter Associated Urinary Tract Infection Rate by at least 25% of the DY2 Baseline. We will measure our progress with two process measures and one outcome measure: SCIP-9 metric (Foley catheter removal postop day 1or 2); and the percentage of compliance with our Foley catheter protocol guidelines. During this time we -- expect that our CAUTI hospital-wide rate (CAUTIS per 1,000 device days) should be at benchmark pooled mean or p-value that is not significantly different.

DY5: Outcome Improvement Target 1: IT 4.3 CAUTI rate reduction by at least 75% of the DY2 Baseline. The goal is to achieve a sustained rate that is at or lower than NHSN benchmark. Numerator: The number of CAUTIs; Denominator: number of Foley catheter days; Multiplier: 1,000 to get the rate. A p-value will be established using the NHSN software for statistical

significance. Goal is to have six months of outcomes at NHSN benchmark or lower or not significantly different per p-value analysis.

Rationale:
Surveillance and reporting methods currently focus on the Intensive Care and Skilled Nursing Units (ICU and SNU). By expanding to a broader population, there is opportunity to reduce device risk and impact associated conditions resulting from Foley catheter use. Utilization of CDC guidelines and NHSN methodology allows opportunity to optimize reporting and rate comparison; standardize interventions; and align with best practice.

Outcome Measure Valuation:
Per CDC, the estimated cost per CAUTI event is approximately $758 per infection. The approach to valuation is first to establish the true baseline for housewide CLABSI surveillance and apply the avoided CAUTI cost of $758 to the number of CAUTIs identified post EPIC workflow changes. The value is the avoided cost difference of the baseline CAUTIs when compared to DY5 CAUTI rates.

CAUTI is the most common UTI HAI infection, accounting for 30% of infections reported by acute care hospitals. CAUTI can lead to such complications such as: cystitis; pyelonephritis, gram negative bacteremia; prostatitis, epididymitis; and orchitis in males and less commonly, endocarditis, vertebral osteomyelitis, septic arthritis, endophthalmitis, and meningitis in all patients. Complications associated with CAUTI cause discomfort to the patient, prolong hospital stay and increase cost and mortality. Each year more than 13,000 deaths are associated with UTIs. Reference: CDC/HIPAC document—Guideline for Prevention of Catheter Associated Urinary Tract Infection 2009.

126675104.3.37	*3.IT-4.3*	***Catheter Associated Urinary Tract Infection (CAUTI) Reduction***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.1.5 – Innovation and Transformation Center*		
Starting Point/Baseline:	***Baseline data:*** *277 patients had a CAUTI* ***Target Population:*** *Adult Hospital-wide Inpatients with Foley catheter days: 8,644 patients* ***Description of Population:*** *Adults*		
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]: Identify/target metric to measure impact of process improvement methodology and establish baseline: Data Source: NHSN Process Milestone 1 Estimated Incentive Payment: $22,324	**Process Milestone 2** [P-X]: Develop a quality dashboard that will quantify and determine the quality of care provided. Data Source: Program records Process Milestone 2 Estimated Incentive Payment: $19,410 **Process Milestone 3** [P-3]: 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. Data Source: Program records. Process Milestone 4 Estimated Incentive Payment: $19,409	**Outcome Improvement Target 1** [IT-4.3]: Catheter Associated Urinary Tract Infection Improvement target: 25% reduction in CAUTIs over baseline Data Source: NHSN Outcome Improvement Target 1 Estimated Incentive Payment*:* $41,596	**Outcome Improvement Target 2** [IT-4.3]: Catheter Associated Urinary Tract Infection Improvement target: 50% reduction in CAUTIs over baseline Data Source: NHSN Outcome Improvement Target 2 Estimated Incentive Payment*:* $99,468
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $22,324	**Year 3 Estimated Outcome Amount: $38,819**	**Year 4 Estimated Outcome Amount: $41,596**	**Year 5 Estimated Outcome Amount: $99,468**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $202,207			

Title of Outcome Measure (Improvement Target): IT-4.4 Surgical Site Infection Prevention

Unique Project ID: 126675104.3.38 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
DY2/DY3 P-1 Identify/target metric to measure impact of process improvement methodology and establish SSI baseline. Current baseline is based on targeted surveillance; new baseline will be captured for the house-wide surveillance program made possible with PI efforts encompassed in this program.

PI teams facilitated by individuals with advanced skill set in Lean, Six Sigma and rapid-cycle improvement will focus on SSI prevention processes/opportunities related workflow opportunities in the inpatient hospital settings in a post-EPIC-EMR implementation environment. The team's focus will be to build/verify electronic surgical protocols that are evidence-based.

Success in this area will create the capability to transition from targeted to housewide SSI surveillance which will require a recalibration of the SSI baseline.

DY3: P-2 Develop a quality dashboard for sharing results

Through the work of the Innovation and Transformation Center's Decision Support infrastructure, the quality dashboard will be developed and include process and outcome measures that will link board measures through process-level measures. This dashboard will provide near real-time feedback to physicians and other clinicians in order to impact SSI improvement. The SSI team will participate in Hospital Engagement Network (HEN) for purposes of shared learning; gaining technical assistance; and validating adoption of evidence-based guidelines.

DY4: Outcome Improvement Target 1: IT 4.4 Surgical Site Infection rate reduction by at least 25% of the DY2 baseline. We will measure progress by achieving a SCIP-INF (1, 2, 3) composite score (perfect care score) at 90% or higher. SCIP INF 1: antibiotic within one hour of surgical incision; SCIP INF 2: Prophylactic Antibiotic Selection for surgical patient; SCIP-INF 3: Prophylactic antibiotic discontinued within 48 hours of surgery end time.

DY5: Outcome Improvement Target 1: IT 4.4 Surgical Site Infection rate reduction by at least 75% of the DY2 baseline. For at least six of 12 months we will achieve a perfect SCIP-INF score of 95% or higher for all procedures listed below; and a NHSN standardized infection ratio (SIR) that is <1 or not significantly different based on NHSN p-value analysis for at least six of eight of the following procedures:

- Cardiac bypass surgery
- Cardiac valve procedures

- Hip arthroplasty
- Knee arthroplasty
- C-sections
- Colons
- Vaginal hysterectomies
- Abdominal hysterectomies

Rationale:
Infection control surveillance was impacted by EMR implementation in May 2012. The accuracy of the data currently being extracted from EPIC combined with the absence of standardized procedure-specific protocols within EPIC has created manual workflows for ICPs and variation in antibiotic usage and timing. EPIC's current capabilities for alerting infection control and caregivers have limited functionality.

Outcome Measure Valuation:
Reduction of SSI will be valued by computing the avoided cost associated with infections. The process milestones focus on designing tools and processes to ensure the clinicians are utilizing appropriate antibiotics, at optimal times, for the prescribed duration, ensuring evidence-based skin prep, temperature management, etc., and to monitor compliance with those processes. While advances have been made in infection control practices, including improved operating room ventilation, sterilization methods, barriers, surgical technique, and availability of antimicrobial prophylaxis, SSI remain a substantial cause of morbidity and mortality among hospitalized patients. In one study, among nearly 100,000 HAIs reported in one year, deaths were associated with SSIs in more than 8,000 cases. Reference: www.cdcgov/nhsn. The value will be determined by calculating avoided cost associated with cost which has been estimated to be $10,443 to $25,546 per infection. Reference: The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention (March 2009). Division of HQPNC for Preparedness, Detection, and Control of Infectious Diseases Coordinating Center for Infectious Diseases Centers for Disease Control and Prevention.

126675104.3.38	***3.IT-4.4***	***Surgical Site Infection Reduction***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.1.5: Innovation and Transformation Center*		
Starting Point/Baseline:	*Target Population: Hospital-wide Inpatients with surgical procedure* *Specific Number: 2,549* *Description of Population: Adults* *Baseline data: The number of SSI divided by the number of procedures X100.*		
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]: Identify/target metric to measure impact of process improvement methodology and establish baseline: Data Source: NHSN Process Milestone 1 Estimated Incentive Payment: $159,730	**Process Milestone 2** [P-X]: Develop a quality dashboard that will quantify and determine the quality of care provided. Data Source: Program records Process Milestone 2 Estimated Incentive Payment: $138,878 **Process Milestone 3** [P-X]: Participate in face-to-face learning (i.e., meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Data Source: Program records. Process Milestone 3 Estimated Incentive Payment: $138,877	**Outcome Improvement Target 1** [IT-4.4]: Surgical Site Infections Improvement Target: 25% reduction in Surgical Site Infections over baseline Data Source: NHSN Outcome Improvement Target 1 Estimated Incentive Payment: $297,622	**Outcome Improvement Target 2** [IT-4.4]: Surgical Site Infections Improvement Target: 75% reduction in Surgical Site Infections over baseline Data Source: NHSN Outcome Improvement Target 2 Estimated Incentive Payment: $711,705
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $159,730	**Year 3 Estimated Outcome Amount: $277,755**	**Year 4 Estimated Outcome Amount: $297,622**	**Year 5 Estimated Outcome Amount: $711,705**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $1,446,812			

Title of Outcome Measure (Improvement Target): IT-4.5 Fall Prevention

Unique Project ID: 126675104.3.39 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
In 2011 JPS fall experience was: 468 falls; 3.18 falls/1,000 patient Days; 72 falls with injury and 0.49 falls/1,000 patient days with injuries. YTD (11/20) 2012 JPS fall experience was: 453 falls; 3.22 falls/1,000 patient days; 78 falls with injury and 0.55 falls/1,000 patient days with injuries. The Network projects an increase in falls and falls with injuries for 2012 as compared to 2011. In order to maximize the effectiveness of the JPS falls prevention program and team, the project will be led by an advanced nurse practitioner; the practitioner will acquire training in Lean, Six Sigma and rapid-cycle improvement or will be assigned a facilitator with those skills. The program will be restructured in order to accelerate falls prevention. The project will be built upon evidence-based strategies to reduce falls among hospitalized patients and include specific approaches to the current thinking on fall prevention. JPS will not only implement evidence-based strategies for fall prevention but will also foster a culture to promote accountability, safety awareness, and teamwork. The purpose of the falls prevention effort is injury prevention and safety.
By the end of the Waiver, our goal is to have fewer than 30% falls per 1,000 patient days. Our milestones include:

DY2: Enhance our falls prevention team/program and develop baseline data for completion of fall risk assessments and completion of fall interventions based on the fall risk assessments.

DY3: Fewer than 414 falls per 1000 patient days (20% reduction over 2011)

DY4: Fewer than 387 falls per 1,000 patient days (30% reduction over 2011)

Rationale:
Statistics indicate patient falls occur in approximately 1.9 to 3.0% of all acute care hospitalizations with anywhere from 2 – 15% of inpatients experiencing at least one fall. An estimated 30% of inpatient falls result in serious injury. According to the Institute of Healthcare Improvement (IHI), falls are a leading cause of death in people ages 65 years and older and 10% of fatal falls for the elderly occur in hospitals
Preventing patient falls is a top priority for caregivers in the clinical setting. Staff across the continuum of care convenes to determine the best ways to identify patients at the highest risk for fall and to develop prevention strategies. Despite heightened attention to this issue, patient fall rates across the United States continue to escalate, putting patient at increasing risk. As patients continue to age and present with increasing vulnerability and comorbidities, their potential for harm increases. Falls are among the significant adverse events experienced in hospitals.

Implementing a more comprehensive falls prevention program ensures interventions can be applied to all patients at risk.

By identifying the presence of patients with falls risk, we have the opportunity to initiate fall prevention strategies and interventions

Outcome Measure Valuation:
Our approach is to increase the reliability of the falls program by assessment, communication, and risk factor intervention planning. Support systems will be in place to promote learning, ongoing evaluation, and improvement of the falls prevention program.
By identifying those patients at risk for falls on admission, we have the opportunity to reliably execute a falls prevention program that will reduce inpatient falls.

126675104.3.39	*3.IT-4.5*	*Fall Prevention*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.1.5 – Innovation and Transformation Center*		
Starting Point/Baseline:	*Target population: 32,894* *2011 Fall Baseline: 72 Falls with Injury*		
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 baselines Goal: Determine baseline of falls with injury in target population Data Source: MIDAS, EPIC Process Milestone 1 Estimated Incentive Payment (*Maximum amount*): $**134,415**	**Outcome Improvement Target 1** [IT-1.16]: Falls with Injury Improvement Target: Reduction in falls with injury by 10% over baseline. Data Source: MIDAS Outcome Improvement Target 1 Estimated Incentive Payment*:* $**233,736**	**Outcome Improvement Target 2** [IT-1.16]: Falls with Injury Improvement Target: Reduction in falls with injury by 15% over baseline. Data Source: MIDAS Outcome Improvement Target 2 Estimated Incentive Payment*:* $**250,454**	**Outcome Improvement Target 3** [IT-1.16]: Improve Quality and efficiency using innovative project option. Improvement Target: Reduction in falls with injury by 30% over baseline. Data Source: EPIC Outcome Improvement Target 3 Estimated Incentive Payment*:* $**598,912**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $134,415	**Year 3 Estimated Outcome Amount: $233,736**	**Year 4 Estimated Outcome Amount: $250,454**	**Year 5 Estimated Outcome Amount: $598,912**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$1,217,517			

Title of Outcome Measure (Improvement Target): IT-4.6 Thromboembolism (VTE) Prevention and Treatment Initiative

Unique Project ID: 126675104.3.40 **(Pass 2)**
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
A reduction in the prevalence of hospital acquired VTEs will be achieved by increasing the reliability in assessing patients' risk for VTE and instituting appropriate prophylactic therapy for patients admitted to JPS. Three process metrics will be tracked across the term of the project. The metrics are:

a. The rate of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission
b. The rate of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [SQ]) anticoagulation and warfarin therapy
c. The rate of patients diagnosed with confirmed VTE who are discharged to home, home care, court/law enforcement or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.

The milestones are:

DY2/DY3 P-1[P-2] Identify/target metric to measure impact of process improvement methodology and establish a valid VTE baseline. PI teams facilitated by individuals with advanced skill set in Lean, Six Sigma and rapid-cycle improvement will put into place VTE data collection and reporting tools; complete a gap analysis of current processes for the assessment and prophylactic treatment of VTE; develop and implement a treatment protocol based on AHRQ/CNEST; implement education on VTE prevention and treatment and report at least six months of data collection on the VTE process measures (a, b, c) for purposes of establishing the baseline and setting goals for the following years.

DY3: P-2 [P-10] Develop a quality dashboard for sharing results

Through the work of the Innovation and Transformation Center's Decision Support infrastructure, the quality dashboard will be developed and include process and outcome measures that will link board measures through process-level measures. This dashboard will provide near real-time feedback to physicians and other clinicians in order to impact VTE improvement. The team will track the progress with the three established metrics; and initiate

rapid-cycle improvement to address variation; complete training for pertinent staff and share data of promising practices, and findings with TMF to foster shared learning and benchmarking across the Texas public hospitals.

The VTE team will participate in Hospital P-3 [P-15] Engagement Network (HEN) for purposes of shared learning; gaining technical assistance; and validating adoption of evidence-based guidelines.

DY4: Outcome Improvement Target 1: IT 4.6 Thromboembolism (VTE) Prevention and Treatment Initiative**:** Improved compliance with Metrics a, b, and c, and a reduction in the VTE incidence by 10% based on the validated baseline computed in DY2

DY5: Target 2: IT 4.6 Thromboembolism (VTE) Prevention and Treatment Initiative**:** Improved compliance with Metrics, a, b, and c and a reduction in the VTE incidence by 30% based on the validated baseline computed in DY2

Rationale:
Improving compliance with screening and prophylactic treatment of VTE has been demonstrated to reduce the occurrence of VTEs.
Costs of VTE prevention initiatives can demonstrate a good return on investment through:

- Improved length of stay, readmission, morbidity, and mortality rates
- Improved documentation of patient acuity and related payment for acuity
- Income generated via incremental physician and allied health professional billing

Outcome Measure Valuation:
Our approach is to increase the reliability of VTE screening, treatment and patient education processes in order to prevent the development of VTEs.

Achieving optimal prevention of hospital-acquired VTE requires incremental monitoring, educational efforts, system change, and coordination of the services of many hospital divisions, all of which may incur incremental costs.

The incremental length of stay and costs of treating a case of a preventable VTE event are substantial. The Agency for Health care Research and Quality (AHRQ) Healthcare Cost and Utilization Projects' estimates of incremental inpatient cost are $10,000 per DVT and $20,000 per PE.
Complications associated with VTE increase resource utilization and length of stay. The value of this project can be computed by determining the cost avoided with the reduction of VTEs.

1. Pharmacologic prophylaxis reduces the incidence of asymptomatic and symptomatic DVT and PE by 50 to 65 percent.

2. Prevention of DVT also prevents PE and fatalities from PE.
3. Cost-effectiveness of VTE prophylaxis has been repeatedly demonstrated.
4. The chief concern of prophylaxis is bleeding, but bleeding risk secondary to pharmacologic prophylaxis is a rare event, based on abundant data from meta-analyses and placebo-controlled randomized controlled trials.
5. Overwhelming evidence reveals that pharmacologic VTE prophylaxis not only prevents adverse patient outcomes, it is also cost-effective.

126675104.3.40	*3.IT 4.6*	*Reduce VTE by 10% Over Validated Baseline*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.1.5: Innovation and Transformation Center*		
Starting Point/Baseline:	*Target Population: JPS Admissions; Intervention Population: Patients Meeting Intervention Protocol Criteria (32,894)* *Numerator: Incidence of HAC VTE, defined as a clot first discovered during the course of hospitalization or within 30 days of prior hospitalization.* *Baseline: 78 had VTE*		
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]: Identify/target metrics to measure impact of process improvement methodology and establish baseline VTE incidence. Baseline/goal: Determine baseline Data Source: TRUVEN & EPIC Process Milestone 1 Estimated Incentive Payment: **$64,192**	**Process Milestone 2** [P-X]: Develop a quality dashboard that will quantify and determine the quality of care provided for the prevention of VTE Goal: Submission of quality dashboard development, utilization and results illustration compliance with VTE prevention metrics; report summary to DFW Hospital Data Source: *Internal data base developed by Innovation & Transformation Decision Support Team* Process Milestone 2 Estimated Incentive Payment: **$111,624**	**Outcome Improvement Target 1 [IT-4.6]** VTE incidence Outcome Improvement Target: VTE validated baseline rate reduced by 10% Data source: TRUVEN & EPIC Outcome Improvement Target 1 Estimated Incentive Payment: **$119,609**	**Outcome Improvement Target 2 [IT-4.6]**: VTE incidence Outcome Improvement Target: VTE validated baseline rate reduced by 10% Data source: TRUVEN & EPIC Outcome Improvement Target 2 Estimated Incentive Payment: **$286,021**
Year 2 Estimated Outcome Amount: $64,192	**Year 3 Estimated Outcome Amount: $111,624**	**Year 4 Estimated Outcome Amount: $119,609**	**Year 5 Estimated Outcome Amount: $286,021**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $581,446			

Title of Outcome Measure (Improvement Target): IT-13.1 Pain assessment (NQF-1637) (**Non-stand-alone measure**). Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

Unique Project ID: 126675104.3.41 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
This measure identifies the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. In DY2, there is a process milestone for project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. A second process milestone is established to manage data systems to report baseline percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. In DY3, there are two process milestones. The first is to establish the baseline percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. The second is to establish outcome improvement targets for improvement in percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening for DYs 4 and 5. DY4 and DY5 have an outcome improvement target to improve the baseline percent of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by a percentage determined in DY3.

Rationale:
The process milestone selected for DY2 is a required building block to accurately identify the baseline rates of patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. The DY3 process milestone related to identifying the baseline rates is a critical step that must be accomplished before improvement targets can be established for increasing the percent of patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Outcome improvement targets will be established in DY3 for DYs 4 and 5.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these

metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

126675104.3.41	*IT-13.1*	**Pain assessment (NQF-1637) (Non-standalone measure)**	
JPS Health Network			*126675104.3.1*
Related Category 1 or 2 Projects:	126675104.2.13		
Starting Point/Baseline:	**<u>Target Population:</u>** **Specific Number: DY3 = 180, DY4 = 314, DY5 = 448 (941 total for DY3, DY4, and DY5)** **Description of Population:** Patients who are terminally or chronically ill as approximated by the CAPC research of over 500 hospitals based on number of staffed beds. For Pain assessment, the population should exclude oncology patients. **<u>Baseline data</u>:** There is no palliative care program at JPS Health Network so there is no baseline data. There is no baseline data on the percent who screened positive for pain and who received clinical assessment within 24 hours. Baseline levels 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-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Baseline/Goal: Complete Project Plan Data Source: Project Documentation Process Milestone 1 Estimated Incentive Payment: $160,231 **Process Milestone 2 [P-3]:** Manage data systems to prepare report indicating baseline percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening Baseline/Goal: Palliative Care Report Data Source: Project Documentation, EMR	**Process Milestone 3 [P-2]:** Establish baseline percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening Baseline/Goal: Baseline Pain Assessment Report Data Source: EMR, Data Report Process Milestone 2 Estimated Incentive Payment: $278,627 **Process Milestone 4 [P-2]:** Establish outcome improvement target for IT-13.1 improvement in percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening Baseline/Goal: Improvement Target Data Source: EMR, Data Report Process Milestone 3 Estimated Incentive Payment: $278,626	**Improvement Target 1** [IT-13.1]: Improve baseline percent of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD Improvement Target: TBD in DY3 Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $597,112	**Outcome Improvement Target 2** [IT-13.1]: Improve baseline percent of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening by TBD Improvement Target: TBD in DY3 Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,427,877

126675104.3.41	*IT-13.1*	**Pain assessment (NQF-1637) (Non-standalone measure)**	
JPS Health Network			*126675104.3.1*
Related Category 1 or 2 Projects:	126675104.2.13		
Starting Point/Baseline:	**<u>Target Population:</u>** **Specific Number: DY3 = 180, DY4 = 314, DY5 = 448 (941 total for DY3, DY4, and DY5)** **Description of Population:** Patients who are terminally or chronically ill as approximated by the CAPC research of over 500 hospitals based on number of staffed beds. For Pain assessment, the population should exclude oncology patients. **<u>Baseline data</u>:** There is no palliative care program at JPS Health Network so there is no baseline data. There is no baseline data on the percent who screened positive for pain and who received clinical assessment within 24 hours. Baseline levels 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 Estimated Incentive Payment: $160,231			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $320,462	**Year 3 Estimated Outcome Amount: $557,253**	**Year 4 Estimated Outcome Amount: $597,112**	**Year 5 Estimated Outcome Amount: $1,427,877**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,902,704			

Title of Outcome Measure (Improvement Target): IT-13.2 Treatment Preferences (NQF 1641) *(Non-stand-alone measure)*

Unique Project ID: 126675104.3.42 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
This measure identifies the percentage of hospice or palliative care patients with chart documentation of preferences for life-sustaining treatments. In DY2, there is a process milestone for project planning to engage stakeholders, identify current capacity, needed resources, determine timelines and document implementation plans. A second process milestone is established to manage data systems and to report baseline percentage of palliative care patients with chart documentation of preferences for life-sustaining treatments. In DY3, there are two process milestones. The first is to establish the baseline percentage of palliative care patients with chart documentation of preferences for life-sustaining treatments. The second is to establish outcome improvement targets for improvement in percentage of palliative care patients with chart documentation of preferences for life-sustaining treatments for DYs 4 and 5. DY4 and DY5 have an outcome improvement target to improve the baseline percent of palliative care patients with chart documentation of preferences for life-sustaining treatments by a percentage determined in DY3.

Rationale:
The process milestone selected for DY2 is a required building block to accurately identify the baseline rates of patients with chart documentation of preferences for life-sustaining treatments. The DY3 process measure related to identifying the baseline rates is a critical step that must be accomplished before improvement targets for patients with chart documentation of preferences for life-sustaining treatments can be compared. Outcome improvement targets will be established in DY3 for DYs 4 and 5.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream

cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

126675104.3.42	*IT-13.2*	**IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure)**	
JPS Health Network			*[RHP Performing Provider - TPI]*
Related Category 1 or 2 Projects:	126675104.2.13		
Starting Point/Baseline:	**<u>Target Population</u>** **Specific Number: DY3 = 269, DY4 = 403, DY5 = 537 (1208 total for DY3, DY4, and DY5)** **Description of Population:** Patients who are terminally or chronically ill as approximated by the CAPC research of over 500 hospitals based on number of staffed beds. **<u>Baseline dataU</u>** There is no palliative care program at JPS Health Network so there is no baseline data. There is no baseline data on the percent who screened positive for pain and who received clinical assessment within 24 hours. Baseline levels 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-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Baseline/Goal: Complete Project Plan Data Source: Project Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $76,469 **Process Milestone 2 [P-3]:** Manage data systems to prepare report indicating baseline percentage of palliative care patients with chart documentation of preferences for life-sustaining treatments. Baseline/Goal: Palliative Care Report Data Source: Project Documentation, EMR Process Milestone 2 Estimated	**Process Milestone 3 [P-2]:** Establish baseline percentage of palliative care patients with chart documentation of preferences for life-sustaining treatments. Baseline/Goal: Baseline Preferences Report Data Source: EMR, Data Report Process Milestone 2 Estimated Incentive Payment: $132,973 **Process Milestone 4 [P-2]:** Establish outcome improvement target percentage of palliative care patients with chart documentation of preferences for life-sustaining treatments for IT-13.2 in DY4 and DY5. Baseline/Goal: Improvement Target Data Source: EMR, Data Report Process Milestone 3 Estimated Incentive Payment: $132,972	**Improvement Target 1** [IT-13.2]: Improve baseline percent of palliative care patients with chart documentation of preferences for life-sustaining treatments by TBD Improvement Target: TBD in DY3 Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $284,967	**Improvement Target 2** [IT-13.2]: Improve baseline percent of palliative care patients with chart documentation of preferences for life-sustaining treatments by TBD Improvement Target: TBD in DY3 Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $681,444

126675104.3.42	*IT-13.2*	**IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure)**	
JPS Health Network			*[RHP Performing Provider - TPI]*
Related Category 1 or 2 Projects:	126675104.2.13		
Starting Point/Baseline:	**<u>Target Population</u>** **Specific Number: DY3 = 269, DY4 = 403, DY5 = 537 (1208 total for DY3, DY4, and DY5)** **Description of Population:** Patients who are terminally or chronically ill as approximated by the CAPC research of over 500 hospitals based on number of staffed beds. **<u>Baseline dataU</u>** There is no palliative care program at JPS Health Network so there is no baseline data. There is no baseline data on the percent who screened positive for pain and who received clinical assessment within 24 hours. Baseline levels 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)**
Incentive Payment: $76,469			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $152,938	**Year 3 Estimated Outcome Amount: $265,945**	**Year 4 Estimated Outcome Amount: $284,967**	**Year 5 Estimated Outcome Amount: $681,444**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,385,294			

Title of Outcome Measure (Improvement Target): IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery

Unique Project ID: 126675104.3.43 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
This measure identifies the cost minimization achieved as a result of implementing an inpatient palliative care consultation program. In DY2, there is a process milestone for project planning to engage stakeholders, identify current capacity, needed resources, determine timelines and document implementation plans. A second process milestone is established to manage data systems to report baseline costs for specific diagnoses that commonly warrant palliative care prior to implementing palliative care services. In DY3, there is a process milestone to establish the baseline cost of care for specific diagnoses. There is a second process milestone to establish the improvement targets for DYs 4 5. DY4 has an outcome improvement target to ensure a reduction by xx% of costs for those with specific diagnoses who receive a palliative care consultation. DY5 has an outcome improvement target to ensure a reduction by xx% of costs for those with specific diagnoses who receive a palliative care consultation.

Rationale:
This outcome measure was selected due to the wide body of evidence that suggests implementation of palliative care services reduces hospital costs.[397] The process milestone selected for DY2 is a required building block to accurately identify the baseline costs of specific diagnoses that commonly warrant palliative care but have not had access to the service. The DY3 process measure related to identifying the baseline costs is a critical step that must be accomplished to compare improvement targets for palliative care patients. Outcome improvement targets for DY4 and DY5 will be established in DY3.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding

[397] Morrison RS, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE. Cost savings associated with US hospital palliative care consultation programs. Palliative Care Leadership Centers' Outcomes Group. *Arch Intern Med*. 2008 Sep 8; 168(16):1783-90.

to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

126675104.3.43	*IT-5.1*	Improved cost savings: Demonstrate cost savings in care delivery (non-standalone measure)	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.13*		
Starting Point/Baseline:	**<u>Target Population</u>:** **Specific Number: DY3 = 269, DY4 = 403, DY5 = 537 (1208 total for DY3, DY4, and DY5)** **Description of Population:** Patients who are terminally or chronically ill as approximated by the CAPC research of over 500 hospitals based on number of staffed beds. **<u>Baseline data</u>:** There is no palliative care program at JPS Health Network so there is no baseline data. There is no baseline data on the percent who screened positive for pain and who received clinical assessment within 24 hours. Baseline levels 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-1]: [P-1.1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Baseline/Goal: Complete Project Plan Data Source: Project Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $59,872 **Process Milestone 2 [P-3]:** Manage data systems to prepare report indicating baseline percentage of palliative care patients with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. Baseline/Goal: Palliative Care Diagnosis Cost Report	**Process Milestone 3 [P-2]:** Establish baseline costs for specific diagnoses that commonly warrant palliative care Baseline/Goal: Baseline cost report Data Source: EMR, patient accounting Process Milestone 2 Estimated Incentive Payment: $104,112 **Process Milestone 4 [P-7 -]:** Establish improvement target for specific diagnoses that commonly warrant palliative care for 3.5.1 Baseline/Goal: Improvement target Data Source: EMR, patient accounting software Process Milestone 2 Estimated Incentive Payment: $104,113	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Goal is to reduce costs of patients who receive palliative care services by TBD compared to baseline established in DY3 Data Source: EMR, Patient accounting software Outcome Improvement Target 1 Estimated Incentive Payment*:* $**223,119**	**Outcome Improvement Target 2 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: Goal is to reduce costs of patients who receive palliative care services by TBD compared to baseline established in DY3 Data Source: EMR, Patient accounting software Outcome Improvement Target 2 Estimated Incentive Payment*:* $**533,545**

126675104.3.43	*IT-5.1*	Improved cost savings: Demonstrate cost savings in care delivery (non-standalone measure)	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.13*		
Starting Point/Baseline:	**<u>Target Population</u>:** **Specific Number: DY3 = 269, DY4 = 403, DY5 = 537 (1208 total for DY3, DY4, and DY5)** **Description of Population:** Patients who are terminally or chronically ill as approximated by the CAPC research of over 500 hospitals based on number of staffed beds. **<u>Baseline data</u>:** There is no palliative care program at JPS Health Network so there is no baseline data. There is no baseline data on the percent who screened positive for pain and who received clinical assessment within 24 hours. Baseline levels 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)**
Data Source: EMR, Patient Accounting software Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $59,873			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $119,745	**Year 3 Estimated Outcome Amount: $208,225**	**Year 4 Estimated Outcome Amount: $223,119**	**Year 5 Estimated Outcome Amount: $533,545**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,084,634			

Title of Outcome Measure (Improvement Target): IT 5.1 Improved cost savings: Demonstrate cost savings in care delivery

Unique RHP Outcome Identification Number: 126675104.3.44 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description: To demonstrate improved cost savings by 20% at the end of the Waiver period by increasing access to a medical provider to 50% of the enrolled Connections individuals.

Process Milestones:
In DY2, we will engage stakeholders to appropriately plan the resources and project. We will establish the baseline and collect and measure the required data.

In DY3, the group will do PDSA cycles to improve the data collection and analysis, and evaluate the baseline data.

Rationale:
Process milestones P-1 through P- 5 were chosen due to the lack of accurate reports or no information. Current resources and processes were not available to accurately measure and monitor data. The analysis tool will be implemented in DY3 with process reviews conducted in preparation for DY4 and DY5 outcome measures.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

126675104.3.44	*3.IT-5.1*	Improved cost savings: Demonstrate cost savings in care delivery	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104-.2.14 Integrated Care Model with outcome based payments*		
Starting Point/Baseline:	*Target Population – Connections population 75,000 individuals* *Intervention Population – 37,500 Connection individuals* *Impact Population – Increase access to 50% of the individuals enrolled and reduce costs*		
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. (Develop an implementation plan to improve cost savings through cost benefit analysis and transition from fee for service to outcome based payment .) Baseline/Goal: Identification of process/steps to implement improvement target. Data Source: Documentation of stakeholder engagement, current reporting capacity, needed resources, and implementation plan. **Process Milestone 1 Estimated Incentive Payment*:*** **$** 165,195 **Process Milestone 2 [P-2]:** Establish baseline rates (Determine current baseline performance in target area.) Baseline/Goal: Establish baseline to determine improvement target. Data Source: Report of data analysis tools	**Process Milestone 4 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities (Conduct performance improvement activities with PDSA model to ensure reliable interactions, data collection, analysis, and reporting) Baseline/Goal: Performance improvement to meet improved target. Data Source: Documentation/Report of PDSA cycle. **Process Milestone 4 Estimated Incentive Payment: $430,834** **Process Milestone 5 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders. (Evaluate implementation plan, baseline rates, data collection and performance improvement activities in a report format and present to stakeholders.) Baseline/Goal: Educate stakeholders on quality outcome initiative/processes. Data Source: Documentation/Report of	**Outcome Improvement Target 1 [IT-5.1]:** Improved cost savings: Demonstrate cost savings in care delivery and transition from fee for service to outcome based payment . a) Type of analysis to be determined by provider: Cost Benefit Analysis and transition from fee for service to outcome based payment . Baseline: New process. Goal: Demonstrate 10% cost savings in care delivery. Data Source: TBD **Outcome Improvement Target 1 Estimated Incentive Payment $921,785**	**Outcome Improvement Target 2 IT-5.1:** Improved cost savings: Demonstrate cost savings in care delivery and transition from fee for service to outcome based payment . a) Type of analysis to be determined by provider: Cost Benefit Analysis and transition from fees for service to outcome based payment . Baseline: New process. Goal: Demonstrate a 20% cost savings in care delivery. Data Source: TBD **Outcome Improvement Target 1 Estimated Incentive Payment $2,204,268**

126675104.3.44	*3.IT-5.1*	Improved cost savings: Demonstrate cost savings in care delivery	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*126675104-.2.14 Integrated Care Model with outcome based payments*		
Starting Point/Baseline:	*Target Population – Connections population 75,000 individuals* *Intervention Population – 37,500 Connection individuals* *Impact Population – Increase access to 50% of the individuals enrolled and reduce costs*		
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 2 Estimated Incentive Payment: $ 165,194 **Process Milestone 3 [P-3]:** Develop and test data systems (Develop and test system to collect and measure required data points) Baseline/Goal: Establish data collection process needed to improved cash savings. Data Source: Documentation/Report of data tests explaining data collection process. **Process Milestone 3 Estimated Incentive Payment: $** 165,194	evaluation. **Process Milestone 5 Estimated Incentive Payment: $** 430,834		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $651,547	**Year 3 Estimated Outcome Amount: $1,132,979**	**Year 4 Estimated Outcome Amount: $1,214,018**	**Year 5 Estimated Outcome Amount: $2,903,087**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $5,901,631			

Title of Outcome Measure (Improvement Target): IT-8.1 Timeliness of Prenatal/Postnatal Care

Unique Project ID: 126675104.3.45 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

Process Milestones:
The overall outcome measure will be to meet or exceed the national benchmarks for women receiving prenatal care in the first trimester and postnatal care between 21 and 56 days following delivery.
DY2:
Process Milestone 1-(P-1) – Partner with identified agencies for project planning to develop protocols/strategies for recruiting and retaining women in to care.
Process Milestone 2-(P-2) – Collaborate with identified partners/agencies (both internal and external) serving the prenatal community to determine baseline rates of the timeliness of prenatal and postnatal care.

Process Milestone 3-(P-3) – Develop and test data systems to ensure validity of information gathered on the timeliness of prenatal and postnatal care.

DY3:
Process Milestone 4-(P-4) – Conduct Plan, Do, Study, Act Cycles (rapid cycle improvement) to identify strategies with partnering agencies for ensuring timeliness of prenatal and postnatal care including effective documentation for receipt of services.

Process Milestone 5-(P-5) – Develop a system to disseminate findings and best practices to stakeholders, including identifying project impacts, "lessons learned", and key challenges associated with expansion of the project. This will include special consideration for safety-net populations.

Outcome Improvement Targets:
DY4 and DY5- Outcome Improvement (IT -8.1) – Increase the number of patients receiving prenatal care in the first trimester and postnatal care in days 21 – 56 following delivery to 50% (DY4) and 75% (DY5) of the national HEDIS metrics.

Rationale:
In collaboration with the University of North Texas Health Science Center's health provider group, UNT Health, and the JPS Health Provider Group (JPSPG), and support from local community groups, we prepose to bring innovative prenatal care to 5,166 (92% of JPS live births received prenatal care in our JPS clinics in FY11) women over the life of the project. We are particularly interested in the CenteringPregnancy and Maternal Medical Home models of group

care because we believe it will address the social risk factors our patients often face and can reduce racial disparities in birth outcomes, a problem that Tarrant County has yet to resolve. The CenteringPregnancy model of care has already been implemented and accepted by Tarrant County women as seen at the University of North Texas Health Science Center and JPS Health Center for Women.

Since several JPS Community Clinics have only one obstetric nurse practitioner who provides women's services, the CenteringPregnancy model is not the best practice. The number of patients in these clinics would not be large enough to create groups for CenteringPregnancy. Therefore, JPS proposes to use the Maternal Medical Home model. The Maternal Medical Home proposes to enhance prenatal care through the addition of supportive services that Texas Medicaid does not cover through improved coordination with existing JPS and community services. Patients will complete a medical and psychosocial assessment at their first visit, and be linked to services as warranted by the assessment findings. Services may include, but are not limited to, doula services, dental services, dietitian and nutritional services, and case management.

JPS has chosen the overall outcome of the timeliness of prenatal and postnatal visits because the JPS patients' timeliness to prenatal care and postnatal care is below the national average, and because the JPS Health Network is the primary, if not only source of preconception and interconception care for low-income women in Tarrant County, an essential component of efforts to improve birth outcomes. In Tarrant County there is an inverse relationship between entrance into prenatal care and infant mortality. Women who did not receive prenatal care were 252% more likely to encounter an infant's death, highlighting the importance of early, consistent and quality prenatal care. The Fetal Infant Mortality Review reported that 42% of the cases reviewed in 2008 reporting having access to care issues, and 48% of women giving birth in Tarrant County received late or no prenatal care.

Women with private insurance were more likely to receive postpartum care (82.8%) than women with Medicaid (62.7%). In Texas, even among women with commercial HMO insurance, only 48% of women received a postpartum visit on or before 21 days and 56 days after delivery. The postpartum care rate at JPS is estimated to be 40%, and the national average is 64.1%. Postpartum care is essential for women who have had a previous adverse outcome, such as preterm birth. For low-income women, the postpartum visit may be the source of medical care until they become pregnant again.

JPS will establish a baseline using data gathered in DY2 and will validate this data to compare to the national benchmark over the life of the Waiver. Also in DY2, JPS will partner with identified agencies for project planning to develop protocols/strategies for recruiting and retaining women in care.

In DY3, JPS will complete the Plan Do Study Act cycles to improve data collection and intervention activities. This is an important part in the data tracking and program implementation. During DY3, JPS will develop a plan of disseminating the findings and best practices to stakeholders. Disseminating this information will demonstrate ongoing improvement opportunities for the program across the clinics. Ongoing engagement and support of community stakeholders is essential to the successful recruitment of women into the program and providing a continuum of care through integrated referrals. JPS will bring together an oversight board consisting of the members of JPS and other pertinent agencies or individuals quarterly. The oversight committee will have several purposes: 1) continue to engage stakeholders in project, 2) share information, 3) identify barriers and develop strategies, 4) provide access to expertise, and 5) help foster wider public support for Journey to Life as an innovative strategy to provide obstetric care as a means to improve birth outcomes.

By DY4, JPS will measure the timeliness of prenatal and postnatal visits. The goal will be to increase prenatal care (defined as those whose began prenatal care during the first 13 weeks of pregnancy or within 42 days of enrollment) and postnatal visits between 21 and 56 days following delivery to meet 50% HEDIS national benchmark by the end DY4 and by 75% HEDIS national benchmark by DY5. JPS plans to continue this model after the completion of DY5 due to the confidence in these innovative programs.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

126675104.3.45	3.IT-8.1	Timeliness of Prenatal/Postnatal Care	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	**126675104.2.15 Journey to Life: Prenatal Care and Healthy Babies Initiative**		
Starting Point/Baseline:	Target Population: Specific Number: Specific Number: 3,084 prenatal women in DY4 and 3,875 prenatal women in DY5 who are defined as the intervention population. These women will have been enrolled and received prenatal care through either of the two evidence-based models, CenteringPregnancy or the Maternity Medical Home. Description of Population: JPS Obstetric Patients Baseline data: JPS 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-1]: Project planning to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Metrics: a. Partner with identified agencies for project planning to develop protocols/strategies for recruiting women into care earlier and for follow-up following delivery. b. Implement a patient tracking system that captures -timeliness of prenatal and postnatal care, and develop systems to proactively bring recruit and retain women in to care c. Identify key challenges associated with the expansion of the project Data Source: EHR/EPIC, written protocols and completion of capacity assessment to meet increasing demands for prenatal care services. Process Milestone 1 Estimated Incentive Payment: $151,470 **Process Milestone 2 [P-2]:**	**Process Milestone 4 [P-4]:** Conduct Plan Do Study Act cycles (rapid cycle improvement) to identify strategies with partnering agencies for ensuring timeliness of prenatal and postnatal care including effective documentation for receipt of services. Goals: a. Predict what the change in outcomes will be b. Plan how the change will be implemented c. Collect the data d. Analyze the data e. Establish baseline benchmarks Data Source: EHR/EPIC Process Milestone 4 Estimated Incentive Payment: $395,085 **Process Milestone 5 [P-5]:** Develop a system to disseminate findings and best practices to internal and external stakeholders including primary care providers, payor sources, and outside agencies. Rationale: By sharing	**Outcome Improvement Target 1** [IT 8.1]: Rate 1: Increase the number of patients receiving prenatal care in the first trimester to 84% (HEDIS 50% national benchmark) Improvement Target: 84% Data Source: EHR/HEDIS Rate 2: Increase the number of patients receiving postnatal care between 21 and 56 days of delivery to 60% (HEDIS 50% national benchmark) Improvement Target: 60% Data Source: EHR/HEDIS Outcome Improvement Target 1 Estimated Incentive Payment: $846,689	**Outcome Improvement Target 2** [IT 8.1]: Rate 1: Increase the number of patients receiving care in the first trimester to 89% (HEDIS 75% national benchmark) Improvement Target: 89% Data Source: EHR/HEDIS Rate 2: Increase the number of patients receiving postnatal care between 21 and 56 days of delivery to 66% (HEDIS 75% national benchmark) Improvement Target: 66% Data Source: EHR/HEDIS Outcome Improvement Target 2 Estimated Incentive Payment: $2,024,692

126675104.3.45	3.IT-8.1	Timeliness of Prenatal/Postnatal Care	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	**126675104.2.15 Journey to Life: Prenatal Care and Healthy Babies Initiative**		
Starting Point/Baseline:	Target Population: Specific Number: Specific Number: 3,084 prenatal women in DY4 and 3,875 prenatal women in DY5 who are defined as the intervention population. These women will have been enrolled and received prenatal care through either of the two evidence-based models, CenteringPregnancy or the Maternity Medical Home. Description of Population: JPS Obstetric Patients Baseline data: JPS 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)**
Establish baseline rates. Goal: Collaborate with identified agencies/partners s (both internal and external) serving the prenatal community to determine baseline rates of the timeliness of prenatal and postnatal care.) Data Source: EHR/EPIC Process Milestone 2 Estimated Incentive Payment: $151,468 **Process Milestone 3 [P-3]:** To develop and test data systems to ensure validity of information regarding prenatal and postnatal care Goal: Validation of data collection for prenatal and postnatal care Data Source: EHR/EPIC Process Milestone 3 Estimated Incentive Payment: $151,468	"lessons learned" with the stakeholders, the program will be more successful and standards will be maintained. Communication of project impacts and best practices is a critical element for innovation spread and sustainability. Goal: Evidence of dissemination of findings including meeting minutes. Data Source: Process documentation Process Milestone 5 Estimated Incentive Payment: $395,085		

126675104.3.45	3.IT-8.1	Timeliness of Prenatal/Postnatal Care	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	**126675104.2.15 Journey to Life: Prenatal Care and Healthy Babies Initiative**		
Starting Point/Baseline:	Target Population: Specific Number: Specific Number: 3,084 prenatal women in DY4 and 3,875 prenatal women in DY5 who are defined as the intervention population. These women will have been enrolled and received prenatal care through either of the two evidence-based models, CenteringPregnancy or the Maternity Medical Home. Description of Population: JPS Obstetric Patients Baseline data: JPS 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $454,406	**Year 3 Estimated Outcome Amount: $790,170**	**Year 4 Estimated Outcome Amount: $846,689**	**Year 5 Estimated Outcome Amount: $2,024,692**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $4,115,957			

Title of Outcome Measure (Improvement Target): IT-9.2 **ED Appropriate Utilization**

Unique RHP outcome identification number(s): 126675104.3.46 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

Process Milestones:
DY2:
Process Milestone 1-(P-1) – Partner with identified agencies for project planning to develop protocols/strategies for educating women on the appropriate utilization of the emergency department.
Process Milestone 2-(P-2) – Partner with identified agencies serving the prenatal community to determine baseline rates of the inappropriate utilization of the emergency department.
Process Milestone 3-(P-3) – Develop and test data systems to ensure validity of information regarding the utilization of the emergency department by prenatal patients.

DY-3:
Process Milestone 4-(P-4) – Conduct Plan, Do, Study, Act Cycles (rapid cycle improvement) to identify strategies with partnering agencies for providing educational opportunities at JPS and in the community to educate prenatal patients on the utilization of the emergency department.

Process Milestone 5-(P-5) – Develop a system to disseminate findings and best practices to stakeholders to help decrease the number of prenatal patients that inappropriately utilize the emergency department, including identifying project impacts, "lessons learned", and key challenges associated with expansion of the project. This will include special consideration for safety-net populations.

Outcome Improvement Targets:
DY-4
Outcome Improvement Milestone 1-(IT-9.2) – Decrease the number of prenatal patients utilizing the emergency department by 5% from established baseline.

DY-5
Outcome Improvement Milestone 2-(IT-9.2) – Decrease the number of prenatal patients utilizing the emergency department by 10% from established baseline.

Rationale:
In collaboration with the University of North Texas Health Science Center's health provider group, UNT Health, and the JPS Health Provider Group (JPSPG), and support from local community groups, we propose to bring innovative prenatal care to 5,166 (92% of deliveries at JPS are receiving prenatal care at JPS clinics based on FY11 data) women over the life of the project. We are particularly interested in the CenteringPregnancy and Maternal Medical Home

models of group care because we believe it will address the social risk factors our patients often face, increase access to care in the outpatient setting, and reduce racial disparities in birth outcomes, a problem that Tarrant County has yet to resolve. The CenteringPregnancy model of care has already been implemented and accepted by Tarrant County women as seen at the University of North Texas Health Science Center and JPS Health Center for Women-Main.

Since several JPS Community Clinics have only one obstetric nurse practitioner who provides women's services, the CenteringPregnancy model is not the best practice. The number of patients in these clinics would not be large enough to create groups for CenteringPregnancy. Therefore, JPS proposes to use the Maternal Medical Home model. The Maternal Medical Home will enhance prenatal care through the addition of supportive services that Texas Medicaid does not cover by enhancing coordination with existing JPS and community services. Patients will complete a medical and psychosocial assessment at their first visit, and be linked to services as warranted by assessment findings. Services may include doula services, dental services, dietitian and nutritional services, and case management. Each patient will have a health care coach and patient navigator who will assist her in scheduling appointments and who will educate her on the appropriate utilization of the emergency department.

Both of these innovative programs help to coordinate prenatal care and decrease barriers to care, which in turn will decrease the inappropriate utilization of the emergency department. In CenteringPregnancy, patients are educated in a group setting, which promotes open discussion and helps to foster questions that might otherwise not be addressed. Through the Maternal Medical Home, patients are given a patient navigator and health care coordinator to help follow up with visits, overcome health care system barriers and provide internal and external community resources.

JPS chose the overall outcome of decreasing the inappropriate utilization of the emergency department by prenatal patients because over 3,000 visits were made to the emergency department by prenatal patients in fiscal year 2011. Health care access refers to an individual's ability to obtain recommended and needed primary and specialty care when needed in the best setting possible. Lack of access and fragmented coordination for the low-income, uninsured population impacts the increased utilization of the ED for health conditions controllable through the outpatient setting. Texans spent over $24 billion on hospitalizations among people ages 18 years and older that could have been prevented if those individuals possessed adequate access to outpatient care.

JPS will identify reasons for inappropriate utilization of the emergency department and track these through the life of the project. JPS will establish baseline using data gathered in DY2, and will validate this data to compare over the life of the Waiver. Also in DY2, JPS will partner with identified agencies for project planning to develop protocols/strategies for educating women at JPS and in the community.

In DY3, JPS will complete the Plan Do Study Act cycles to improve data collection and intervention activities. This is an important part in the data tracking and program implementation. During DY3, JPS will develop a plan to disseminate findings and best practices to internal and external stakeholders. Disseminating this information will demonstrate ongoing improvement opportunities for the program across the clinics. Ongoing engagement and support of community stakeholders is essential to the successful recruitment of women into the program and providing a continuum of care through integrated referrals. JPS will bring together an oversight board consisting of the members of JPS and other pertinent agencies or individuals quarterly. The oversight committee will have several purposes: 1) continue to engage stakeholders in project, 2) share information, 3) identify barriers and develop strategies, 4) provide access to expertise, and 5) help foster wider public support for Journey to Life as an innovative strategy to provide obstetric care as a means to improve birth outcomes and decrease emergency department utilization.

By DY4, JPS will measure the utilization of the emergency department by prenatal patients. The goal will be to decrease the frequency of inappropriate emergency department visits by prenatal patients by 5% of the baseline. By DY5, the goal will be to decrease the frequency of inappropriate emergency department visits by prenatal patients by 10% of the baseline. JPS plans to continue this model after completion of DY5 due to the confidence in these innovative programs.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

126675104.3.46	3.IT-9.2	ED Appropriate Utilization	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.15 **Journey to Life: Prenatal Care and Healthy Babies Initiative**		
Starting Point/Baseline:	Target Population: Specific Number: 3,084 prenatal women in DY4 and 3,875 prenatal women in DY5 who are defined as the intervention population. These women will have been enrolled and received prenatal care through either of the two evidence-based models, CenteringPregnancy or the Maternity Medical Home. Description of Population: JPS Obstetric Patients Baseline data: 3,230 ED visits were provided in FY11 for patients who were identified as pregnant. Baseline data will be established in DY2 to determine which of these ED visits were potentially preventable.		
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 to engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Goals: a. Partner with identified agencies for project planning to develop protocols/strategies for educating prenatal patients at JPS and in the community. b. Implement a patient tracking system that captures the utilization of the emergency department and develop systems to proactively educate prenatal women on the appropriate utilization of the emergency department c. Identify key challenges associated with the expansion of the project Data Source: EHR/EPIC and Written protocols and completion	**Process Milestone 4 [P-4]:** Conduct Plan Do Study Act cycles(rapid cycle improvement) to identify strategies with partnering agencies for effective community education regarding appropriate use of the emergency department. Goal: f. Predict what the change in outcomes will be g. Plan how the change will be implemented h. Collect the data i. Analyze the data j. Establish baseline benchmarks Data Source: EHR/EPIC Process Milestone 4 Estimated Incentive Payment: $97,586	**Outcome Improvement Target 1 [IT-9.2]:** Rate 1: Decrease the number of prenatal patients utilizing the emergency department by 5% which equates to 162 fewer visits. Improvement Target: 5% fewer visits which equates to 162 fewer visits. Data Source: EHR/HEDIS Outcome Improvement Target 1 Estimated Incentive Payment: $104,566	**Outcome Improvement Target 2 [IT 9.2]:** Rate 1: Decrease the number of prenatal patients utilizing the emergency department by 10% which equates to 323 fewer visits. Improvement Target: 10% fewer visits which equates to 323 fewer visits. Data Source: EHR/HEDIS Outcome Improvement Target 2 Estimated Incentive Payment: $250,050

126675104.3.46	3.IT-9.2	ED Appropriate Utilization	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.15 **Journey to Life: Prenatal Care and Healthy Babies Initiative**		
Starting Point/Baseline:	Target Population: Specific Number: 3,084 prenatal women in DY4 and 3,875 prenatal women in DY5 who are defined as the intervention population. These women will have been enrolled and received prenatal care through either of the two evidence-based models, CenteringPregnancy or the Maternity Medical Home. Description of Population: JPS Obstetric Patients Baseline data: 3,230 ED visits were provided in FY11 for patients who were identified as pregnant. Baseline data will be established in DY2 to determine which of these ED visits were potentially preventable.		
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)**
of the assessment to identify inappropriate utilization of the emergency department. Process Milestone 1 Estimated Incentive Payment: $18,706 **Process Milestone 2 [P-2]:** Establish baseline rates. Goals: a. Partner with identified agencies serving the prenatal community to determine baseline rates of the inappropriate utilization of the emergency department b. Establishment of a baseline rate for the inappropriate utilization of the emergency department for prenatal patients. Data Source: EHR/EPIC Process Milestone 2 Estimated Incentive Payment: $18,706 **Process Milestone 3 [P-3]:** Develop and test data systems to			

126675104.3.46	3.IT-9.2	ED Appropriate Utilization	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	126675104.2.15 **Journey to Life: Prenatal Care and Healthy Babies Initiative**		
Starting Point/Baseline:	Target Population: Specific Number: 3,084 prenatal women in DY4 and 3,875 prenatal women in DY5 who are defined as the intervention population. These women will have been enrolled and received prenatal care through either of the two evidence-based models, CenteringPregnancy or the Maternity Medical Home. Description of Population: JPS Obstetric Patients Baseline data: 3,230 ED visits were provided in FY11 for patients who were identified as pregnant. Baseline data will be established in DY2 to determine which of these ED visits were potentially preventable.		
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)**
ensure validity of information regarding the inappropriate utilization of the emergency department for prenatal patients. Goal: Validation of data collection for the inappropriate utilization of the emergency department for prenatal patients seen at JPS. Data Source: EHR/EPIC Process Milestone 3 Estimated Incentive Payment: $18,707			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $56,119	**Year 3 Estimated Outcome Amount: $97,586**	**Year 4 Estimated Outcome Amount: $104,566**	**Year 5 Estimated Outcome Amount: $250,050**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $508,321			

Title of Outcome Measure (Improvement Target): IT-9.3 Pediatric/Young Adult Asthma Emergency Department Visits

Unique Project ID: 126675104.3.47 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

DY2: Process milestone 1 (P-2) – Establish baseline rates – Partner with identified agencies serving the underserved pediatric and young adult population to determine baseline data specific to pediatric/young adult asthma emergency department visits.
DY3: Process milestone 2 (P-4) – Plan-Do-Study-Act cycle will be utilized to identify appropriate communication flow between partnering agencies for seamless coordination of care and prevention of potentially preventable ED admissions.
DYs 4 and 5: Outcome improvement – Reduce the percentage of pediatric and young adult patients with asthma who have greater than or equal to one visit to the emergency room by 10% (DY4) and 15% (DY5) from established baseline.

Rationale:
Tarrant County is home to 401,322 children ages 0-14. According to CCHAPS, a Community-wide Children's Health Assessment and Planning Survey, 18.6% of those children have asthma.[1] Asthma is the most common chronic disease in childhood and children in low-income families are more than twice as likely to have been diagnosed with asthma than children in families that are not low-income.[2] Asthma is the leading cause of emergency department visits and hospitalizations for children in the United States[3] and is one of the leading causes of school absenteeism. Asthma-related illnesses lead to almost 13 million school days missed per year.[4]

Treating children with asthma in emergency departments (ED) is not only costly, but in many cases, unnecessary. Research shows that ED visits typically cost five times as much as primary care visits, and 17 percent of all pediatric ED visits could be eliminated by proper therapy.[5] The estimated annual cost of treating asthma in children is $8 billion.[6] Among Medicaid-enrolled children with persistent asthma, the underuse of controller medications is widespread, reaching as high as 73%. As a result, there are more episodes, greater use of emergency departments and hospitals, and increased treatment costs.[7]

Children with asthma continue to suffer as adults affecting not only their quality of life, but also their lifetime productivity. It has been calculated that the economic costs of asthma for all people born in the year 2000 who develop this diagnosis (approximately 380,000 people) will be: $7.2 billion, including 3.2 billion in medical costs and $4 billion in work/productivity loss.[8]

When children receive tailored asthma education and ongoing treatment, they are less likely to require costly hospitalizations and avoidable emergency room visits.[8] A focus on chronic, complex care will require workflow redesign and increased emphasis on connected and coordinated disease-based care teams. With the implementation of this DSRIP project, we believe that aggressive, proactive, and coordinated multidisciplinary care will significantly reduce emergency department visits in our target population.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

References:

1. Cook Children's Healthcare System Fort Worth, Texas. (2009). CCHAPS Community-wide Children's Health Assessment and Planning Survey.
2. U.S. Department of Health and Human Services, National Center for Health Statistics, 2008 National Health Interview Survey. Calculations by Children's Defense Fund.
3. Tolomeo C, Savrin C, Heinser M. & Bazzy-Asaad A. (2009) Predictors of asthma-related pediatric department visits and hospitalizations. *J Asthma*, 2009 Oct;46 (8);829-34.
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5. Challenging assumptions: the emergency department demonstration program. (2012). http://www.pediatricasthma.org/emergency_departments.
6. Soni A. The five most costly children's conditions, 2006: Estimates for the U.S. civilian noninstitutionalized children, aged 0-17. Medical Expenditure Panel Survey; Statistical Brief #242. April 2009.
7. Stanton MW & Dougherty D. Chronic Care for low-income children with asthma: strategies for improvement. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action Issue 18. AHRQ Pub. No. 05-0073.
8. Corso, P. & Fertig, A. H. The Long-term Economic Costs of Asthma. Partnership for America's Economic Success. Washington, DC. Issue Paper #13. (2009) ww.readynation.org/uploads/20090708_asthmafinalformatted.pdf.
9. Clouiter MM et al. Use of asthma guidelines by primary care providers to reduce hospitalizations and emergency room visits in poor, minority, urban children. *Journal of Pediatrics*. 2005;146 (5):591-597.

126675104.3.47	3.IT-9.3	Pediatric/Young Adult Asthma Emergency Department Visits	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	**126675104.2.16 - Expand Chronic Care Management Models- School Based Collaborative Chronic Disease Care Model**		
Starting Point/Baseline:	**Target Population***:* 2,035 unduplicated Pediatric and Young Adult Asthma patients – 395 will visit the ED. **Description of population:** Pediatric and Young Adult patients with a diagnosis of Asthma currently receiving primary care services in our 19 School Based Health Centers. This identified population has limited to no access to chronic care management services. **Baseline data:** Currently there is no baseline data available. Baseline data will be collected on this population 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. Baseline/Goal: Partner with identified agencies serving the underserved pediatric and young adult population with a diagnosis of asthma to determine baseline data specific to Pediatric/Young Adult Asthma Emergency Department visits. Data Source: EPIC EMR, HIE, Excel spreadsheets, School Based data system information Process Milestone 1 Estimated Incentive Payment: $1,664	**Process Milestone 2 [P-4]:** Conduct Plan-Do-Study-Act cycles to improve data collection and intervention activities Baseline/Goal: Plan-Do-Study-Act cycle will be utilized to identify appropriate communication flow between partnering agencies for seamless coordination of care and prevention of potentially preventable ED admissions. Data Source: PDSA cycle results and evidence of dissemination of findings to external and internal stakeholders. Process Milestone 2 Estimated Incentive Payment: $2,892	**Outcome Improvement Target 1 [IT-9.3]:** Reduce the percentage of pediatric and young adult patients with asthma who have greater than or equal to one visit to the emergency room. Goal: Reduce ED visits by 10% from established baseline Data Source: EPIC EMR, HIE Outcome Improvement Target 1 Estimated Incentive Payment*:* $3,101	**Outcome Improvement Target 2 [IT-9.3]:** Reduce the percentage of pediatric and young adult patients with asthma who have greater than or equal to one visit to the emergency room. Goal: Reduce ED visits by 15% from established baseline Data Source: EPIC EMR, HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $7,415
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $1,664	**Year 3 Estimated Outcome Amount: $2,894**	**Year 4 Estimated Outcome Amount: $3,101**	**Year 5 Estimated Outcome Amount: $7,415**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $15,074			

Title of Outcome Measure (Improvement Target): IT-3.11 Pediatric Asthma 30-Day Readmission Rate

Unique Project ID: 126675104.3.48 (Pass 2)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

DY2: Process milestone 1 (P-1) – Project Planning – Establish community linkages to develop a project plan focused on chronic care management for asthma in the pediatric and young adult population.

DY2: Process milestone 2 (P-2) – Establish baseline rates – Partner with identified agencies serving the underserved pediatric and young adult population to determine baseline data specific to pediatric asthma 30-day readmission rates specific to our population.

DY3: Process milestone 3 (P-3) – Develop and test data systems to ensure validity of information gathered specific to pediatric asthma 30-day readmission rates.

DYs 4-5: Outcome improvement (IT 3.11) – Reduce the percentage of pediatric and young adult patients with asthma who are readmitted to the hospital for any cause within 30 days of discharge from initial admission by 10% (DY4) and 15% (DY5) from established baseline.

Rationale:
Tarrant County is home to 401,322 children ages 0-14. According to CCHAPS, a Community-wide Children's Health Assessment and Planning Survey, 18.6% of those children have asthma.[1] Asthma is the most common chronic disease in childhood and children in low-income families are more than twice as likely to have been diagnosed with asthma than children in families that are not low-income.[2] Asthma is the leading cause of emergency department visits and hospitalizations for children in the United States[3] and is one of the leading causes of school absenteeism. Asthma-related illnesses lead to almost 13 million school days missed per year.[4]

Hospitalizations and emergency department visits for children with asthma is not only costly, but in many cases, unnecessary. The estimated annual cost of treating asthma in children is $8 billion[5] and inpatient hospitalizations represent the largest single direct medical expense for this chronic condition. Among Medicaid-enrolled children with persistent asthma, the underuse of controller medications is widespread, reaching as high as 73%. As a result, there are more episodes, greater use of emergency departments and hospitals, and increased treatment costs.[6]

Children with asthma continue to suffer as adults affecting not only their quality of life but their lifetime productivity as well. It has been calculated that the economic costs of asthma for all people born in the year 2000 who develop this diagnosis (approximately 380,000 people) will be: $7.2 billion, including 3.2 billion in medical costs and $4 billion in work/productivity loss.[7]

When children receive tailored asthma education and ongoing treatment, they are less likely to require costly hospitalizations and avoidable emergency room visits.[8] Research indicates that having a written asthma management plan is associated with reduced rates of hospitalizations.[9] A focus on chronic, complex care will require workflow redesign and increased emphasis on connected and coordinated disease-based care teams. With the implementation of this DSRIP project, we believe that aggressive, proactive, and coordinated multidisciplinary care will significantly reduce 30-day readmission rates in our target population.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

References:

1. Cook Children's Healthcare System Fort Worth, Texas. (2009). CCHAPS Community-wide Children's Health Assessment and Planning Survey.
2. U.S. Department of Health and Human Services, National Center for Health Statistics, 2008 National Health Interview Survey. Calculations by Children's Defense Fund.
3. Tolomeo C, Savrin C, Heinser M. & Bazzy-Asaad A. (2009) Predictors of asthma-related pediatric department visits and hospitalizations. *J Asthma*, 2009 Oct;46 (8);829-34.
4. Akinbami, LJ. The state of childhood asthma 1980-2005. Data from Vital and Health Statistics; no 381, December 2006. Hyattsville, MD. National Center for Health Statistics, 2006.

5. Soni A. The five most costly children's conditions, 2006: Estimates for the U.S. civilian noninstitutionalized children, aged 0-17. Medical Expenditure Panel Survey; Statistical Brief #242. April 2009.
6. Stanton MW & Dougherty D. Chronic care for low-income children with asthma: strategies for improvement. Rockville (MD): Agency for Healthcare Research and Quality; 2005. Research in Action Issue 18. AHRQ Pub. No. 05-0073.
7. Corso P & Fertig AH. The long-term economic costs of asthma. partnership for america's economic success. Washington, DC. Issue Paper #13. (2009) ww.readynation.org/uploads/20090708_asthmafinalformatted.pdf.
8. Clouiter MM et. Al. Use of asthma guidelines by primary care providers to reduce hospitalizations and emergency room visits in poor, minority, urban children. *Journal of Pediatrics*. 2005;146 (5):591-597.
9. Lieu T, Quesenbery C, Capra A, Sorel M, Martin K & Melodoza G. (1997) Outpatient management practices associated with reduced risk of pediatric asthma hospitalization and emergency department visits. *Ped Digest*, 100(3), 334-341.

126675104.3.48	3.IT-3.11	Pediatric Asthma 30-Day Readmission Rate	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	**126675104.2.16 - Expand Chronic Care Management Models- School Based Collaborative Chronic Disease Care Model**		
Starting Point/Baseline:	**Target Population***:* 2,035 unduplicated Pediatric and Young Adults diagnosed with Asthma. **Description of population:** Pediatric and Young Adult patients with a diagnosis of Asthma currently receiving primary care services in our 19 School Based Health Centers. This identified population has limited to no access to chronic care management services. **Baseline data:** Currently there is no baseline data available. Baseline data will be collected on this population 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]Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Baseline/Goal: Establish community linkages focused on chronic care management for Asthma in the Pediatric and Young Adult Population Data Source: Submission of resource planning documents Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $11,027 **Process Milestone 2** [P-2]: Establish baseline rates. Baseline/Goal: Partner with identified agencies serving the underserved pediatric and young adult population with a diagnosis of asthma to determine baseline data specific to Pediatric Asthma 30 day Readmission rates specific to our population.	**Process Milestone 3 [P-3]:** Develop and test data systems to ensure validity of information gathered. Baseline/Goal: Develop effective HIE for the sharing of accurate and reliable data for ongoing monitoring related to Pediatric Asthma 30 day Readmission rates. Data Source: EMR, HIE, EPIC, Excel spreadsheets. Process Milestone 3 Estimated Incentive Payment: $38,352	**Outcome Improvement Target 1:** [IT-3.11] Reduce the percentage of pediatric and young adult patients with asthma who are readmitted to the hospital for any cause within 30 days of discharge from initial admission. Goal: by 10% from established baseline: Data Source: EPIC EMR, HIE Outcome Improvement Target 1: Estimated Incentive Payment*:* $41,096	**Outcome Improvement Target 2**: [IT-3.11] Reduce the percentage of pediatric and young adult patients with asthma who are readmitted to the hospital for any cause within 30 days of discharge from initial admission. Goal: by 15% from established baseline: Data Source: EPIC EMR, HIE Outcome Improvement Target 2 Estimated Incentive Payment*:* $98,272

126675104.3.48	3.IT-3.11	Pediatric Asthma 30-Day Readmission Rate	
JPS Health Network			126675104
Related Category 1 or 2 Projects:	**126675104.2.16 - Expand Chronic Care Management Models- School Based Collaborative Chronic Disease Care Model**		
Starting Point/Baseline:	**Target Population***:* 2,035 unduplicated Pediatric and Young Adults diagnosed with Asthma. **Description of population:** Pediatric and Young Adult patients with a diagnosis of Asthma currently receiving primary care services in our 19 School Based Health Centers. This identified population has limited to no access to chronic care management services. **Baseline data:** Currently there is no baseline data available. Baseline data will be collected on this population 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)**
Data Source: EPIC EMR, HIE, Excel spreadsheets, School Based data system information Process Milestone 2 Estimated Incentive Payment: $11,028			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $22,055	**Year 3 Estimated Outcome Amount: $38,352**	**Year 4 Estimated Outcome Amount: $41,096**	**Year 5 Estimated Outcome Amount: $98,272**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $199,775			

Title of Outcome Measure (Improvement Target): IT-4.9 Average Length of Stay

Unique Project ID: 126675104.3.49 (Pass 3)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
Rehab Provider will reduce the average inpatient length of stay for JPS Connections patients eligible for inpatient rehab. Rehab Provider will provide a high-quality appropriate care delivery setting for earlier rehabilitation for JPS Health Network to refer patients with a specific set of serious, acute conditions. The outcome will quantify how much the care coordination and transition agreement, shared data, and coordinated protocols between the two provider systems shortens the average time that these patients sit in an acute care bed prior to being able to begin rehabilitative therapy.

Process Milestones:
In DY2, JPS Health Network and Rehab Provider will establish electronic data systems and tracking mechanisms for patients referred from the ED. In DY3, JPS Health Network and Rehab Provider will establish a baseline average length of stay for JPS Connections with applicable diagnoses.

Outcome Improvement Targets for each year:
In DY4, average length of stay at JPS Health Network will decrease by 10% over baseline. By DY5, average length of stay at JPS Health Network will decrease by 15% over baseline.

Rationale:
The process milestones chosen (testing data systems, establishing a baseline) will prepare the two providers to track patients and understand the improvements that will result from the Category 2 care transitions intervention. The improvement targets were chosen based on reasonable reductions in ALOS resulting from a carefully coordinated referral program.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc) to achieve a particular targeted outcome. We then allocated more funding to these

metrics. For example, we gave a greater weight to a hypertension or diabetes related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

Specifically to the value placed on the outcome of reduced length of stay, we identified the average cost of stay for the inpatient rehabilitation patient, reduced in accordance with our model for less than maximum individual and community impact, and multiplied by the number of patients impacted and number of days length of stay is to be reduced.

126675104.3.49	*3.IT-4.9*	*Average Length of Stay*	
Rehab Provider			*126675104*
Related Category 1 or 2 Projects:	*126675104.2.17*		
Starting Point/Baseline:	*Target population: JPS Health Network inpatients who are in need of rehabilitation services* *Count: 140* *Description: JPS Connections inpatients with a primary diagnosis covering stroke, neuro and falls who quality for inpatient rehab after being admitted.*		
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]: Develop and test data systems Data Source: Documentation of data systems Process Milestone 1 Estimated Incentive Payment: $236,744	**Process Milestone 2** [*P-2*]: Establish baseline rates Data Source: JPS claims data Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $411,676	**Outcome Improvement Target 1** [IT-3.12]: ALOS Improvement Target: Reduce average length of stay by 10% over baseline Data Source: JPS claims data Outcome Improvement Target 1 Estimated Incentive Payment*:* $441,123	**Outcome Improvement Target 2** [IT-3.12]: ALOS Improvement Target: Reduce average length of stay by 15% over baseline Data Source: JPS claims data Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,054,859
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $236,744	Year 3 Estimated Outcome Amount: $411,676	Year 4 Estimated Outcome Amount: $441,123	Year 5 Estimated Outcome Amount: $1,054,859
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,144,402			

Title of Outcome Measure (Improvement Target): IT-6.1(5) – Percent Improvement Over Baseline of Patient Satisfaction Scores – overall health status/functional status of JPS Connections Patients presenting with 3 specific CMGs

Unique Project ID: 126675104.3.50 (Pass 3)
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
JPS Connections patients exhibiting the 3 selected CMGs for stroke, hip replacement and hip fracture and that match Rehab Provider's admission requirements will be transferred from JPS Health Network inpatient after stabilization to Rehab Provider for their rehabilitation care. The patient satisfaction measure will be used to assess the impact of the care transition protocols and systems established and implemented collaboratively by JPS Health Network and Rehab Provider.

Process Milestones:
In DY2, JPS Health Network will develop a CG-CAHPS-based survey specifically designed to capture patient satisfaction with inpatient rehab care for stroke, hip replacement or hip fracture patients. In DY3, JPS will test this survey in order to establish a baseline and confirm the validity of this survey.

Outcome Improvement Targets for each year:
In DY4 and 5, the survey will be utilized to track improvement of patient satisfaction that results from the Category 2 inpatient rehab referral intervention.

Rationale:
The process milestones chosen (developing and piloting the survey instrument and methodology and establishing a baseline) will prepare us for fielding the instrument to each patient both pre- and post-intervention (care transition). The improvement targets will be determined once pre-intervention baseline is established.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension or diabetes related outcome

over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

Specifically to the value placed on the outcome of increase patient satisfaction, we identified the revenue associated with inpatient rehabilitation patients and conservatively assumed a hospital could expect to realize a maximum of two percent (2%) of that revenue from a future referral from just one patient. Then, that maximum amount was discounted based on the individual and community impact; which for this population was presumed less than the maximum amount. In other words, of the $4.7 million dollars per year of charges associated with our inpatient rehabilitation patients, we assumed the ability to capture less than two percent of that revenue from future referrals as a result of improved patient satisfaction.

126675104.3.50	*3.IT-6.1(5)*	*Patient Satisfaction: JPS Connection Patients with Selected CMGs Will Be Transitioned to Rehab Provider*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*(126675104.2.17) 2.12.1 Develop, Implement and evaluate standardized clinical protocols and evidence-based delivery model to improve care transitions – Develop rehab transition process for JPS Connections patients*		
Starting Point/Baseline:	*Target population: JPS Connections Patients admitted due to stroke, hip replacement or hip fracture and requiring inpatient rehabilitative course of treatment post-stabilization* *Count: An estimated 140 JPS patients annually based on historical data*		
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]: Develop CG-CAHPS-based patient satisfaction survey instrument and survey design and methodology to survey target population after initial stabilization (JPS) and again after institutional transition for inpatient rehabilitative treatment (Rehab Provider). Process Milestone 1 Estimated Incentive Payment: $31,566	**Process Milestone 2** [*P-2*]: Pilot test survey instrument with 50-100 patients and finalize survey method and instrument. Establish a baseline satisfaction level for target population pre-intervention. Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $54,891	**Outcome Improvement Target 1** [IT-6.1]: Measure improvement in patient-reported health status/functional status for JPS Connections patients transitioned to Rehab Provider for rehabilitation care. Improvement Target: - 10% over baseline. Baseline unknown as functional status surveys have not been implemented. Data Source: JPS/Rehab Provider survey data Outcome Improvement Target 1 Estimated Incentive Payment*:* $58,817	**Outcome Improvement Target 2** [[IT-6.1]: Measure improvement in patient-reported health status/functional status for JPS Connections patients transitioned to Rehab Provider for rehabilitation care. Improvement Target: -12% over baseline. Baseline unknown as functional status surveys have not been implemented. Data Source: JPS/Rehab Provider survey data Outcome Improvement Target 2 Estimated Incentive Payment*:* $140,650
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $31,566	Year 3 Estimated Outcome Amount: $54,891	Year 4 Estimated Outcome Amount: $58,817	Year 5 Estimated Outcome Amount: $140,650

126675104.3.50	*3.IT-6.1(5)*	*Patient Satisfaction: JPS Connection Patients with Selected CMGs Will Be Transitioned to Rehab Provider*	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*(126675104.2.17) 2.12.1 Develop, Implement and evaluate standardized clinical protocols and evidence-based delivery model to improve care transitions – Develop rehab transition process for JPS Connections patients*		
Starting Point/Baseline:	*Target population: JPS Connections Patients admitted due to stroke, hip replacement or hip fracture and requiring inpatient rehabilitative course of treatment post-stabilization* *Count: An estimated 140 JPS patients annually based on historical data*		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $285,924			

Title of Outcome Measure (Improvement Target): IT-1.1 Reduce Third Next Available Appointment

Unique RHP outcome identification number(s): 126675104.3.51
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

By the end of the Waiver, our goal is to reduce the 3rd next available appointment for routine eye exam to 30 days or less.

Process Milestones:

- In DY2, the baseline data will be verified and validated. Data reported for in a new EMR for end of 2012 is over 100 days to next available appointment for routine eye exam. There are approximately 17,000 diabetic patients in the network that will require a routine eye exam each year.

Outcome Improvement Targets for each year:

- In DY3, our goal is to reduce the third next available appointment for routine eye exam to 75 days or less.

- In DY4, our goal is to reduce the third next available appointment for routine eye exam to 50 days or less.

Rationale:

The 3rd next available appointment is the industry standard to measure practice health and is directly related to patient satisfaction scores. Wait times are currently over 100 days for the ophthalmology service. Compliance with annual eye exams for patients with diabetes is both a HEDIS and AHRQ quality measure. The addition of optometrists to the ophthalmology service will enhance both access to service and compliance with preventive eye exams for the JPS medical home population.

Outcome Measure Valuation:

This outcome was not included in the original submission and will have no value; other outcomes for this project will remain at original dollar value.

126675104.3.51	***IT-1.1***	***IT-5.3 Reduce 3rd next available appointment***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	126675104.1.3: Expand Specialty Care for Ophthalmology and Wound Care		
Starting Point/Baseline:	*100 days for routine eye exam*		
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]: Engage stakeholders, identify resources needed, document implementation plans Data Source: Documented implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* No value **Process Milestone 2** [P-2]: Verify and validate data Data Source: EMR and claims data Process Milestone 2 Estimated Incentive Payment: No value **Process Milestone 3 [P-3]:** Develop job descriptions and recruit to hire optometrists and support staff for 4 sites Data Source: Job descriptions and hiring documentation Process Milestone 3 Estimated Incentive Payment: No value	**Process Milestone 4** [P-4]: Review data, determine gaps and plan focused interventions to meet improvement targets Data Source: Documented improvement plan and goal to meet improvement targets Process Milestone 3 Estimated Incentive Payment: No value **Outcome Improvement Target 1** [IT-1.1]: Improvement Target: Reduce time to third next available appointment for routine eye exams from 100 to 75 days Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* No payment	**Outcome Improvement Target 2** [IT-1.2]: Improvement Target: Reduce time to third next available appointment for routine eye exams from 75 days to 50 days Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* No payment	**Outcome Improvement Target 3** [IT-1.3]: Improvement Target: Reduce 3rd next available appointment for routine eye exams from 50 days to 30 days or less Data Source: EMR Outcome Improvement Target 3 Estimated Incentive Payment No payment

Title of Outcome Measure (Improvement Target): IT-2.11 Ambulatory Care Sensitive Conditions Admission Rate

Unique RHP outcome identification number(s): 126675104.3.52
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:

DY2
Process Milestone 1:
P-1: Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Partner with MedStar Medical Control Authority, JPS emergency department and JPS case management staff for project planning to develop protocols for identification of patients in the ED who might normally be held for overnight observational admission who can be safely managed in their home with medical monitoring and effective transition to their PCP.

Process Milestone 2-
Partner with MedStar Medical Control Authority, JPS emergency department and JPS case management staff to determine baseline rates specific to Ambulatory Care Sensitive Condition Admission rates for the Observation Avoidance Program.

Process Milestone 3:
P-3: Develop and test data systems
Develop eligible patient identification and referral system. Establish network for patient referrals and test appointment scheduling and referral system specific to the Observation Avoidance Program to ensure data reliability.

DY3
Process Milestone 4:
Plan-Do-Study-Act Cycle will be utilized to identify the resources available for patients who are identified as having an ACSC that can be managed at home versus an overnight observational admission.

Improvement Target 1: (IT-2.11) - Initiate care observational admission avoidance services to targeted patients. Targeted patients include all ASCS and Diabetes, End Stage Renal Disease, Cardiovascular Disease /Hypertension, Behavioral Health/Substance Abuse, Chronic Obstructive Pulmonary Disease, and Asthma using the Observation Admission Avoidance Program. by 5% from established baseline. Anticipated impact 5 patients.

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DY 4 Improvement Target 2 (IT-2.11): This program will reduce the number of PPA for those with ambulatory sensitive conditions by 10% from established baseline. Anticipated impact 15 patients.

DY 5: Improvement Target 3 (IT-2.11): This program will reduce the number of PPA for those with ambulatory sensitive conditions by 15% from established baseline. Anticipated impact 30 patients.

Rationale

Data from July 2011 through June 2012 revealed a subset of individuals in the JPS Connection program having 452 out of 10,239 cases of Avoidance Admissions for ASCS. JPS Connection provides eligible Tarrant County residents with low cost medical care at JPS locations. Eligibility is based on household size and gross monthly income according to the current Federal Poverty Income levels.

In our community, one hospital and payer group has identified 3,000 patients that were admitted to 23 hour "Observation" at a cost of $5,000 per admission. In some cases, these observational admissions are simply because the ED physician is uncomfortable sending the patient home to an unknown and medically unsupervised setting. Under this program, MedStar will receive these patients into their community health program and conduct any necessary follow-up visits until the patient can be scheduled for follow-up with their primary care provider.

Valuation

During DY 2, we will determine the use data for Observational Admissions and the costs associated with this use. We will then determine the processes necessary to achieve the Improvement Milestones implement the program and measure the change in use patterns of the target population. The baseline costs of prior use will then be compared to the actual costs of the target population's use of healthcare services, along with a tool to measure the patient's perception of their health status.

Once established, we will apply currently measured data metric to the expanded population each year as described above.

Rationale/Justification: Please describe your rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc.

Using the emergency care system and overnight observation for low-acuity and preventable admissions and readmissions results in lack of care coordination, uses high cost resources for low-acuity activities and deprives patients needing those resources when they are consumed by low acuity patients. The economic costs of these services can be easily tracked and benchmarked over time. The clinical results can best be measured by the patient's own perception of their health status and their ability to manage their own healthcare needs.

The milestones and metrics for this program has been based on actual experiences of JPS and MedStar conducting limited enrollment pilot projects in each of these areas, tracking the actual data as described and measuring results.

This navigation program significantly expands already operating, proven programs the impact larger number of patients. This increase in patient populations will allow for a more robust analysis of the impact to the patient and the costs of care for possible replication in other areas.

126675104.3.52	*3-IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	
John Peter Smith Health Network			126675104
Related Category 1 or 2 Projects:	**2.9 JPS-MedStar Patient Navigation Program**		
Starting Point/Baseline:	Target Population: Specific Number: 450 Description of Population: This program will be focused on reducing potentially avoidable observation admissions for patients that can be effectively managed at home, with medical support, while awaiting their follow-up PCP appointment. In many cases, the ED physician may be uncomfortable sending the patient home due to lack of available resources or the concern the patient does not have an option for care if needed at home. Under this program, these patients would be referred to the MedStar Community Health Program (CHP) for in-home follow up care during the brief transition from ED to PCP. The patient will receive scheduled home visits and a 10-digit non-emergency phone number to contact the MedStar personnel assigned to assist them. ACSC most typically enrolled in this program will be seizures, falls, COPD, CHF, hypertension, diabetes and angina. Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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:** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Partner with MedStar Medical Control Authority, JPS emergency department and JPS case management staff for project planning to develop protocols for identification of patients in the ED who might normally be held for overnight observational admission who can be safely managed in their home with medical monitoring and effective transition to	**Process Milestone 4:** Plan-Do-Study-Act Cycle will be utilized to identify the resources available for patients who are identified as having an ACSC that can be managed at home versus an overnight observational admission. Data source: Documentation of PDSA Cycle and evidence of the number of individuals' stakeholders receiving information and lessons learned based on PDSA results	**Improvement Target 2 (IT-2.11):** This program will reduce the number of PPA for those with ambulatory sensitive conditions. **Metric:** Monitoring and tracking of acute care hospitalizations during the reporting period for Ambulatory Sensitive Conditions. • Care coordination and patient navigators will help manage transitions. **Data Source**: Epic, Information on MedStar ePCR dispositions and potential participation in a health	**Improvement Target 3 (IT-2.11):** This program will reduce the number of PPA for those with ambulatory sensitive conditions. **Metric:** Monitoring and tracking of acute care hospitalizations during the reporting period for Ambulatory Sensitive Conditions. • Care coordination and patient navigators will help manage transitions. **Data Source:** Epic, Information on MedStar ePCR dispositions and potential participation in a health

126675104.3.52	*3-IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	
John Peter Smith Health Network			126675104
Related Category 1 or 2 Projects:	**2.9 JPS-MedStar Patient Navigation Program**		
Starting Point/Baseline:	Target Population: Specific Number: 450 Description of Population: This program will be focused on reducing potentially avoidable observation admissions for patients that can be effectively managed at home, with medical support, while awaiting their follow-up PCP appointment. In many cases, the ED physician may be uncomfortable sending the patient home due to lack of available resources or the concern the patient does not have an option for care if needed at home. Under this program, these patients would be referred to the MedStar Community Health Program (CHP) for in-home follow up care during the brief transition from ED to PCP. The patient will receive scheduled home visits and a 10-digit non-emergency phone number to contact the MedStar personnel assigned to assist them. ACSC most typically enrolled in this program will be seizures, falls, COPD, CHF, hypertension, diabetes and angina. Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
their PCP. **Metric**: Written protocols and completion of capacity assessment to meet increasing demands for primary care services. **Data Source:** Agendas, meeting minutes, established written protocols Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $24,500 **Process Milestone 2-**	Process Milestone 4 Estimated Incentive Payment: $63,897 **Improvement Target 1 (IT-2.11):** Initiate care observational admission avoidance services to targeted patients. Targeted patients include all ASCS. **Metric:** Monitoring and tracking of acute care hospitalizations during the reporting period for Ambulatory Sensitive Conditions. • Care coordination and	information exchange and spreadsheets. **Goal:** 10% reduction from established baseline. (Anticipated impact-15 patients) Improvement Target 2 Estimated Incentive Payment: $136,711	information exchange and spreadsheets. **Goal:** 15% reduction from established baseline. (Anticipated impact 30 patients). Improvement Target 3 Estimated Incentive Payment: $326,918

126675104.3.52	*3-IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	
John Peter Smith Health Network			126675104
Related Category 1 or 2 Projects:	**2.9 JPS-MedStar Patient Navigation Program**		
Starting Point/Baseline:	Target Population: Specific Number: 450 Description of Population: This program will be focused on reducing potentially avoidable observation admissions for patients that can be effectively managed at home, with medical support, while awaiting their follow-up PCP appointment. In many cases, the ED physician may be uncomfortable sending the patient home due to lack of available resources or the concern the patient does not have an option for care if needed at home. Under this program, these patients would be referred to the MedStar Community Health Program (CHP) for in-home follow up care during the brief transition from ED to PCP. The patient will receive scheduled home visits and a 10-digit non-emergency phone number to contact the MedStar personnel assigned to assist them. ACSC most typically enrolled in this program will be seizures, falls, COPD, CHF, hypertension, diabetes and angina. Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
Partner with MedStar Medical Control Authority, JPS emergency department and JPS case management staff to determine baseline rates specific to Ambulatory Care Sensitive Condition Admission rates for the Observation Avoidance Program. **Data source:** EMR, Excel spreadsheets, JPS ED data, MedStar MEDUSA Siren electronic patient care reporting (ePCR) data.	patient navigators will help manage transitions. **Data Source**: Epic, Information on MedStar ePCR dispositions and potential participation in a health information exchange and spreadsheets. Baseline/Goal: 5% reduction from established baseline. (Anticipated impact 5 patients). Improvement Target 1 Estimated Incentive Payment: $63,898		

126675104.3.52	*3-IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	
John Peter Smith Health Network			126675104
Related Category 1 or 2 Projects:	**2.9 JPS-MedStar Patient Navigation Program**		
Starting Point/Baseline:	Target Population: Specific Number: 450 Description of Population: This program will be focused on reducing potentially avoidable observation admissions for patients that can be effectively managed at home, with medical support, while awaiting their follow-up PCP appointment. In many cases, the ED physician may be uncomfortable sending the patient home due to lack of available resources or the concern the patient does not have an option for care if needed at home. Under this program, these patients would be referred to the MedStar Community Health Program (CHP) for in-home follow up care during the brief transition from ED to PCP. The patient will receive scheduled home visits and a 10-digit non-emergency phone number to contact the MedStar personnel assigned to assist them. ACSC most typically enrolled in this program will be seizures, falls, COPD, CHF, hypertension, diabetes and angina. Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
Information on established baseline metrics. EMR, Excel spreadsheets, JPS ED data, MedStar data. Process Milestone 2 Estimated Incentive Payment: $24,500 **Process Milestone 3:** P-3: Develop and test data systems Develop eligible patient identification and referral system. Establish network for patient referrals and test appointment scheduling and referral			

126675104.3.52	*3-IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	
John Peter Smith Health Network			126675104
Related Category 1 or 2 Projects:	**2.9 JPS-MedStar Patient Navigation Program**		
Starting Point/Baseline:	Target Population: Specific Number: 450 Description of Population: This program will be focused on reducing potentially avoidable observation admissions for patients that can be effectively managed at home, with medical support, while awaiting their follow-up PCP appointment. In many cases, the ED physician may be uncomfortable sending the patient home due to lack of available resources or the concern the patient does not have an option for care if needed at home. Under this program, these patients would be referred to the MedStar Community Health Program (CHP) for in-home follow up care during the brief transition from ED to PCP. The patient will receive scheduled home visits and a 10-digit non-emergency phone number to contact the MedStar personnel assigned to assist them. ACSC most typically enrolled in this program will be seizures, falls, COPD, CHF, hypertension, diabetes and angina. Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
system specific to the Observation Avoidance Program to ensure data reliability. Data source: EMR, Excel spreadsheets, JPS ED data, MedStar ePCR data. Process Milestone 3 Estimated Incentive Payment: $24,501			

126675104.3.52	*3-IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	
John Peter Smith Health Network			126675104
Related Category 1 or 2 Projects:	**2.9 JPS-MedStar Patient Navigation Program**		
Starting Point/Baseline:	Target Population: Specific Number: 450 Description of Population: This program will be focused on reducing potentially avoidable observation admissions for patients that can be effectively managed at home, with medical support, while awaiting their follow-up PCP appointment. In many cases, the ED physician may be uncomfortable sending the patient home due to lack of available resources or the concern the patient does not have an option for care if needed at home. Under this program, these patients would be referred to the MedStar Community Health Program (CHP) for in-home follow up care during the brief transition from ED to PCP. The patient will receive scheduled home visits and a 10-digit non-emergency phone number to contact the MedStar personnel assigned to assist them. ACSC most typically enrolled in this program will be seizures, falls, COPD, CHF, hypertension, diabetes and angina. Baseline data: If no baseline data, please indicate your plan to collect baseline data as a process measure in DY2 or DY3 in lieu of setting an outcome improvement target.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $73,501	Year 3 Estimated Outcome Amount: $127,795	Year 4 Estimated Outcome Amount: $136,711	Year 5 Estimated Outcome Amount: $326,918
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $664,925			

Title of Outcome Measure (Improvement Target): IT-4.8 Sepsis Resuscitation and Management: Reduce Mortality
Unique RHP outcome identification number(s): 126675104.3.53
Performing Provider Name/TPI: JPS Health Network/126675104

Outcome Measure Description:
A reduction in mortality rate will be driven by the early identification, intervention and evidence based management while in ED and ICU of patients septic patients admitted through ED. Early intervention will circumvent the development of organ failure and other complications which are the result of poorly managed sepsis. By avoiding these complications, treatment intensity, resources, and LOS in the ICU are reduced.

Process Milestones:
Year 2 Process Milestones: Reactivating the Sepsis Response team for the purpose of project planning; establishing baseline rates; developing data systems; re-designing processes and communicating results(Rapid cycle PI). Other Y2 Milestones are, hiring the sepsis coordinator, clinical analyst and 2.5 FTEs which will expand the existing Medical Emergency Team and provide 24/7 Sepsis Response Team coverage. Mortality Improvement Milestones for year 2 are not defined, because process standardization will be in evolution.
Year 3 Process Milestones: The team's utilization of the tools for the rapid response to and the management of sepsis will improve compliance with diagnosis to 65% (224 patients) and sepsis management to 75%(259 patients). Rapid cycle improvement, lean, six sigma and other PI methods will drive continued improvement in the management of these patients. Better management of sepsis and the avoidance of complications are expected to reduce mortality to 15% in Y3 (17 saved lives/345 target)).

Outcome Improvement Targets for each year:
Year 4 Milestones: Improved compliance with diagnosis to 75% (249 patients/576 target) and sepsis management to 85% (293 patients/576 target); ICU LOS reduction to 5%(4.2 ICU ALOS). Mortality rate of 15%.

Year 5 Milestones: Improved compliance with diagnosis to 85% (293 patients/576 target); sepsis management to 95% % (327 patients/576 target); ICU LOS reduction to 10% % (3.7 ICU ALOS). Mortality rate of 12%, representing 28 saved lives over the waiver period.

JPS Health Network is proposing the erection of an Innovation and Transformation Center (Category 2) which will increase competencies in performance improvement and also support the Network's Measurement System. Secondly we also reactivating our Harm Avoidance teams for reducing Health Acquired Infections (CAUTI, CLABSI, SSI) which could result in reducing Sepsis acquired after admission.

Rationale:

By identifying the presence of sepsis early on in the course of care, we have the opportunity to initiate early and appropriate treatment which reduce complications and associated mortality.The refinement of the data bases, dashboards and methods of disseminating, participation in learning and PI meetings will provide feedback and further engage clinicians.

Outcome Measure Valuation:

A value was not placed on reducing mortality; this project was valued based on reduction in ICU length of stay. As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

126675104.3.53	***3.IT-4.8***	***Improvement in risk adjusted PPC SEPSIS MORTALITY***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*[Unique Category 1 or 2 project identifier(s), e.g. [TPI].1.4, [TPI].2.3]*		
Starting Point/Baseline:	*Target Population: Patients who present to the ED with suspected infection.* *Intervention Population: Patients presenting in ED with a diagnosis of severe sepsis, septic shock, &/or lactate>4mmol/L(36mg/dl) (Calendar Year 2011)* *Impact Population: Patients with confirmed sepsis/septic shock diagnosis with initiation and completion of bundles.* *Baseline data: 20%(To be validated)*		
Process Milestone 1 [P-1]: Project Planning, engage stakeholders(Code Sepsis Improvement Team), identify current capacity and needed resources(4.5 ftes), determine timelines and document implementation team. Data Source: At least monthly meeting minutes documenting resources Process Milestone 1 Estimated Incentive Payment *(maximum amount): $* **Process Milestone 2** [P-2]: Perform a deep dive review of the cases in the SSC database to validate presence of sepsis for inclusion in the baseline. Establish baseline mortality rate. Data Source: EPIC, Surviving Sepsis Campaign (SSC)data base Process Milestone 2 Estimated	**Process Milestone 4** [P-4]: Target opportunities for improvement based on results of baseline in PI, P2 and P3 and plan for PDSA cycles Targeted interventions could include additional education, implementation of a sepsis resuscitation bundle checklist, timing of interventions; and ensuring all portions of bundle are implemented. Data source: SSC data based info Process Milestone 2 Estimated Incentive Payment *: $* **Outcome Improvement Target 1** [IT-]: **Milestone 5 [I-13] Progress to target/goal** **Metric 1[1-13.1]:** Sepsis Mortality Rate: 18% Outcome Improvement Target 1	**Milestone6** [P-4] Target opportunities for improvement based data findings and P3 and plan for PDSA cycles Targeted interventions could include additional education, implementation of a sepsis resuscitation bundle checklist, timing of interventions; and ensuring all portions of bundle are implemented. Data Source: Process Milestone 2 Estimated Incentive Payment *: $* **Outcome Improvement Target 2** [I-13]: **Metric 1[1-13.1]:** Sepsis Mortality Rate :15% Outcome Improvement Target 2 Estimated Incentive Payment *: $*	**Outcome Improvement Target 3** [IT-] **Goal: Metric: Mortality Rate: 12%; 28** saved lives over the waiver period Outcome Improvement Target 3 Estimated Incentive Payment *: $*

126675104.3.53	***3.IT-4.8***	***Improvement in risk adjusted PPC SEPSIS MORTALITY***	
JPS Health Network			*126675104*
Related Category 1 or 2 Projects:	*[Unique Category 1 or 2 project identifier(s), e.g. [TPI].1.4, [TPI].2.3]*		
Starting Point/Baseline:	*Target Population: Patients who present to the ED with suspected infection.* *Intervention Population: Patients presenting in ED with a diagnosis of severe sepsis, septic shock, &/or lactate>4mmol/L(36mg/dl) (Calendar Year 2011)* *Impact Population: Patients with confirmed sepsis/septic shock diagnosis with initiation and completion of bundles.* *Baseline data: 20%(To be validated)*		
Incentive Payment *: $* **Milestone 3** [P-3] Develop and test data systems-analyze collected data; correlate measures for identifying sepsis, managing sepsis, and sepsis mortality; expand current quality dashboard Data Source: SSC & Chart Review Process Milestone 2 Estimated Incentive Payment *: $*	Estimated Incentive Payment *: $*		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $	Year 3 Estimated Outcome Amount: $	Year 4 Estimated Outcome Amount: $	Year 5 Estimated Outcome Amount: $
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $			

Title of Outcome Measure (Improvement Target): IT-1.7- Controlling High Blood Pressure (NCQA-HEDIS, 2012, NQF 0018) (Stand-alone)

Unique RHP outcome identification number(s): 135036506.3.1
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:

IT-1.7: Controlling high blood pressure *(Standalone measure)*

- Numerator: The number of patients in the denominator whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year
- Denominator: Patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension

As one of our primary care metrics we chose blood pressure control. As high blood pressure is a prerequisite to many other chronic illnesses and serious medical conditions, getting BP under control with proper PCP supervision, medications and regular visits can help patients' quality of life and overall health.

By the end of the Waiver, our goal is to have > 63.3% of patients who are Baylor Clinic patients at Baylor All Saints Medical Center have good blood pressure control (< 140/80 mmHg). This is a projected 6.1% improvement over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic.

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. Baylor currently tracks BP control and uses a threshold of <130/80 mmHg for patients who have hypertension. Based on our current data, 57.5% of patients with hypertension have controlled BP (130/80 mmHg). We will reestablish our DY2 baseline based on new patients to the Baylor Clinic.
- In DY3, our goal is increase the % of patients who have BP control (< 140/80 mmHg) to 59.6% (or 2.1% improvement over baseline established in DY2)
- In DY4, our goal is increase the % of patients who have BP control (< 140/80 mmHg) to 61.6% (or 4.1% improvement over baseline established in DY2)
- In DY5, our goal is increase the % of patients who have BP control (< 140/80 mmHg) to 63.6% (or 6.1% improvement over baseline established in DY2)

Rationale:

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data

that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Controlling high blood pressure is essential in avoiding heart attacks, stroke, heart failure and a multitude of other diseases and complications. Through medication management, proper primary care attention and education, patients can achieve better blood pressure control in the outpatient setting. In Region 10, Hypertension was identified as one of the top 5 most prevalent diseases in the area, with over 1,000 preventable admissions in 2010[398]. A recent article in the New York Times suggested that hypertensive complications can be especially deadly in the African-American population, who make up 12% of the RHP 10 population[399]. Blood pressure is a standard metric that all Baylor Clinics monitor and regulate. Patients who are uncontrolled will receive the attention they need to get their hypertension under control. Patients will receive medication management, lifestyle management techniques and education about their illness in this clinic PCMH setting. Our metrics and milestones are designed to increase improvement in BP control for the target population.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension or diabetes control would have greater impact than patient satisfaction.

[398] RHP 10 Community Health Needs Assessment
[399] http://health.nytimes.com/health/guides/disease/hypertension/complications.html

135036506.3.1	*3.IT-1.7*	*Controlling high blood pressure*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.1.1- Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor All Saints Medical Center had 57.5% of patients with controlled BP (130/80 mmHg)* ***Target Population:*** *Underserved/uninsured patients in Tarrant County without a PCP/PCMH with uncontrolled BP (>140/80 mmHg)*		
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-1.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **13,419** **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment *(maximum amount):* **$ 13,419**	**Outcome Improvement Target 1** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Stand-alone) Improvement Target: > 59.6% (or 2.1% over DY2 baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $**31,109**	**Outcome Improvement Target 2** [IT-1.7]: Controlling High Blood Pressure (NCQA-HEDIS 2012, NQF 0018) (Stand-alone) Improvement Target: > 61.6% (or 4.1% over DY2 baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $**49,919**	**Outcome Improvement Target 3** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Stand-alone measure) Improvement Target: > 63.6% (or 6.1% over DY2 baseline) of patients 18-85 with hypertension that are a Baylor Clinic patient will have BP control of <140/80 mmHg Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $**119,372**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**26,838**	Year 3 Estimated Outcome Amount: $**31,109**	Year 4 Estimated Outcome Amount: $**49,919**	Year 5 Estimated Outcome Amount: $**119,372**
,TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**227,238**			

Title of Outcome Measure (Improvement Target): IT-6.1- Percent improvement over baseline of patient satisfaction scores (Stand-alone measure)

1) Patients are getting timely care, appointments and information (Stand-alone measure): Measurement of Satisfaction Related to Clinic Wait Times

Unique RHP outcome identification number(s): 135036506.3.2
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; ***(Standalone measure)***
(2) how well their doctors communicate; ***(Standalone measure)***
(3) patient's rating of doctor access to specialist; ***(Standalone measure)***
(4) patient's involvement in shared decision making, and ***(Standalone measure)***
(5) patient's overall health status/functional status. ***(Standalone measure)***

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring is to improve the satisfaction scores in regards to clinic wait times. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic.
By the end of the Waiver, our goal is to have the Baylor Clinic at Baylor All Saints Medical Center obtain a patient satisfaction score of 84.9% on the survey question related to wait time to appointment satisfaction. This falls under metric (1)- patients are getting timely care, appointments and information of 3.6.1.
Although the Baylor Clinic at Baylor All Saints Medical Center is at a 84th percentile score of patients satisfaction related to this particular metric, we believe there is still opportunity to improve and that with any incremental gain in patient satisfaction equates to better compliance and outcomes for our patients. The baseline percentile score of 84.9% is equivalent to a 60th percentile score nationally, which also presents an opportunity to improve for this Baylor Clinic. By maintaining high standards and enforcing metrics around satisfaction for our staff, we will continue to pursue high patient satisfaction scores in our Baylor Clinics.

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. Currently, the Baylor Clinic at Baylor All Saints Medical Center is at 82.4% satisfaction with clinic wait times. We will reestablish our DY2 baseline based on new patients to the Baylor Clinic.
- In DY3, our goal is increase the % of patient satisfaction related to wait times to 83.3% (or 0.9% improvement over DY2 baseline)
- In DY4, our goal is increase the % of patient satisfaction related to wait times to 84.1% (or 1.7% improvement over DY2 baseline)
- In DY5, our goal is increase the % of patient satisfaction related to wait times to 84.9% (or 2.5% improvement over DY2 baseline)

Rationale:

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease[400]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction, however there is opportunity for improvement. This outcome has an impact on the Region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic PCMH model.

1) Patients are getting timely care, appointments and information (Stand-alone measure): We will measure this particular metric through monitoring and improving the survey question around improving wait times for patients

[400] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

135036506.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.1.1-*. Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor All Saints Medical Center had a satisfaction rate related to clinic wait times of 82.4%* ***Target Population:*** *Underserved/uninsured patients in a Baylor Clinic PCMH*		
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: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **10,064**	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Stand-alone) Improvement Target: > 83.3% (or 0.9% improvement over DY2 baseline) satisfaction rate with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $**11,666**	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Stand-alone) Improvement Target: > 84.1% (or 1.7% improvement over DY2 baseline) satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $**18,720**	**Outcome Improvement Target 3** [IT-6.1]: Percent improvement of patient satisfaction scores (Stand-alone) Improvement Target: > 84.9% (or 2.5% improvement over DY2 baseline) satisfaction with clinic wait times will be achieved in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $**44,764**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**10,064**	Year 3 Estimated Outcome Amount: $**11,666**	Year 4 Estimated Outcome Amount: $**18,720**	Year 5 Estimated Outcome Amount: $**44,764**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**85,214**			

Title of Outcome Measure (Improvement Target): IT-6.1- Percent improvement over baseline of patient satisfaction scores (**Stand-alone measure)**

1) Patients are getting timely care, appointments and information (Stand-alone measure): Measurement of Satisfaction Related to Response Time to Patient Phone Calls

Unique RHP outcome identification number(s): 135036506.3.3
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:

IT-6.1: Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:

(1) are getting timely care, appointments, and information; ***(Standalone measure)***
(2) how well their doctors communicate; ***(Standalone measure)***
(3) patient's rating of doctor access to specialist; ***(Standalone measure)***
(4) patient's involvement in shared decision making, and ***(Standalone measure)***
(5) patient's overall health status/functional status. ***(Standalone measure)***

Patient satisfaction is an important part of overall treatment and encourages participation and compliance of patients' in their own care. For this metric we will be measuring improvement in the responsiveness to patient phone calls in a timely manner.

By the end of the Waiver, our goal is to have the Baylor Clinic at Baylor All Saints Medical Center obtain a patient satisfaction score of 95.0% on the survey question related to patient phone calls being returned in a timely fashion. This falls under metric (1) Patients are getting timely care, appointments and information of 3.6.1. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. Currently, the Baylor Clinic at Baylor All Saints Medical Center is at 94.2% satisfaction with patients receiving a response to their phone calls in a timely manner. We will reestablish our DY2 baseline based on new patients to the Baylor Clinic.
- In DY3, our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 94.5% (or 0.3% improvement over DY2 baseline)

- In DY4, our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 94.8% (or 0.6% improvement over DY2 baseline)
- In DY4, our goal is increase the % of patient satisfaction related to receiving a timely response to a patient phone call to 95.0% (or 0.8% improvement over DY2 baseline)

Although the Baylor Clinic at Baylor All Saints Medical Center is at a 94th percentile score of patient satisfaction related to this particular metric, we believe there is still opportunity to improve and that with any incremental gain in patient satisfaction equates to better compliance and outcomes for our patients. By maintaining high standards and enforcing metrics around satisfaction for our staff, we will continue to pursue high patient satisfaction scores in our Baylor Clinics.

Rationale:

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

Patients' ability and perception of receiving timely care, appointments and information can greatly impact the level of compliance and trust the patient has with their clinic and provider. Data from Press Ganey Associates in 2007 has demonstrated that patients judge a medical practice by the way they are treated as people, not the way they are treated for their disease[401]. Additionally, they found that satisfied patients are more likely to comply with treatment plans, ultimately having better outcomes which lowers costs; are more rewarding to care for and take up less physician/staff time, reducing length of visits and wait times for the overall practice. Baylor Clinics have historically had high performance in all measures related to patient satisfaction, however there is opportunity for improvement. This outcome has an impact on the Region through increasing utilization of outpatient based primary care. If patients are satisfied, they will continue to come to their appointments, stay healthier and stay out of the ED. We anticipate that we will be able to raise patient satisfaction in the domains mentioned below through the Baylor Clinic PCMH model.

1) Patients are getting timely care, appointments and information (Stand-alone measure): We will measure this particular metric through monitoring and improving the survey question around improving wait times for patients

[401] Drain, M., & Kaldenberg, D. O. (1999). Building patient loyalty and trust: The role of patient satisfaction. *Group Practice Journal*, 48(9),32-35.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

135036506.3.3	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.1.1 -Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor All Saints Medical Center had a satisfaction rate related to clinic response to patient phone call of 94.2%* ***Target Population:*** *Underserved/uninsured PCMH patients of the Baylor Clinic*		
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: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **10,064**	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement of patient satisfaction scores (Stand-alone) Improvement Target: > 94.5% (or 0.3% improvement over DY2 baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $**11,666**	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement of patient satisfaction scores (Stand-alone) Improvement Target: > 94.8% (or 0.6% improvement over DY2 baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $**18,720**	**Outcome Improvement Target 3** [IT-6.1]: Percent improvement of patient satisfaction scores (Stand-alone) Improvement Target: > 95.0% (or 0.8% improvement over DY2 baseline) satisfaction rate with timely response to patient phone calls in the Baylor Clinic Data Source: E.H.R/Patient Satisfaction Surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $**44,764**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**10,064**	Year 3 Estimated Outcome Amount: $**11,666**	Year 4 Estimated Outcome Amount: $**18,720**	Year 5 Estimated Outcome Amount: $**44,764**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ **85,214**			

Title of Outcome Measure (Improvement Target): IT-12.1- Breast Cancer Screening (Non-Stand-alone)

Unique RHP outcome identification number(s): 135036506.3.4
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:

IT-12.1: Breast Cancer Screening (HEDIS 2012) *(Non-standalone measure)*

- Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period.
- Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded

By the end of the Waiver, our goal is to have > 50.4% of women ages 40-69 who are patients of the Baylor Clinic at Baylor All Saints Medical Center to have a breast cancer screening. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic.

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. The Baylor Clinic at Baylor All Saints Medical Center is at a 42.1% screening rate for women between 40-69. We will reestablish our DY2 baseline based on new patients to the Baylor Clinic.
- In DY3, our goal is increase the % of patients have had a breast cancer screen to at least 45.0% (or 2.9% improvement over DY2 baseline)
- In DY4, our goal is increase the % of patients have had a breast cancer screen to at least 47.7% (or 5.6% improvement over DY2 baseline)
- In DY5, our goal is increase the % of patients have had a breast cancer screen to at least 50.4% (or 8.3% improvement over DY2 baseline)

Rationale:

Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

In Tarrant County, only 58% of women over 40 receive breast cancer screenings. There is room for improvement with this metric to screen more women and utilize early detection methods for breast cancer[402].

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

[402] RHP 10 Community Health Needs Assessment

135036506.3.4	*3.*IT-12.1	*Breast Cancer Screening*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.1.1-Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor All Saints Medical Center had only 42.1% of women over 40 receive a breast cancer screen* ***Target Population:*** *Underserved women in Tarrant County who are over the age of 40 in Tarrant 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: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $**16,774**	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Stand-alone) Improvement Target: > 45.0% (or 2.9% improvement over DY2 baseline) of women over the age of 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $**19,443**	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Stand-alone) Improvement Target: > 47.7% (or 5.6% improvement over DY2 baseline) of women over 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $**31,199**	**Outcome Improvement Target 3** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) (Non-Stand-alone) Improvement Target: > 50.4% (or 8.3% improvement over DY2 baseline) of women over 40 will have a breast cancer screening completed Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $**74,607**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**16,774**	Year 3 Estimated Outcome Amount: $**19,443**	Year 4 Estimated Outcome Amount: $**31,199**	Year 5 Estimated Outcome Amount: $**74,607**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**142,024**			

Title of Outcome Measure (Improvement Target): IT-12.5- Other USPSTF-endorsed screening outcome measures (Non-Stand-alone): Influenza Vaccination Rate

Unique RHP outcome identification number(s): 135036506.3.5
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.
As part of primary care, the influenza vaccine is a simple, cost effective way for patients to protect themselves from the flue and other potential clinical exacerbations.

By the end of the Waiver, our goal is to have > 67.8% of Baylor Clinic patients over the age of 18 receive an influenza vaccination. This is an improvement of 5.3% over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.Improvement will be measured primarily on new patients to the Baylor Clinic
Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. The Baylor Clinic at Baylor All Saints Medical Center is at a 62.5% rate for patients over 18 that have received an influenza vaccine in the past 12 months. We will reestablish our DY2 baseline based on new patients to the Baylor Clinic.
- In DY3, our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 64.4% (or 1.9% improvement over DY2 baseline)
- In DY4, our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 66.2% (or 3.7% improvement over DY2 baseline)
- In DY4, our goal is increase the % of patients >18 years old that have had an influenza vaccination in the past 12 months to 67.8% (or 5.4% improvement over DY2 baseline)

Rationale:
In Tarrant County, only 40% of individuals over 18 received an influenza vaccination in the past 12 months. Less than one out of every three African-American or Hispanic individuals in Tarrant County received an influenza vaccination. There were 290 influenza-related deaths in RHP 10 in

2010.[403] The rate of influenza vaccinations in the Region is quite low and there is an opportunity to increase the number in the target population that receive this basic vaccination in order to prevent exacerbations of health issues, reduce the prevalence of influenza and prevent ED visits related to influenza that can otherwise be handled in an outpatient setting.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

[403] RHP 10 Community Health Needs Assessment

135036506.3.5	*IT-12.5*	*Other USPSTF-endorsed screening outcome measures (Influenza Vaccination)*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.1.1- Expand Existing Primary Care Capacity-Baylor Clinic Capacity Expansion*		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor All Saints Medical Center had 62.5% of patients over the age of 18 will receive an influenza vaccination* ***Target Population:*** *Underserved/uninsured patients 18 years and older in Tarrant 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-1.1] Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete planning processes for primary care expansion Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **16, 774**	**Outcome Improvement Target 1** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Stand-alone) Improvement Target: > 64.4% (or 1.9% improvement over DY2 baseline) of patients over 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $**19,443**	**Outcome Improvement Target 2** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Stand-alone) Improvement Target: > 66.2% (or 3.7% improvement over baseline) of patients over 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $**31,199**	**Outcome Improvement Target 3** [IT-12.5] Other USPSTF-endorsed screening outcome measures (Influenza Vaccination Rate) (Non-Stand-alone) Improvement Target: > 67.8% (or 5.4% improvement over baseline) of patients over 18 will receive an influenza vaccination Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $**74,607**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**16,774**	Year 3 Estimated Outcome Amount: $**19,443**	Year 4 Estimated Outcome Amount: $**31,199**	Year 5 Estimated Outcome Amount: $**74,607**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**142,024**			

Title of Outcome Measure (Improvement Target): IT-11.1- Improvement in Clinical Indicator in identified disparity group. Improvement in Asthma Percent of Opportunities Achieved

Unique RHP outcome identification number(s): 135036506.3.6
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
The disparity group for this metric is the underserved/uninsured population in Tarrant County that has uncontrolled Asthma.
IT□11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure)*

- Numerator: Number of asthma opportunities completed/fulfilled
- Denominator: Asthma appropriate opportunities x number of asthma patients

By the end of the Waiver, our goal is to have achieved a 68.6% percent of opportunities achieved for the Baylor Health Care System Asthma Percent of Opportunity Achieved (POA). Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.
At Baylor Health Care System, we have a standard Asthma POA which consists of: documentation of action/management plan, severity assessment, controller therapy for those who are eligible, and spirometry within last two years. We measure this yearly for our asthma patients and calculate POA by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from bundle performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in asthma management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their asthma patients than in the prior reporting period. For example: For asthma- there are four opportunities (i.e. metrics) per patient (1) documentation of action/management plan, 2) severity assessment, 3) controller therapy for those who are eligible, and 4) spirometry within last two years). The denominator would be number of patients times 4. So, for example, if there are 10 patients times 4 opportunities each = 40 opportunities to be achieved. If, in the course of the year, only 30 of those opportunities were completed; this means that our POA (Percent of Opportunities Achieved) = 30/40=75%. To achieve a 10% improvement in POA, we would have to have completed at least 34/40 opportunities to get at 85% achievement.

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. A preliminary E.H.R data analysis shows that 63.4% POA was achieved for Asthma patients
- In DY3, our goal is to increase the POA % for Asthma patients to 65.2% (or 1.8% improvement over DY2 baseline)
- In DY4, our goal is to increase the POA % for Asthma patients to 67.0% (or 3.6% improvement over DY2 baseline)
- In DY5, our goal is to increase the POA % for Asthma patients to 68.6% (or 5.2% improvement over DY2 baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that Pulmonologists should handle more complex cases but also use this opportunity to help educate the underserved population (especially Hispanics and African-Americans) about the importance of screenings and prevention.

Rationale:

We plan on measuring the improvement in Asthma for Baylor Clinic patients who receive care from a specialist. At Baylor Health Care System, we have a standard Asthma Percent of Opportunities Achieved which consists of: documentation of action/management plan, severity assessment, controller therapy for those who are eligible, and spirometry within last two years. We feel that this measure is a comprehensive way to measure the patients with asthma in the Baylor Clinic and manage their condition holistically.

Asthma affects about 9% of the Tarrant County population and had approximately 1158 cases of hospitalization in 2010[404]. According to the Office of Minority Health, African-Americans were 30% more likely to have Asthma than non-Hispanic whites and were three times more likely to die from an asthma-related issue than non-Hispanic whites. Hispanics are 30% more likely to visit the hospital for Asthma than non-Hispanic whites[405].

A study by Meng, Leung, et al. found that patients with Asthma that saw a specialist had higher rates of compliance because specialists were more likely to identify the disease and follow national guidelines and protocols to treat these patients leading to better quality outcomes and long(er) term control[406]. Making the pulmonologist a part of our Asthma patients' care team will help to avoid exacerbations, prevent complications and reduce hospitalizations.

Many of the underserved patients in the Region require specialty care related to chronic diseases. Lack of timely access to this needed care, often results in clinical exacerbations and worsening of their health conditions that can be avoided or lessened through improved access. A study

[404] RHP 10 Community Health Needs Assessment
[405] Office of Minority Health: http://www.minorityhealth.hhs.gov
[406] Meng YY, Leung KM, Berkbigler D, Halbert RJ. Compliance with US asthma management guidelines and specialty care: a Regional variation or national concern? J Eval Clin Pract. 1999 May;5(2):213-21.

conducted in 2010 by Bellinger, et al. confirmed that minority and underserved populations not only receive less care but access to care is mitigated by physician referral, geographic location and insurance type.[407]

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

[407] Bellinger, JD, Hassan, RM, et.al. Specialty care use in US patients with chronic diseases. *Int J Env. Res Public Health* 2010, 7, 975-990.

135036506.3.6	*3.IT-11.1*	*Improvement in Clinical Indicator in indentified disparity group-Asthma management in underserved/uninsured population*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.1.2- Improve Access to Specialty Care-Expand Specialty Care Services*		
Starting Point/Baseline:	***Definition of Metric:*** Percent of Opportunities Achieved for Asthma patients = Number of opportunities (metrics) fulfilled divided by the number of opportunities appropriate per patient x number of patients ***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor All Saints Medical Center had 63.4% of its Asthma patients in the acceptable range of the Asthma Bundle.* ***Target Population:*** *Underserved/uninsured patients in Tarrant County with uncontrolled Asthma*		
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: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $**22,453**	**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 65.2% (or 1.8% improvement over DY2 baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* **$39,039**	**Outcome Improvement Target 2** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 67.0% (or 3.6% improvement over DY2 baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* **$62,644**	**Outcome Improvement Target 3** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: > 68.6% (or 5.2% improvement over DY2 baseline) Asthma Percent of Opportunities Achieved from: documentation of Action/Mgmt Plan, Severity Assessment, Controller Therapy for those who are eligible, and Spirometry within last two years. Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* **$149,800**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**22,453**	Year 3 Estimated Outcome Amount: **$39,039**	Year 4 Estimated Outcome Amount: **$62,644**	Year 5 Estimated Outcome Amount: **$149,800**

135036506.3.6	*3.IT-11.1*	*Improvement in Clinical Indicator in indentified disparity group-Asthma management in underserved/uninsured population*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.1.2- Improve Access to Specialty Care-Expand Specialty Care Services*		
Starting Point/Baseline:	***Definition of Metric:*** Percent of Opportunities Achieved for Asthma patients = Number of opportunities (metrics) fulfilled divided by the number of opportunities appropriate per patient x number of patients ***Baseline:*** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor All Saints Medical Center had 63.4% of its Asthma patients in the acceptable range of the Asthma Bundle.* ***Target Population:*** *Underserved/uninsured patients in Tarrant County with uncontrolled Asthma*		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**273,935**			

Title of Outcome Measure (Improvement Target): IT-12.2- Cervical Cancer Screening (HEDIS 2012) (Non-Stand-alone Measure)

Unique RHP outcome identification number(s): 135036506.3.7
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:

IT-12.2: Cervical Cancer Screening (HEDIS 2012) *(Non-standalone measure)*

- Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years.
- Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

As part of preventive care and screenings, cervical cancer screening is a standard practice that PCP/PCMHs provide for their patients. Education and regular exams can be the difference between early detection and death. By the end of the Waiver, our goal is to have > 75.9% of patients who are Baylor Clinic at Baylor All Saints Medical Center be screened for Cervical Cancer. This is a 5.9% improvement over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. A preliminary E.H.R data analysis shows that 72% of patients at the Baylor Clinic at Baylor All Saints Medical Center at Fort Worth have had a cervical cancer screening.
- In DY3, our goal is increase the % of patients who have received a cervical cancer screening to at least 73.3% (or 1.3% improvement over DY2 baseline)
- In DY4, our goal is increase the % of patients who have received a cervical cancer screening to at least 74.6% (or 2.6% improvement over DY2 baseline)
- In DY5, our goal is increase the % of patients who have received a cervical cancer screening to at least 75.9% (or 3.9% improvement over DY2 baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that OB/GYNs should handle more complex cases but also use this opportunity to help educate underserved women about the importance of screenings and prevention.

Rationale:

In Tarrant County approximately 77% of women received a Pap smear in the last year, however this percentage was lower for the minority populations in the county[408]. According to the National Cancer Institute, African-American women are more likely to be diagnosed with

[408] RHP 10 Community Health Needs Assessment

cervical cancer and Hispanic women have the highest cervical cancer incidence rate amongst all women[409]. There is opportunity to increase the screenings in the minority population through engaging OB/GYNs to provide screenings and education for this population. Additionally, these specialists can provide the advanced screenings and education that would not be available in a PCP/PCMH setting.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream

[409] National Cancer Institute: http://www.cancer.gov

135036506.3.7	*3.IT-12.2*	*Cervical Cancer Screening*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.1.2*- Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	**Baseline:** The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor All Saints Medical Center had a screening rate of 71.9% **Target Population:** Underserved/uninsured women between the ages of 21-64		
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: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ **22,453**	**Outcome Improvement Target 1** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Stand-alone measure) Improvement Target: > 73.3% (or 1.3% improvement over DY2 baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* **$19,519**	**Outcome Improvement Target 2** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Stand-alone measure) Improvement Target: > 74.6% (or 2.6% improvement over DY2 baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* **$31,322**	**Outcome Improvement Target 3** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Stand-alone measure) Improvement Target: > 75.9% (or 3.9% improvement over DY2 baseline) of women between ages 21-64 that are patients of the Baylor Clinic will receive Cervical Cancer screenings Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* **$74,900**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**22,453**	Year 3 Estimated Outcome Amount: **$19,519**	Year 4 Estimated Outcome Amount: **$31,322**	Year 5 Estimated Outcome Amount: **$74,900**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $148,194**			

Title of Outcome Measure (Improvement Target): IT-12.3- Colorectal Cancer Screening (HEDIS 2012) (Non-Stand-alone Measure)

Unique RHP outcome identification number(s): 135036506.3.8
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

- Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years
- Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

By the end of the Waiver, our goal is to have > 34.3% of patients who are Baylor Clinic patients at Baylor All Saints Medical Center be screened for Colorectal Cancer. This is an improvement of 10.9% over baseline. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2.

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. A preliminary E.H.R data analysis shows that only 23.4% of patients at the Baylor Clinic at Baylor All Saints Medical Center at Fort Worth have had a Colorectal Cancer Screening
- In DY3, our goal is increase the % of patients who have received a colorectal cancer screening to at least 27.2% (or 3.8% improvement over DY2 baseline)
- In DY4, our goal is increase the % of patients who have received a colorectal cancer screening to at least 30.9% (or 7.5% improvement over DY2 baseline)
- In DY5, our goal is increase the % of patients who have received a colorectal cancer screening to at least 34.3% (or 10.9% improvement over DY2 baseline)

In order to meet these improvements, primary care and specialists in the community will have to work together to meet these goals. We feel that Gastroenterologists should handle more complex cases but also use this opportunity to help educate underserved women about the importance of screenings and prevention. The Baylor Clinic is currently only at a 23% completion rate and will need the help of their specialist partners to meet these goals.

Rationale:
In Tarrant County less than 13% of individuals 50 and over obtained a fecal occult blood test within the past 2 years and less than 10% of Tarrant county residents 50 and over met colorectal cancer screening guidelines. There is a definite need for these services in Tarrant County and the

Baylor Clinic plans to provide these screenings to a greater number of people. There is greater need for patients to receive (appropriate) sigmoidoscopies/ colonoscopies in the Region as a preventive measure[410]. According to the Centers for Disease Control and Prevention, Hispanics and African-Americans are less likely to get screened for colorectal cancer and it is often found in the latter stages of the disease as compared to their Caucasian counterparts[411]. There is an opportunity to increase the colorectal cancer screening rates by engaging specialists in the Tarrant County area to provide these basic and advanced screenings along with education that is focused on this particular topic.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

[410] RHP 10 Community Health Needs Assessment
[411] Centers for Disease Control and Prevention: http://www.cdc.gov

135036506.3.8	*3.*IT-12.3	*Colorectal Cancer Screening*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.1.2-* Improve Access to Specialty Care-Expand Specialty Care Services		
Starting Point/Baseline:	**Baseline:** *The baseline for this project will be confirmed again in DY2 but in the past year the Baylor Clinic at Baylor All Saints Medical Center had a screening rate of 23.4%* **Target Population:** *Underserved/uninsured adults between the ages of 50-75 in Tarrant 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: Documentation of planning reports/agreements with specialists Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $**22,453**	**Outcome Improvement Target 1** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Stand-alone measure) Improvement Target: > 27.2% (or 3.8% improvement over DY2 baseline) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $**19,519**	**Outcome Improvement Target 2** [IT-12.2]: Colorectal Cancer Screening (HEDIS) (Non-Stand-alone measure) Improvement Target: > 30.9% (or 7.5% improvement over DY2) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $**31,322**	**Outcome Improvement Target 3** [IT-12.2]: Cervical Cancer Screening (HEDIS) (Non-Stand-alone measure) Improvement Target: > 34.3% (or 10.9% improvement over DY2) of adults between 50-75, who are patients of the Baylor Clinic will receive the appropriate colorectal cancer screening Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $**74,900**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**22,453**	Year 3 Estimated Outcome Amount: $**19,519**	Year 4 Estimated Outcome Amount: $**31,322**	Year 5 Estimated Outcome Amount: $**74,900**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**148,194**			

Title of Outcome Measure (Improvement Target): IT-1.10- Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Stand-alone measure)

Unique RHP outcome identification number(s): 135036506.3.9
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
IT-1.10 Diabetes care: *HbA1c poor control (>9.0%) (Standalone measure)*

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

By the end of the Waiver, our goal is to have < 21% of patients 18-75 years old with diabetes (type 1 or type 2) out of glycemic control (HbA1c >9.0%). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program. The additional qualifiers for this metric are the following: 1) a patient has been engaged in chronic care management for at least 6 months, 2) Two HbA1c measures will be taken per patient and the most recent HbA1c score will be used for reporting.

One of the outcome measures we have chosen for our chronic care management program is HbA1c performance, as determined by a reduction in poor control, defined as the percent of the population with HbA1c > 9.0%. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. A preliminary E.H.R data analysis shows that at least 25% of patients at the Baylor Clinic at Baylor All Saints Medical Center at Fort Worth have an HbA1c > 9.0%
- In DY3, our goal is to reduce this rate to < 23.8% (or reduction of HbA1c >9.0% by 1.2% over DY2 baseline)
- In DY4, our goal is to reduce this rate to < 22.6% (or reduction of HbA1c >9.0% by 2.4% over DY2 baseline)
- In DY5, our end goal is to have this rate be at < 21.4% (or reduction of HbA1c >9.0% by 3.6% over DY2 baseline)

Rationale:
Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an

ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

In Tarrant County, more than 8% of the population has a diagnosis of diabetes with more than 37% of the population classified as obese and at risk for developing diabetes. In 2010, there were over 2000 cases of avoidable hospitalizations related to diabetes (diabetes short-term complications: 1,136 cases and diabetes long-term complications): 1,986 cases[412] Traditionally, the underserved population does not have access to the necessary medications and supplies to manage their diabetes thus many patients go undiagnosed or have poor glucose control. Lack of proper education coupled with a lack of primary care attention often leads to more severe. Lack of proper education coupled with a lack of primary care attention often leads to more severe complications and poor health outcomes for those with diabetes. This project would facilitate timely and appropriate care for those with diabetes and ensure that regular labs and point of care testing is completed to monitor results and make appropriate interventions.

Bodenheimer et al., found that patient self-management of chronic disease conditions, such as diabetes, that was co-located in a primary care setting led to significant improvement in HbA1c control in patients[413]. A recent of edition of Managed Care found that patients with an HbA1c > 9 had on average almost $5000 worth of hospitalization costs, while those with an HbA1c of < 7 had about $2700 in hospitalization costs[414]. Focusing efforts on improving glycemic control should result in reduced comorbid conditions and improved complication rates for these patients. We expect that at least 5-7% of patients who are seen regularly in a Baylor Clinic will have improved HbA1c levels.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we

[412] RHP 10 Community Health Needs Assessment

[413] Bodenheimer, T., Lorig, K.., Holman, H., Grumbach, K. Patient Self-management of Chronic Disease in Primary Care *JAMA* (May 15, 2008).

[414] Menzin J, Korn, J, Cohen, J, et.al Relationship between glycemic control and diabetes related hospital costs in patients with type 1 or type 1 diabetes mellitus. *J Manag Care Pharm*. 2010; 16(4):264-275.

gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

135036506.3.9	*3.IT-1.10*	*Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Stand-alone measure)*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.2.1*- Expand Chronic Care Management Models		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2. An initial data analysis from our E.H.R shows that at least 25% of patients at the Baylor Clinic at Baylor All Saints Medical Center have an HbA1c > 9.0%* ***Target Population:*** *Uninsured/undeserved patients in Tarrant County with an HbA1c > 9.0%*		
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: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 20,448 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 20,448	**Outcome Improvement Target 1** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Stand-alone measure) Improvement Target: < 23.8% (or 1.2% improvement over DY2 baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $36,870	**Outcome Improvement Target 2** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Stand-alone measure) Improvement Target: < 22.6% (or 2.4% improvement over DY2 baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment: $59,163	**Outcome Improvement Target 3** [IT-1.10]: Diabetes Care: HbA1c poor control (> 9.0%)- NQF 0059 (Stand-alone measure) Improvement Target: < 21.4% (or 3.6% improvement over DY2 baseline) of patients will have an HbA1c >9.0% Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $141,478
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$**40,896**	Year 3 Estimated Outcome Amount: $**36,870**	Year 4 Estimated Outcome Amount: $**59,163**	Year 5 Estimated Outcome Amount: $**141,478**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**278,408**			

Title of Outcome Measure (Improvement Target): IT-1.11- Diabetes Care: BP control (<140/80 mmHg) NQF 0061 (Stand-alone measure)

Unique RHP outcome identification number(s): 135036506.3.10
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
IT-1.11 Diabetes care: *BP control (<140/80mm Hg)- (Standalone measure)*

- Numerator: Use automated data to identify the most recent blood pressure (BP) reading during the measurement year. The member is numerator compliant if the BP is less than 140/90 mm Hg.
- Denominator: Members 18 to 75 years of age as of December 31 of the measurement year with diabetes (type 1 and type 2)

By the end of the Waiver, our goal is to have > 57.9% of patients 18-75 years old with diabetes (type 1 or type 2) under BP control (< 140/80 mmHg). This is a 7% improvement over baseline. This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program for at least 6 months. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. A preliminary E.H.R data analysis shows that at least 50.9% of patients with diabetes at the Baylor Clinic at Baylor All Saints Medical Center at Fort Worth have BP less than 130/80 mmHg.
- In DY3, our goal is increase the % of patients in good BP control (<140/80 mmHg) to 53.4% of patients at the Baylor Clinic who have engaged in the chronic care management program (or 2.5% improvement over DY2 baseline)
- In DY4, our goal is increase the % of patients in good BP control (<140/80 mmHg) to 55.7% (or 4.8% improvement over DY2 baseline) of patients at the Baylor Clinic who have engaged in the chronic care management program
- In DY5, our goal is have at least 57.9% (or 7% improvement over DY2 baseline) of patients in good BP control (<140/80 mmHg)

Rationale:
Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data

that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic. We will have to review our baseline numbers in DY2. Historically, in our E.H.R we have been tracking BP control as <130/80 mmHg. In order to meet the requirements of this project, we will have to re-analyze the numbers and re-establish our new baseline.

As part of the standard of care for diabetes management, optimal blood pressure control is an included component of this protocol. At Baylor Health Care System, blood pressure control and management is a required part of the diabetes care bundle in order to avoid other comorbid conditions such as heart disease and stroke. A 2010 study in the New England Journal of Medicine by Cushman, et al. showed that better and less severe health outcomes related to cardiovascular episodes and stroke were achieved with tight blood pressure control in diabetic patients[415]. Events that would be fatal with higher blood pressure became nonfatal under better blood pressure control in these studies completed. As part of an outpatient, clinic based protocol, blood pressure control can be achieved in patients who will come to the Baylor Clinic as part of the primary care expansion project.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

[415] Cushman WC, Evans, GW, et Al. Effects of intensive blood pressure control in type 2 diabetes mellitus. N Engl J Med. 2010. Apr 29; 362(17): 1575-85

135036506.3.10	*3.IT-1.11*	*Diabetes Care: BP control (<140/80 mmHg)*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.2.1.*- Expand Chronic Care Management Models		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2 and redefined as <140/80 mmHg. Currently, we have about 50% of our patients that have a BP < 130/80 mmHg at the Baylor Clinic at Baylor All Saints Medical Center at Fort Worth.* ***Target Population:*** *Underserved/uninsured diabetic patients with BP >140/80 mmHg in Tarrant 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: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,112 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $5,112	**Outcome Improvement Target 1** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Stand-alone measure) Improvement Target: > 53.4% (or 2.5% improvement over DY2 baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $36,870	**Outcome Improvement Target 2** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Stand-alone measure) Improvement Target: > 55.7% (or 4.8% improvement over DY2 baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $59,163	**Outcome Improvement Target 3** [IT-1.11]: Diabetes Care: BP control (<140/80 mmHg)-NQF 0061 (Stand-alone measure) Improvement Target: > 57.9% (or 7% improvement over DY2 baseline) of diabetic patients will have BP control (<140/80 mmHg) Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $141,478
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**10,224**	Year 3 Estimated Outcome Amount: $**36,870**	Year 4 Estimated Outcome Amount: $**59,163**	Year 5 Estimated Outcome Amount: $**141,478**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**247,735**			

Title of Outcome Measure (Improvement Target): IT-1.13- Diabetes Care: Diabetes care: Foot exam- NQF 0056

Unique RHP outcome identification number(s): 135036506.3.11
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
IT-1.13 Diabetes care *Foot exam- (Non- standalone measure)*

- Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year.
- Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

One of the outcome measures we have chosen for our chronic care management program is to improve foot screenings for patients with diabetes.
By the end of the Waiver, our goal is to have > 97.2% of patients 18-75 years old with diabetes (type 1 or type 2) receive a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year(s). This is for patients who are Baylor Clinic patients and have engaged in the chronic care management program. Our baseline number is an estimate based on historical data and will require further refinement and establishment during DY2

Process Milestones and Outcome Improvement Targets for each year: Actual percentages based on current baseline were included as were relative percentage improvements in (parentheses) in order to account for the establishment of a new baseline number in DY2.

- In DY2, we will confirm and establish our baseline. A preliminary E.H.R data analysis shows 96% of diabetic patients who are seen by a diabetes educator at the Baylor Clinic at Baylor All Saints Medical Center at Fort Worth receive a foot exam
- In DY3, our goal is to increase this rate to at least 96.5% (or 0.5% improvement over DY2 baseline) of diabetic patients receiving a foot exam
- In DY4, our goal is to increase this rate to at least 96.8% (or 0.8% improvement over DY2 baseline) of diabetic patients receiving a foot exam
- In DY5, our goal is to increase this rate to at least 97.2% (or 1.2% improvement over DY2 baseline) of diabetic patients receiving a foot exam

Rationale:
Category 3 metrics for proposed projects were identified using several key criteria. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Additionally, metrics selected were based on historical Baylor Clinic data

that showed material improvement in a 2-3 year time period. Outcomes such as readmissions actually had an increase in the preliminary years after patients obtained a PCMH at a Baylor Clinic.

An innovative part of this project is that the educators (CHWs and RN Care Managers) will be able to conduct diabetic foot exams as part of their education session with their patients. This will increase the rate of screening and allow these providers to identify issues such as ulcers and nerve issues earlier and more often. Foot exams are a low-cost, highly effective way to avoid costly interventions such as wound care and management, amputations, neuropathy and other complex issues. This is better utilization and management of resources through early identification and prevention of serious diabetes foot-related issues. It is recommended by the American Diabetes Association that diabetic patients receive yearly foot exams to determine if there are predisposing factors for ulceration and amputation[416].

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

[416] American Diabetes Association: http://www.ada.org

135036506.3.11	*3.IT-1.13*	*Diabetes Care: Foot Exam*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.2.1* - Expand Chronic Care Management Models		
Starting Point/Baseline:	***Baseline:*** *The baseline for this project will be confirmed again in DY2. An initial data analysis from our E.H.R shows that about 96% of diabetic patients seen by a diabetes educator at the Baylor Clinic at Baylor All Saints Medical Center receive a foot exam* ***Target Population:*** *Underserved/uninsured patients with diabetes in Tarrant 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-3.1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 10,224 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 10,224	**Outcome Improvement Target 1** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Stand-alone measure) Improvement Target: >96.5% (or 0.5% improvement over DY2 baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $9,218	**Outcome Improvement Target 2** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Stand-alone measure) Improvement Target: >96.8% (or 0.8% improvement over DY2 baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $14,791	**Outcome Improvement Target 3** [IT-1.13]: Diabetes Care: Foot exam NQF 0056 (Non-Stand-alone measure) Improvement Target: >97.2% (or 1.2% improvement over DY2 baseline) of Patients in the chronic care management program will have a foot exam completed Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $35,369
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**20,448**	Year 3 Estimated Outcome Amount: $**9,218**	Year 4 Estimated Outcome Amount: $**14,791**	Year 5 Estimated Outcome Amount: $**35,369**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $79,825**			

Title of Outcome Measure (Improvement Target): 11.1- Improvement in Clinical Indicator in Identified Disparity Group. Clinical indicator to be improved and disparity group to be determined by provider.

Diabetes Percent of Opportunities Achieved Improvement

Unique RHP outcome identification number(s): - 135036506.3.16 (Pass 3b)
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider *(Standalone measure)*

- Numerator: Number of patients with an improved Diabetes POA (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter
- Denominator: Total number of patients with a Behavioral Health intervention/ encounter

One of the outcome measures we have chosen for our behavioral health program is to improve Baylor's standard diabetes percent of opportunities achieved (POA) (HbA1c, LDL, BP) for patients who have engaged in our behavioral health program. We define the disparate population as the underserved individuals in Tarrant County that have both a diagnosis of diabetes and a behavioral health issue. This amounts to almost 23,000 people in the Tarrant County area (8% of total population has diabetes and 15-30% of those individuals also has a behavioral health issue)

By the end of the Waiver, our goal is to have > 15% of patients who have had a behavioral health intervention/encounter to have improvement in our diabetes POA (HbA1c, LDL, BP) that have uncontrolled values for these measures and have an identified behavioral health issue.

- HbA1c < 8%
- LDL < 100
- BP < 130/80 mmHg

Our Baylor Clinics currently track the Diabetes Percent of Opportunities Achieved (POA) for all patients with diabetes. We measure this yearly for our Diabetic patients and calculate POA. This is calculated by dividing the total number of services or targets achieved over the total number of eligible services or targets within a sample population. POA = number of processes or targets achieved divided by the total number of eligible services or targets within the sample population. This metric differs slightly from "bundle" performance which is usually an all-or-none metric calculating the percentage of patients who've achieved ALL the processes or targets within a bundle. Improvement in POA can be translated as follows: An improvement in diabetes management POA from 50% to 60% within a population means the clinic was successful in achieving 10% more processes/targets for their diabetic patients than in the prior reporting period.

For an illustrative example: For diabetes- there are three opportunities (i.e. metrics) per patient (1) LDL < 100 (2) A1c < 8 and (3) BP < 130/80 mmHg. The denominator would be number of patients times 3. So, for example, if there are 10 patients x 3 opportunities each = 30 opportunities to be achieved. If, in the course of the year, only 20 of those opportunities were completed, this means that our POA (Percent of Opportunities Achieved) = 20/30=67%. To achieve a 10% improvement in POA, we would have to have completed at least 23/30 opportunities to get at 76% achievement

Process Milestones and Outcome Improvement Targets for each year:

- In DY2 we will establish a baseline of current status of the Diabetes POA for patients who have a reported behavioral health issue
- In DY3, we will improve the Diabetes POA for 5% of patients who have had at least one behavioral health intervention/encounter in one year
- In DY3, we will improve the Diabetes POA for 10% of patients who have had at least one behavioral health intervention/encounter in one year
- In DY3, we will improve the Diabetes POA for 15% of patients who have had at least one behavioral health intervention/encounter in one year

Rationale:

Category 3 metrics for this projects were identified using literature only. Baylor has had no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Our main goal by selecting this outcome was to recognize and increase awareness of patients who have co-occurring behavioral health and diabetes health issues. By recognizing this, we believe we can positively impact diabetes outcomes by addressing underlying behavioral health issues that patients may have.

In DY2, we will collect our baseline information about the status of the Diabetes POA (HbA1c, LDL, BP) for patients who have a documented behavioral health issue. The problem with this collection is that because this program is new, both patients and clinicians are not actively looking for and documenting behavioral health problems that patients have. As part of our project, we plan to increase screenings using PHQ2/9, GAD-7 and substance abuse tools but until that is implemented, the numbers we will report for baseline will be underreported. Once there is more awareness about the screenings and program, we anticipate that more patients will disclose their behavioral health issue and their providers will also be more aware of these conditions.

We believe if we increase the treatment rates of behavioral health issues, that we will also see an increase in patient compliance rates with other preventive screening/testing and clinical recommendations made by their providers.

A recent study conducted in early 2012, by Jeffery Johnson, et al. showed a direct correlation between diabetes and depression. They cited that depression is the most common comorbid condition present in 15-30% of patients with type 2 diabetes and less than 50% are recognized as having depression. Depression is associated with poorer self-care behaviors, decreased quality of life and substantially higher health care costs. Both diabetes and behavioral health issues are prevalent across the Region, warranting measurement of the efficacy of a behavioral health program on chronic diseases.[417]

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

[417] Johnson, JA, Sayah, FA, et.al. Controlled trial of a collaborative primary care team model for patients with diabetes and depression: rationale and design for a comprehensive evaluation. BMC Health Services Research. 2012, 12:358

- 135036506.3.16	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*- 135036506.2.4- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Definition of Metric**:* *Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter* *Denominator: Total number of patients with a Behavioral Health intervention/encounter* ***Baseline:** The baseline for Baylor All Saints will be established in DY2.* ***Target Population:** On average, 15-30% of patients with diabetes have a comorbid behavioral health diagnosis (usually Depression), this would amount to 23,000 people in Tarrant county that would have a subset of diabetes + behavioral health issue*		
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-1.1] Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Complete planning processes for behavioral health program Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $17,234 **Process Milestone 2** P-3.2: Establish baseline rates	**Process Milestone 3** [P-3.2]: Establish baseline rates Metric: Compare DY2 baseline assessment of patients with uncontrolled Diabetes POA and documented behavioral health issues to DY3 data period Goal: Determine if more self or clinician reported data around identification of behavioral health issues has an impact on DY2 baseline reporting Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $19,977	**Outcome Improvement Target 2** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 10% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R	**Outcome Improvement Target 3** [IT-11.1]: Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 15% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R

- 135036506.3.16	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*- 135036506.2.4- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Definition of Metric:*** *Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter* *Denominator: Total number of patients with a Behavioral Health intervention/encounter* ***Baseline:*** *The baseline for Baylor All Saints will be established in DY2.* ***Target Population:*** *On average, 15-30% of patients with diabetes have a comorbid behavioral health diagnosis (usually Depression), this would amount to 23,000 people in Tarrant county that would have a subset of diabetes + behavioral health issue*		
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)**
Metric: Determine current status of patients with co-occurring illnesses Goal: Determine number of patients with out of range Diabetes POA (HbA1c, LDL, BP) that have a documented behavioral health issue Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $17,235	**Outcome Improvement Target 1** IT-11.1 Improve Clinical Indicator in identified disparity group. Improvement Target: Improve Diabetes POA (HbA1c, LDL, BP) for at least 5% of patients who have had at least 1 behavioral health encounter/intervention Numerator: # of patients with improved Diabetes POA Denominator: # of patients with at least 1 behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment:	Outcome Improvement Target 2 Estimated Incentive Payment: $85,482	Outcome Improvement Target 3 Estimated Incentive Payment: $204,415

- 135036506.3.16	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*- 135036506.2.4- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Definition of Metric**:* *Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter* *Denominator: Total number of patients with a Behavioral Health intervention/encounter* ***Baseline:** The baseline for Baylor All Saints will be established in DY2.* ***Target Population:** On average, 15-30% of patients with diabetes have a comorbid behavioral health diagnosis (usually Depression), this would amount to 23,000 people in Tarrant county that would have a subset of diabetes + behavioral health issue*		
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)**
	$19,977		

- 135036506.3.16	*IT-11.1*	*Improvement in clinical indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider- Diabetes POA improvement*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*- 135036506.2.4- Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Definition of Metric**:* *Numerator: Number of patients with an improved Diabetes Percent of Opportunities Achieved (POA) improvement (LDL, A1c, BP) score that have had a Behavioral Health intervention/encounter* *Denominator: Total number of patients with a Behavioral Health intervention/encounter* ***Baseline:** The baseline for Baylor All Saints will be established in DY2.* ***Target Population:** On average, 15-30% of patients with diabetes have a comorbid behavioral health diagnosis (usually Depression), this would amount to 23,000 people in Tarrant county that would have a subset of diabetes + behavioral health issue*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**34,469**	Year 3 Estimated Outcome Amount: $**39,954**	Year 4 Estimated Outcome Amount: $**85,482**	Year 5 Estimated Outcome Amount: $**204,415**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $**364,320**			

Title of Outcome Measure (Improvement Target): IT-11.3- Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-stand-alone measure)

Unique RHP outcome identification number(s): - 135036506.3.17 (Pass 3b)
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services and treatment) in target population with identified disparity. *(Non-standalone measure)*

- Numerator: patients who are Baylor clinic patient who engage in a behavioral health treatment/intervention
- Denominator: patients who are Baylor clinic patients who are eligible for behavioral health services

One of the outcome measures we have chosen for our behavioral health program is to increase the number of patients in the underserved population who have improved utilization rates for receiving behavioral health treatments/interventions. The subset of the target population that suffers from mental health issues is prevalent in the Region and affects 25% of the African-American population in Tarrant county. The disparate population that we will be focusing on is the underserved/uninsured patients in Tarrant County.

By the end of the Waiver, our goal is to have > 20% of patients who are eligible to participate in the behavioral health program, engage in the program.
The idea of this metric is that by engaging patients in behavioral health treatment/interventions that their subsequent medical care will also improve. Patients who engage are those who have had at least one behavioral health intervention/encounter in the past 12 months. Patients eligible for behavioral health entail those that have 1) been identified through the PHQ2/9, GAD-7 and Substance Abuse screening tools that are in need of intervention, 2) self- identified need or 3) provider/clinician identification of patient need for behavioral health counseling

Process Milestones and Outcome Improvement Targets for each year:

- In DY2 we will establish a baseline of how many patients have a behavioral health issue (substance abuse, anxiety, depression, other) based on our E.H.R, self-reported or clinician reported status.
- In DY3, we will improve behavioral health treatment rates by 10%
- In DY4, we will improve behavioral health treatment rates by 15%
- In DY5, we will improve behavioral health treatment rates by 20%
-

Rationale:
Category 3 metrics for this projects were identified using literature only. Baylor has had no previous experience with a behavioral health program of this nature. Because of the strong focus on outpatient services, selected metrics are applicable to care provided in an ambulatory setting. Our main goal by selecting this outcome was to demonstrate increased access and utilization of the behavioral health program we are proposing.
In DY2, we will collect our baseline information about the number of patients who have a behavioral health issue. The problem with this collection is that because this program is new, both patients and clinicians are not actively looking for and documenting behavioral health problems that patients have. As part of our project, we plan to increase screenings using PHQ2/9, GAD-7 and substance abuse tools but until that is implemented, the numbers we will report for baseline will be underreported. Once there is more awareness about the screenings and program, we anticipate that more patients will disclose their behavioral health issue and their providers will also be more aware of these conditions.

We believe if we increase the treatment rates of behavioral health issues, that we will also see an increase in patient compliance rates with other preventive screening/testing and clinical recommendations made by their providers.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

- 135036506.3.17	*3.IT-11.3*	*Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. The disparate population is the underserved/uninsured patients with behavioral health issues.*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.2.3: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor All Saints will be established in DY2.* ***Target Population:*** *The target population in the Tarrant county area is over 101,000 underserved individuals who suffer from a 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)**
Process Milestone 1 [P-1]: Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $17,235 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 17,234	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment: $19,977 **Outcome Improvement Target 1** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 10% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 1 Estimated Incentive Payment*:* $19,977	**Outcome Improvement Target 2** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 15% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 2 Estimated Incentive Payment*:* $42,741	**Outcome Improvement Target 3** [IT-11.3]: Improve utilization rates of clinical preventive services Improvement Target: Increase rate of patient engagement by 20% Numerator: # of patients engaged in behavioral health treatment/intervention Denominator: # of patients eligible for behavioral health treatment/intervention Data Source: E.H.R Outcome Improvement Target 3 Estimated Incentive Payment*:* $102,207

- 135036506.3.17	*3.IT-11.3*	*Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. The disparate population is the underserved/uninsured patients with behavioral health issues.*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.2.3: Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor All Saints will be established in DY2.* ***Target Population:*** *The target population in the Tarrant county area is over 101,000 underserved individuals who suffer from a 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**34,469**	Year 3 Estimated Outcome Amount: $**39,954**	Year 4 Estimated Outcome Amount: $**42,741**	Year 5 Estimated Outcome Amount: $**102,207**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**219,371**			

Title of Outcome Measure (Improvement Target): IT-5.1- Improved Cost Savings: Demonstrate cost savings in care delivery (Non-Stand-alone measure)

Unique RHP outcome identification number(s): - 135036506.3.18
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (*Standalone measure for Project 2.5 only. For all other projects –Non- standalone measure)*

- Type of analysis to be determine by provider from the following list: Cost of Illness Analysis, Cost Minimization Analysis, Cost Effectiveness Analysis (CEA), Cost Consequence Analysis, Cost Utility Analysis, Cost Benefit Analysis

By the end of the Waiver, our goal is to have > 25% cost savings in health care services utilization (through fewer ED visits and less overall utilization) for patients who have engaged in our care navigation program and have a confirmed appointment with a PCP/PCMH.

One of the outcome measures we have chosen for our care navigation program is to improve cost savings in the health care delivery system for those patients who have been served by the care navigation program.

Process Milestones and Outcome Improvement Targets for each year:

- In DY2 we will establish a baseline of average cost savings incurred by patients who have been seen by the care navigation program while in the ED and have a confirmed appointment with a PCP/PCMH. We will compare pre- and post-utilization patterns of enrolled patients to determine the total cost savings incurred (inpatient and outpatient) per patient. For example, if prior to being seen by our care navigation program, a patient's total cost utilization was $10,000 we anticipate that after being connected to the appropriate resource and being seen for an appointment that over the course of 1 year, total costs would decrease by 20% (DY4) to $8,000.
- In DY3, we aim to improve cost savings for those patients who have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 15% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year
- In DY4, we aim to improve cost savings for those patients who have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 20% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year
- In DY5, we aim to improve cost savings for those patients who have been 1) seen by our care navigation and program and 2) have a confirmed appointment by 25% using a pre/post analysis of utilization patterns for total cost of care over the course of 1 year

Rationale:
In DY2, we plan to do some in depth utilization analysis to determine a baseline of what the cost utilization patterns are for patients seen at Baylor All Saints Medical Center at Fort Worth. This, based on our historical experience with similar programs on other campuses, we anticipate a 15%, 20% and 25% cost savings over the subsequent years in total cost of care savings.

The reason we chose this metric is because financial constraints are a main concern for the Region in being able to provide high-quality care to the underserved population. Cost savings and effectiveness are a key part of the overall Waiver and require providers to be good stewards of their resources. This metric is appropriate because it emphasizes appropriate utilization of resources and reinforces the concept of cost effectiveness. We plan to measure the cost effectiveness and cost utilization of this project. According to the Texas Medical Association, the cost of treating a condition that could be treated in the doctor's office for $56.21 (including lab and x-ray) costs $193.92 in the emergency department[418]. This cost differential multiplied by the 443,000 uninsured in Tarrant County creates a significant cost to the county and Region.

Outcome Measure Valuation:
As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

[418] Texas Medical Association: http://www.texmed.org

- 135036506.3.18	*3.IT-5.1*	*Improved cost savings: demonstrate cost savings in care delivery*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.2.5: Establish/Expand a Patient Care Navigation Program- Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor All Saints will be established in DY2. Typical costs for an inpatient stay for an uninsured patient is $19,400* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH in Tarrant 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: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 16,708 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 16,708	**Outcome Improvement Target 1** [IT-5.2]: Improved Cost Savings Improvement Target: For patients who have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 15% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 1 Estimated Incentive Payment*:* $25,823	**Outcome Improvement Target 2** [IT-5.2]: Improved Cost Savings Improvement Target: For patients who have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 20% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 2 Estimated Incentive Payment*:* $41,436	**Outcome Improvement Target 3** [IT-5.2]: Improved Cost Savings Improvement Target: For patients who have been seen by the care navigation program, have a confirmed PCP/PCMH appointment, cost savings should be 25% in a pre-post utilization analysis Data Source: E.H.R/Care Navigation database Outcome Improvement Target 3 Estimated Incentive Payment*:* $99,086
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**33,416**	Year 3 Estimated Outcome Amount: $**25,823**	Year 4 Estimated Outcome Amount: $**41,436**	Year 5 Estimated Outcome Amount: $**99,086**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**199,761**			

Title of Outcome Measure (Improvement Target): IT-9.2- ED appropriate utilization (Stand-alone measure)

Unique RHP outcome identification number(s): - 135036506.3.19
Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth / 135036506

Outcome Measure Description:
IT-9.2 ED appropriate utilization *(Standalone measure)*

- Reduce all ED visits (including ACSC)
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)-N/A
- Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease/Hypertension
  - Behavioral Health/Substance Abuse
  - Chronic Obstructive Pulmonary Disease
  - Asthma

By the end of the Waiver, our goal is to have > 35% reduction in inappropriate ED utilization for all causes and > 20% reduction in inappropriate ED utilization for targeted conditions: CHF, diabetes, ESRD, CVD/hypertension, behavioral health/substance abuse, asthma

One of the outcome measures we have chosen for our care navigation program is to reduce ED utilization. The protocol mentions three parts to this metric:

1) Reduce all ED visits (including ACSC)
2) Reduce pediatric Emergency Department visits (CHIPRA Core Measure)-*we will not be measuring this outcome as we do not see pediatric patients at Baylor All Saints Medical Center at Fort Worth*
3) Reduce ED visits for target conditions
   a. CHF
   b. Diabetes
   c. ESRD
   d. CVD/Hypertension
   e. Behavioral Health/Substance Abuse
   f. COPD
   g. Asthma

Process Milestones and Outcome Improvement Targets for each year:

- In DY2 we will establish a baseline for the aforementioned components of the improvement metric (less #2- pediatric ED visits) and determine the full opportunity for improvement
- In DY3, we aim to reduce all ED visits by 25% and ED visits for targeted conditions by 10%
- In DY4 we aim to reduce all ED visits by 30% and ED visits for targeted conditions by 15%
- In DY5, we aim to reduce all ED visits by 35% and ED visits for targeted conditions by 20%

Rationale:

Baylor All Saints Medical Center at Fort Worth sees very few children, thus metric 2 is not applicable to this project. We do not see enough pediatric patients to make a material impact on the ED utilization rate for this population. Historically, we have not tracked the ED utilization for targeted conditions (i.e. CHF, diabetes, etc.), for this type of project thus we do not have a baseline measurement for these specific diseases. We plan to measure these in DY2 and DY3 and target a modest improvement of ED utilization in the subsequent years.
According to the Community Health Needs Assessment of Region 10, there were 798,904 emergency department visits in 2011, comprising a majority of the 1 million plus visits in the Region[419]. The stakeholder survey conducted amongst performing providers also indicated that there is a significant overuse of emergency department services due to patients' inability to access primary care. This metric is at the heart of the care navigation project we are proposing and will have a direct impact on patients in Tarrant County utilizing the ED at a decreased rate. This project uses the popular concept created by Dr. Atul Gawande, referred to as "hot spotting" indicating a focus on finding the high risk/high utilization rates of the ED and determining the root cause for these visits, and then working to remedy those issues[420]. Issues such as transportation, navigation of community and appropriate resources are just two examples that can lead to more effective use of the ED.

Outcome Measure Valuation:

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort to achieve a particular targeted outcome, we then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as

[419] RHP 10 Community Health Needs Assessment
[420] Gawande, A. The hot spotters: can we lower medical costs by giving the neediest patients better care? The New Yorker. (2011).

patient satisfaction because of the quality impact and downstream cost savings/clinical implications hypertension/diabetes control would have than patient satisfaction.

- 135036506.3.19	*3.IT-9.2*	*ED Appropriate Utilization*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.2.5- Establish/Expand a Patient Care Navigation Program-Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor All Saints will be established in DY2. Based on historical performance of similar programs, ED utilization typically decreased by 30% in the first year.* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH that are frequent users of the ED*		
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: Documentation of planning reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $16,708 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: E.H.R Process Milestone 2 Estimated Incentive Payment: $ 16,708	**Process Milestone 3** [P-2]: Establish baseline rates in comparison to DY2 Data Source: E.H.R Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $25,823 **Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 25% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc.) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 10% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 1 Estimated Incentive Payment*:* $25,822	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 30% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc.) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 15% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 2 Estimated Incentive Payment*:* $82,872	**Outcome Improvement Target 3** [IT-9.2]: ED Appropriate Utilization Improvement Target: Reduce ED Utilization for All ED Visits by 35% for those patients who have been served by the care navigation program and have a confirmed appointment with the PCP/PCMH Improvement Target: Reduce ED utilization for patients with targeted conditions (CHF, Diabetes, etc.) that have been served by the care navigation program and have a confirmed appointment with a PCP/PCMH by 20% Data Source: E.H.R/Care Navigation database Outcome Improvement Target 3 Estimated Incentive Payment*:* $198,173

- 135036506.3.19	*3.IT-9.2*	*ED Appropriate Utilization*	
Baylor All Saints Medical Center at Fort Worth			*135036506*
Related Category 1 or 2 Projects:	*135036506.2.5- Establish/Expand a Patient Care Navigation Program-Care Connect*		
Starting Point/Baseline:	***Baseline:*** *The baseline for Baylor All Saints will be established in DY2. Based on historical performance of similar programs, ED utilization typically decreased by 30% in the first year.* ***Target Population:*** *Underserved/uninsured patients without a PCP/PCMH that are frequent users of the ED*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**33,416**	Year 3 Estimated Outcome Amount: $**51,645**	Year 4 Estimated Outcome Amount: $**82,872**	Year 5 Estimated Outcome Amount: $**198,173**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**366,107**			

Title of Outcome Measure (Improvement Target): Right Care, Right Setting – IT-9.2 – ED appropriate utilization

Unique RHP outcome identification number(s): 127304703.3.1
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Azle / 127304703

Outcome Measure Description:

Process Milestones:

The process milestones in DY2 are to establish one Walk-In Clinic and hire fulltime staff to operate the clinic (P-1). In DY3 we will conduct a Plan Do Study Act cycles to determine if we are meeting goals, and reaching the target population with information regarding the clinic and the benefits for them (P-4).

Outcome Improvement Targets for each year:

By the end of Waiver, there will be a 50% reduction in unfunded/ Medicaid and Medicare patients in the Emergency Department for non-emergent[421] visits compared to baseline year, which translates to a 5.9% reduction in all ED visits. In DY2, one Walk-In Care Clinic will be established.

- In DY3, 3.3% reduction in all ED visits from baseline
- In DY4, 4.6% reduction in all ED visits from baseline
- In DY5, 5.9% reduction in all ED visits from baseline

Rationale:

The reason for selecting P-1 is to ensure that the proposed clinic is developed in a way that meets community needs; P-2 will help us establish the current number of non-emergent patients seen THAZ's ED; for P-4 we will look at how effective we are at marketing and reaching out to the targeted population to educate them on the benefits of the clinic for them, versus using the emergency department for primary care services. It is anticipated that the clinic could see approximately 7,000 patients per year, with at least 25% of these being patients who would have used the Emergency Department for their non-emergent care.

In DY3, we believe that we will be able to reach 30% of the unfunded, Medicaid and Medicare patients who visit the ED for non-emergent reasons – this translates to a 3.3% reduction in all ED visits. In DY4 with marketing and patient education efforts we aim to reach 40% of the target population, and by DY5 we should be able to effectively reach one out of every two patients in the target population that would have normally used the ED for non-emergent complaints.

Outcome Measure Valuation:

[421] Emergency Severity Index, 2012. The ESI Triage Research Team, LLC. Retrieved on October 11, 2012 from http://www.esitriage.org/.

- **Approach/Methodology:** For every ED visit for the intervention population that is avoided, $150 in cost is saved by the health care system.[422] The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale:** ED visit outcome improvement targets are dependent on the target population served (e.g., with either hypertension or diabetes), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already navigate frequent flyers away from the ED. Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[422] Based on 2011 historical ED visits data for Texas Health Azle

127304703.3.1	*3.IT-9.2*	*ED appropriate utilization-Reduce all ED visits*	
Texas Health Harris Methodist Hospital Azle			*1273047-03*
Related Category 1 or 2 Projects:	*127304703.1.1 Establish more primary care clinics – Walk-in Clinic*		
Starting Point/Baseline:	***Target Population**: Defined as Texas Health Harris Methodist Azle's emergency department visits, from October 1, 2011 through September 30, 2012. The number of emergency department visits n 2011 was 25,162.* ***Baseline/Intervention Population**: As determined by review of the emergency department patients records, there were 2,703 unfunded/Medicaid and Medicare patients treated for non-emergent care, as define by level four or five on the ESI classification scale.*		
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]: Project Planning-engage stakeholders, identify current utilization, determine timelines and document implementation plans Baseline/Target: Establish one walk-in clinic. Data Source: Human Resources Records Milestone 1 Estimated Incentive Payment $6,301 **Milestone 2 [P-2]:** Establish baseline rates for non-emergent ED visits by unfunded or Medicare/Medicaid patients over intervention population which is currently 2700-2900 visits per year. Data Source: EHR, Registration data, claims. Milestone 1 Estimated Incentive Payment $6,300	**Milestone 3 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: EHR, Registration data, claims. Milestone 2 Estimated Incentive Payment $9,959 **Outcome Improvement Target 1 [IT-9.2]:** ED appropriate utilization Goal: Reduction in target population ED visits 30%, which is approximately 840 visits. Data Source: EHR, Registration data, claims. Outcome Improvement Target 1 Estimated Incentive Payment $9,958	**Outcome Improvement Target 2 [IT-9.2]:** ED appropriate utilization Goal: Reduction in target population ED visits 40%, which is approximately 1150 visits. Data Source: EHR, Registration data, claims. Outcome Improvement Target 2 Estimated Incentive Payment $21,307	**Outcome Improvement Target 3 [IT-9.2]:** ED appropriate utilization Goal: Reduction in target population ED visits 50%, which is approximately 1490 visits. Data Source: EHR, Registration data, claims. Outcome Improvement Target 3 Estimated Incentive Payment $50,951

127304703.3.1	*3.IT-9.2*	*ED appropriate utilization-Reduce all ED visits*	
Texas Health Harris Methodist Hospital Azle			*1273047-03*
Related Category 1 or 2 Projects:	*127304703.1.1 Establish more primary care clinics – Walk-in Clinic*		
Starting Point/Baseline:	***Target Population**: Defined as Texas Health Harris Methodist Azle's emergency department visits, from October 1, 2011 through September 30, 2012. The number of emergency department visits n 2011 was 25,162.* ***Baseline/Intervention Population**: As determined by review of the emergency department patients records, there were 2,703 unfunded/Medicaid and Medicare patients treated for non-emergent care, as define by level four or five on the ESI classification scale.*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): **$12,601**	Year 3 Estimated Outcome Amount: **$19,917**	Year 4 Estimated Outcome Amount: **$21,307**	Year 5 Estimated Outcome Amount: **$50,951**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* **$104,775**			

Title of Outcome Measure (Improvement Target): Right Care, Right Setting: ED Appropriate Utilization – IT – 9.2 for HELP Chronic Disease Management Program

Unique RHP outcome identification number(s): 127304703.3.2
Performing Provider Name/TPI: Texas Health Harris Methodist Hospital Azle / 127304703

Outcome Measure Description:

By the end of the Waiver, our goal is to reduce by 50% the number of unfunded/Medicaid patients who are treated in the emergency department for a chronic disease.

In 2011 the emergency department at Texas Health Azle, 56% of the patients were either unfunded or Medicaid. This translates into approximately 13,154 patients. A review of the patient records indicates there were 1,902 of these patients were treated for an uncontrolled chronic disease.

Process Milestones:

- In DY2, the goal is to formalize the project planning by establishing a multidisciplinary team of 4.0 full-time employees to help patients with chronic disease better manage their condition.

Outcome Improvement Targets for each year:

- In DY3, the goal is to reduce by 10% the number of unfunded/Medicaid patients who are treated in the emergency department for an uncontrolled chronic disease.
- In DY4, the goal is to reduce by 25% the number of unfunded/Medicaid patients who are treated in the emergency department for an uncontrolled chronic disease.
- In DY5, the goal is to reduce by 50% the number of unfunded/Medicaid patients who are treated in the emergency department for an uncontrolled chronic disease.

Rationale:

This project was specifically selected because of its relevancy to providing improved cost-effective, competent care to help manage hypertension, high cholesterol and diabetes in the uninsured population. We know this program is needed because, in August 2011, we conducted focus groups for uninsured patients living in our community with chronic disease. Findings from those focus groups indicated that while chronic disease patients recognized their need for primary care and assistance with disease management, most felt they didn't have sufficient support and primary care access to do so.[423] Most focus group participants said they knew what they needed to do in order to be compliant – exercise, take proper medication, and improve their nutrition. Unfortunately, the same participants pinpointed their inability to pay as a critical barrier to following through with these needed management techniques and supports. Most

[423] Our focus group findings were compiled in a June 2011 report, "What the Disadvantaged of Tarrant and Parker County Need to Improve Their Chronic Disease Self-Management Efforts."

respondents admitted to taking their medicine every other day to stretch out the medicine. Respondents also said they didn't want to use hospital ERs as their only source of care when their disease flared, but lacked any alternative.

Based on patient records, there were 1,902 unfunded or Medicaid patients seen in the emergency department for uncontrolled chronic disease. According to the results of three focus groups conducted with these patients, the prevalent reason for going to the emergency department for treatment is limited or no access to primary care. The patients wait until the condition is at an emergent level, then they come to the emergency department. When the prescription runs out, the cycle starts again. This is a costly and dangerous way to manage a chronic disease.

Outcome Measure Valuation:

- **Approach/Methodology:** For every ED visit avoided, $1,322 in cost is saved by the health care system. The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** ED visit outcome improvement targets are dependent on the target population served (e.g., with either hypertension or diabetes), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.
- **Community benefits** were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

127304703.3.2	*3.IT-9.2*	*ED Appropriate Utilization – HELP Chronic Disease Management Program*	
Texas Health Harris Methodist Hospital Azle			*1273047-03*
Related Category 1 or 2 Projects:	*127304703.2.1 Expand Chronic Care Management Models – Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – Healthy Education and Lifestyles Program (HELP) Chronic Disease Management Program*		
Starting Point/Baseline:	**Baseline data**: In 2011, the actual number of ED visits in the unfunded and Medicaid population is 13,154. **Target Populations**: Unfunded or Medicaid patients with a chronic disease. **Specific number**: In 2011, the number of ED visits in the unfunded/Medicaid population treated in the Texas Health Azle's emergency department for an uncontrolled chronic disease was 1,902. **Description of population**: Unfunded/Medicaid patients with a chronic disease (specifically, hypertension. diabetes, congestive heart failure.)		
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]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Goal**: Establish a multidisciplinary team with 4.0 full-time employees. **Data Source:** HR records Milestone 1 Estimated Incentive Payment $35,974	**Improvement Target 1 [IT-9.2]:** ED appropriate utilization **Goal:** 10% decrease in the number of unfunded/Medicaid visits, who are treated in the emergency department for an uncontrolled chronic disease compared to baseline, estimated 190 visits. **Data Source**: Patient Records Milestone 2 Estimated Incentive Payment $56,861	**Improvement Target 2 [IT-9.2]:** ED appropriate utilization **Goal:** 25% decrease in the number of unfunded/Medicaid visits, who are treated in the emergency department for an uncontrolled chronic disease compared to baseline, estimated 475 visits. **Data Source**: Patient Records Milestone 3 Estimated Incentive Payment $60,828	**Improvement Target 3 [IT-9.2]:** ED appropriate utilization **Goal:** 50% decrease in the number of unfunded/Medicaid visits, who are treated in the emergency department for an uncontrolled chronic disease compared to baseline, estimated 951 visits. **Data Source**: Patient Records Milestone 4 Estimated Incentive Payment $145,459
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $35,974	Year 3 Estimated Outcome Amount: $56,861	Year 4 Estimated Outcome Amount: $60,828	Year 5 Estimated Outcome Amount: $145,459
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $299,123			

Title of Outcome Measure (Improvement Target): IT-10.1- Quality of Life (Substance Abuse Expansion)

Unique RHP outcome identification number(s): 127373205.3.1
Performing Provider Name/TPI: Helen Farabee Centers / 127373205

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
The outcome measure is designed to track improvement in quality of life scores as measured by the Substance Abuse Adult/Child Treatment Assessment. This is the assessment mandated by the Department of State Health Services and maintained in the Clinical Management for Behavioral Health Services (CMBHS) database. The assessment is a multipurpose tool developed for adult and child substance abuse services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The process milestones are designed to track reporting of findings, lessons learned, and best practices to local stakeholders. This reporting summarizes the status of the referenced category 1 project implementation. The expected improvement milestone for DY4 is to see improvement in quality of life, comparing assessments at first contact with assessments at three months, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of patients in Wise County. The milestone increases to 10% for year 5.

Rationale:
The process milestones were selected in order to provide stakeholders with status reports regarding the new interventions in Wise County. The outcome improvement target was selected in order to quantify any change in quality of life as the result of the new services.

Outcome Measure Valuation:
Substance abuse imposes a heavy burden on emergency department and primary care settings. When individuals are screened for substance abuse and receive appropriate treatment, the related utilization and abuse of health care settings will go down 50% with a savings of $3.81 to $4.30 for every dollar spent on treatment services. We used the average of $4.05 saved for every dollar spent on treatment services.

The savings of $4.05 was determined by the Texas Drug Demand Reduction Advisory Committee Report to state leadership[424]. That savings amount was determined based on costs saved from incarceration, hospitalization, emergency department usage, and homelessness.

[424] Texas Drug Demand Reduction Advisory Committee: Report to State Leadership, January 2009 (http://www.dshs.state.tx.us/sa/ddrac/)

127373205.3.1	*3.IT-10.1*	*Quality of Life (Substance Abuse Expansion)*	
The Helen Farabee Center/ Wise County			*127373205*
Related Category 1 or 2 Projects:	*127373205.1.1*		
Starting Point/Baseline:	*0 Services performed at Wise County clinic to date.*		
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-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment*:* $15,879	**Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment*:* $36,598	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life-275,276,277 (*Stand-alone measure)* Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of the target population. Data Source: Substance Abuse Adult/Child Treatment Assessment Outcome Improvement Target 1 Estimated Incentive Payment*:* $39,127	**Outcome Improvement Target 2** [IT-10.1]: Quality of Life-275,276,277 (*Stand-alone measure)* Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 10% of the target population. Data Source: Substance Abuse Adult/Child Treatment Assessment Outcome Improvement Target 2 Estimated Incentive Payment*:* $85,006
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $15,879	Year 3 Estimated Outcome Amount: $36,598	Year 4 Estimated Outcome Amount: $39,127	Year 5 Estimated Outcome Amount: $85,006
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$176,610			

Title of Outcome Measure (Improvement Target): IT-10.1- Quality of Life (Open Access)

Unique RHP outcome identification number(s): 127373205.3.2
Performing Provider Name/TPI: Helen Farabee Centers / 127373205

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
The outcome measure is designed to track improvement in quality of life scores as measured by the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths assessment (CANS). The ANSA and CANS are multipurpose tools developed for adult and child behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. These tools are mandated for use by the Department of State Health Services within the Texas Recovery and Resiliency model of care. The process milestones are designed to track reporting of findings, lessons learned, and best practices to local stakeholders. This reporting summarizes the status of the referenced category 1 project implementation. The measurement time frame is one assessment at Intake compared to the subsequent assessment 3 months post intake. This measurement time frame is chosen to avoid measuring any effects produced by the Peer Support project (127373205.2.1). The expected improvement milestone for DY4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the ANSA, for 5% of patients in Wise County. The milestone increases to 10% for year 5.

Rationale:
The process milestones were selected in order to provide stakeholders with status reports regarding the new interventions in Wise County. The outcome improvement target was selected in order to quantify any change in quality of life as the result of the new services.

Outcome Measure Valuation:
The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years. Based on the literature, an estimated Quality of Life Year gained by this intervention is 0.0245 years. The result is a $1,225 quality of life improvement per patient impacted.

The valuation is aligned with the Medicaid Waiver goals to develop programs that enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. The primary valuation method uses cost-utility analysis (a type of cost-effectiveness research). Cost-utility analysis (CUA) measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses

a quality-adjusted life-years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known (e.g.,, emergency department visits that are avoided). In order to make the valuations fair across potentially different types of interventions the common health goal, or outcome, is the number of life-years added. The number of life-years added is based on a review of the scientific literature. A search of the scientific literature identified the following two studies. The first study looked at telemedicine and mental health and was conducted by Pyne (2010)[425] which showed a 0.015 incremental QALY for patients with depression in rural New Mexico who received depression treatment by telemedicine. Another study by Hollinghurst et al. (2010)[426] examining online cognitive behavioral treatment (CBT) of depression found the QALY gain for the waitlist control group of 0.494 (sd=0.099) while the QALY gain for the intervention group was 0.528 (sd=0.081). The additional QALY gain for intervention was 0.034. The average of the two estimated QALYs is 0.0245.

[425]Pyne, J. M., Fortney, J. C., Tripathi, S. P., Maciejewski, M. L., Edlund, M. J., & Williams, D. K. (2010). Cost-effectiveness analysis of a rural telemedicine collaborative care intervention for depression.*Arch Gen Psychiatry, 67*(8), 812-821.

[426]Hollinghurst, S., Peters, T. J., Kaur, S., Wiles, N., Lewis, G., & Kessler, D. (2010). Cost-effectiveness of therapist-delivered online cognitive-behavioral therapy for depression: randomized controlled trial. *Br J Psychiatry, 197*(4), 297-304.

127373205.3.2	*3.IT-10.1*	*Quality of Life (Open Access)*	
The Helen Farabee Center/ Wise County			*127373205*
Related Category 1 or 2 Projects:	*127373205.1.2*		
Starting Point/Baseline:	*0 routine on demand psychiatric evaluations at Wise County to date*		
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-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment*:* $2,944	**Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment*:* $7,459	**Outcome Improvement Target 1** [IT-10.1]:Quality of Life-275,276,277 (*Stand-alone measure)* Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 5% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 1 Estimated Incentive Payment*:* $8,007	**Outcome Improvement Target 2** [IT-10.1]:Quality of Life-275,276,277 (*Stand-alone measure)* Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 10% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 2 Estimated Incentive Payment*:* $17,466
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $2,944	Year 3 Estimated Outcome Amount: $7,459	Year 4 Estimated Outcome Amount: $8,007	Year 5 Estimated Outcome Amount: $17,466
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:***$35,876			

Title of Outcome Measure (Improvement Target): IT-10.1- Quality of Life (Peer Support)

Unique RHP outcome identification number(s): 127373205.3.3
Performing Provider Name/TPI: Helen Farabee Centers / 127373205

Outcome Measure Description:

Process Milestones Outcome Improvement Targets for each year:
The outcome measure is designed to track improvement in quality of life scores as measured by the Adult Needs and Strengths Assessment (ANSA). The ANSA is a multipurpose tool developed for adult behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. It is the tool mandated for use by the Department of State Health Services within the Texas Recovery and Resiliency model of care. The process milestones are designed to track reporting of findings, lessons learned, and best practices to local stakeholders. This reporting summarizes the status of the referenced category 2 project implementation. The measurement time frame is one assessment 3 months post intake compared to a subsequent assessment 6 months later. This measurement time frame is chosen to avoid measuring any effects produced by the Open Access project (127373205.1.2). The expected improvement milestone for DY4 is to see improvement in quality of life, comparing assessments at 3 months with assessments at 6 months, as measured by the ANSA for 5% of adults receiving peer support services in Wise county. The milestone increases to 10% for year 5.

Rationale:
The process milestones were selected in order to provide stakeholders with status reports regarding the new interventions in Wise County. The outcome improvement target was selected in order to quantify any change in quality of life as the result of the new services.

Outcome Measure Valuation:
Applied a benefit-cost ratio of $3.71 per dollar invested.

The closest studies relating to valuation of peer support programs came from Sari et al. (2008)[427] who found the benefit-cost ratio for a peer support program related to preventing adolescent suicide was $3.71 for each dollar invested. Kuyken et al. (2008)[428], in another peer-support program for prevention of adolescent suicide, found a benefit cost ratio of $43 for each dollar invested for Native American Youth. The average benefit cost ratio between

[427]Sari, N., de Castro, S., Newman, F.L., & Mills, G. (2008). Should we invest in suicide prevention programs? *The Journal of Socio-Economics 37 (2008),* 262–275.
[428]Kuyken, W., Byford, S., Taylor, R. S., Watkins, E., Holden, E., White, K., . . . Teasdale, J. D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression.*J Consult ClinPsychol, 76(6)*, 966-978.

these two studies is $23.36, however since our target population contains little or no Native American represe
ntation, we chose the conservative amount of $3.71.

127373205.3.3	*3.IT-10.1*	*Quality of Life (Peer Support)*	
[The Helen Farabee Center/ Wise County]			*127373205*
Related Category 1 or 2 Projects:	*127373205.2.1*		
Starting Point/Baseline:	*0 Peer Services specific to Wise County to date.*		
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-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment*:* $8,034	**Process Milestone 2**[P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment*:* $18,205	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life-275,276,277 (*Stand-alone measure)* Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 5% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 1 Estimated Incentive Payment*:* $19,472	**Outcome Improvement Target 2** [IT-10.1]: Quality ofLife-275,276,277 (*Stand-alone measure)* Improvement Target: Demonstrate improvement in quality of life (QOL) scores, as measured by the CANS/ANSA assessment, for 10% of the target population. Data Source: Adult Needs and Strengths Assessment Outcome Improvement Target 2 Estimated Incentive Payment*:* $42,323
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $8,034	Year 3 Estimated Outcome Amount: $18,205	Year 4 Estimated Outcome Amount: $19,472	Year 5 Estimated Outcome Amount: $42,323
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:***$88,034			

Title of Outcome Measure (Improvement Target): IT-9.4 Other Outcome Improvement Target (Number of Telephonic Psychiatric Consultations)

Unique RHP outcome identification number(s): 127373205.3.4 (Pass 2)
Performing Provider Name: Helen Farabee Centers/127373205
Outcome Measure Description:

The outcome measure is designed to track the number of telephonic psychiatric consultation events between physicians in enrolled primary care settings and psychiatrists under contract with Helen Farabee Centers.

Rationale:
The process milestones related to project planning and disseminating findings were chosen to match the implementation and design activities associated with the project during DYs 2 and 3. The outcome improvement target was created in order to measure utilization of telephonic psychiatric consultation by enrolled primary care settings. These targets were established so that we would not only have some primary providers enrolled and satisfied with the service (per outcomes in Category 2), but that we would also respond to utilization patterns by refining the service so that it appeals to all enrolled providers.
Outcome Measure Valuation:
The valuation methodology is based on an assumed gain of 0.335 Quality Life Years gained by using the proposed project. One Quality Life Year is commonly estimated at $50,000. Assuming 15 clients were served in the program, the annual valuation is $251,250 ($50,000 x 0.335 = $16,750. $16,750 x 15 = $251,250).

We used Cost-utility Analysis (CUA), which measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses Quality-adjusted life years (QALY) analysis that combines health quality (utility) with the length of time in a particular health state. The benefits of the proposed program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard. One study examined collaborative care intervention for multisymptom patients including depression, diabetes, and coronary heart disease (Keaton, 2012).[429] In this study, the effect of the intervention was 0.335 incremental life years gained. This can be considered a conservative gain given that the study focused on depression, which is likely to be the most prevalent and least intense behavioral health condition presented in primary care settin

[429] Katon W, Russo J, Lin EH, Schmittdiel J, Ciechanowski P, Ludman E, Von Korff M. (2012). Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. *Arch Gen Psychiatry, 69(5),* 506-514.

127373205.3.4	*IT-9.4*	*Other Outcome Improvement Target*	
Helen Farabee Centers			*127373205*
Related Category 1 or 2 Projects:	*127373205.2.2*		
Starting Point/Baseline:	*No current telephonic psychiatric consultation services in Wise 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: Project Documentation Process Milestone 1 Estimated Incentive Payment: $8,996	**Process Milestone 2** [P-2]: Disseminate findings, including lessons learned and best practices, to stakeholders. Data Source: Project Documentation Process Milestone 2 Estimated Incentive Payment: $20,857	**Outcome Improvement Target 1** [IT-9.4]: Other Outcome Improvement Target: Number of telephonic psychiatric consultations in a primary care setting. Improvement Target: Telephonic psychiatric consultations completed with 50% of enrolled primary care settings. Data Source: Service Activity Database Outcome Improvement Target 1 Estimated Incentive Payment: $22,350	**Outcome Improvement Target 2** [IT-9.4]: Other Outcome Improvement Target: Number of telephonic psychiatric consultations in a primary care setting. Improvement Target: Telephonic psychiatric consultations completed with 60% of enrolled primary care settings. Data Source: Service Activity Database Outcome Improvement Target 2 Estimated Incentive Payment: $48,584
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $8,996	**Year 3 Estimated Outcome Amount: $20,857**	**Year 4 Estimated Outcome Amount: $22,350**	**Year 5 Estimated Outcome Amount: $48,584**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $100,787			

Title of Outcome Measure (Improvement Target): IT-2.4 Behavioral Health/Substance Abuse Admission Rate

Unique RHP outcome identification number(s): 130606006.3.1
Performing Provider Name/TPI: Wise Regional Health System/ 130606006

Outcome Measure Description:
In DY3 there will be program development and gathering baseline data from October 1, 2013 to September 30, 2014 through MedeAnalytics data reporting program at Wise Regional Health System on all discharges from acute medical and psychiatric services with the identified diagnostic codes for Behavioral Health/Substance Abuse. Data on these same metrics will be established in DY3 as well at North Texas Community Hospital. We will continue to develop and test data systems in DY3. The outcome is to reduce admission rates for persons with Behavioral Health/Substance Abuse in DY4 with an improvement target of 3% and in DY5 by 7.5% for IT-2.4. When compared to the denominator, the goal is a .55% reduction. We have estimated our reduction in BH/SA admissions with either primary or secondary diagnosis at the end of the Waiver to be 246.

The challenge and opportunity is to develop an Intensive Outpatient Program that addresses both Behavioral Health / Substance Abuse in order to reduce acute care costs associated with the use of higher cost services such as the ED,[430] Inpatient Psychiatric Facility, and acute care.

An Intensive Outpatient Program with evidence-based services[2] has the potential to make a proportional reduction in inpatient admissions for BH/SA target and reduce costs beyond the five-year projected time frame. This program development will also benefit the community at large by providing services to a target population that is underserved, that affects costs of medical health care, and has an impact on the cost of acute care and judicial services in the county.

Process Milestones and Outcome Improvement Targets for each year:
The following parameters are used in determining this outcome measure:

1. One for BH/SA as the principal diagnosis; The ranges/intervals/brackets of BH/SA codes as Principal Secondary Diagnosis is following:
    a. Numerator: All discharges for patients ages 18 years and older with a principal diagnosis of behavioral health or substance abuse (ICD 9 CM categories below).
        i. Behavioral Health codes: 290.X; 293.X-302.X; 306.7-306.9; 307.0-307.1; 307.3-307.7; 307.80, 307.89, 307.9; 308.X-309.X; 310.0, 310.1, 301.9; 311; 312.X –314.X; 315.0X- 315.2; 315.31-315.34, 315.39; 315.4-315.9; 316-319; 327.X; 388.45; 758.X-758.3X; 759.83; 780.02; 780.1; 780.50, 780.52; 780.54-780.59; 784.6X; 797; 799.2X; 799.51, 799.52, 799.54-799.59; V62.84; V71.0X.

[430] http://www.ahrq.gov/qual/nhqr11/nhqr11.pdf. National Health care Quality Report, 2011

ii. Substance Abuse codes: 291.X; 292.X; 303.X; 304.X; 305.0X; 305.2X-305.9X; 790.03.

b. Denominator: Number of residents age 18 and older living in the RHP counties

2. A second category in which a significant BH/SA secondary diagnosis is present. A list of the ranges/intervals/brackets of BH/SA codes as Secondary Diagnosis is following:
   a. Numerator: All discharges for patients ages 18 years and older with a principle or secondary diagnosis of behavioral health or substance abuse (ICD 9 CM categories below).
      i. Behavioral Health and Substance Abuse diagnosis codes: 290.11; 290.3; 390.41- 290.43; 290.8-290.9; 291.X; 292.0X-292.84; 292.89; 293.0X-293.84; 294.11, 294.21, 294.8; 295.X; 296.00-296.04; 296.2X-296.4X; 296.50-296.54; 296.6X-296.8X;298.X; 299.00, 299.80; 300.01-300.02, 300.11, 300.13, 300.21, 300.3, 300.81;301.51, 301.83; 303.01-303.02, 303.91-303.92; 304.00-304.02, 304.11-304.12,304.20-304.22, 304.31, 304.40, 304.42, 304.50, 304.70-304.72, 304.80-304.82,304.91; 305.01, 305.31, 305.41-305.42, 305.51-305.52, 305.61-305.62, 305.71-305.72, 305.81-305.82, 305.91; 307.1, 307.50-307.51; 308.1; 039.81; 312.00, 312.30, 312.34; 318.1-318.2l 348.39; 760.71-760.72; 965.0X, 965.6X; 967.0-967.1; 986.0; 969.1-969.6, 969.8-969.9; 970.1, 970.9; 977.0, 977.3; 995.5X; E950.X; E951.0-E957.1; E952.0-E952.1, E952.9; E953.0-E93.1, E953.9; E955.6, E957.X; V61.21,V62.84.
   b. Denominator: Number of residents age 18 and older living in the RHP counties

Rationale:

The focus in DY2 is to gather baseline data, plan processes and redesign a Behavioral Health /Substance Abuse Intensive Outpatient Program to reduce admission rates in acute care setting that are more costly. It is supported by statistical data from "Mede analytics" program at Wise Regional Health System that reflects 897 discharges for a primary diagnosis and 1904 for a secondary diagnosis of BH/SA-related disorders from acute medical and psychiatric services during October 2011 to September 2012. During this same time period North Texas Community Hospital showed discharges for a related primary diagnosis of 379 and secondary diagnosis of 101.

Outcome Measure Valuation:

- **Approach/Methodology:** Our valuation approach is consistent with the method within our RHP. We have estimated our reduction of BH/SA admissions with either primary or secondary diagnosis at 7.5%, or 246, from both hospitals by the end of the Waiver period. We take 246 and apply a value of $7,100 per admission to give us an annual value of $1,746,600 in cost savings. We then apply this for five years to get a total outcome value

of $8,733,000. The value is then distributed proportionately across the categories and demonstration years according to the allocation described in the Funding and Mechanics Protocol. This total represents approximately 74% of our total project value and was allocated accordingly.

- **Rationale/Justification:** The value of $7,100 per BH/SA admission was chosen by our RHP using data from AHRQ documented in the Health care Cost and Utilization Project.

130606006.3.1	*IT-2.4*	Behavioral Health/Substance Abuse (BH/SA) Admission Rate (**Stand-alone measure**)	
Wise Regional Health System			130606006
Related Category 1 or 2 Projects:	**130606006.2.1** Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.		
Starting Point/Baseline:	**<u>Target Population:</u>** **Specific Number: Based on 897 discharges with primary diagnosis and 1904 with a secondary diagnosis of BH/SA from acute medical and psychiatric inpatient services, 2801 total discharges from WRHS. NTCH had 379 discharges with primary diagnosis and 101 discharges with secondary diagnosis, 480 total discharges. Between both hospitals there were 3,281 total discharges meeting the definition of behavioral health/substance abuse.** **Description of Population: Target population is ED and Inpatient discharges from both hospitals meeting these requirements related to Behavioral Health/Substance Abuse for Wise County persons 18 years and older.** **Census for 2011 Estimate - 59,833 for Wise County.** **<u>Baseline data:</u>** **Diagnostic codes specified for primary Behavioral Health / Substance Abuse and second category in which BH/SA secondary diagnosis is present. Baseline will be established in DY3 once programs are in place.**		
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: Documentation of plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $182,022	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Population of Wise County, EMR data from WRHS and NTCH on BH/SA discharges Process Milestone 2 Estimated Incentive Payment: $210,988	**Outcome Improvement Target 1** [IT-2.4]: Behavioral Health/Substance Abuse (BH/SA) Admission Rate Improvement Target: Reduce admissions by 3%, or .22% of the denominator Data Source: Population of Wise County, EMR data from WRHS and NTCH Outcome Improvement Target 1 Estimated Incentive Payment*:* $338,561	**Outcome Improvement Target 2** [IT-2.4]: Behavioral Health/Substance Abuse (BH/SA) Admission Rate Improvement Target: Reduce admissions by 7.5%, or .55% of the denominator Data Source: Population of Wise County, EMR data from WRHS and NTCH Outcome Improvement Target 2 Estimated Incentive Payment*:* $809,604

130606006.3.1	*IT-2.4*	Behavioral Health/Substance Abuse (BH/SA) Admission Rate (**Stand-alone measure**)	
Wise Regional Health System			130606006
Related Category 1 or 2 Projects:	**130606006.2.1** Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.		
Starting Point/Baseline:	**<u>Target Population:</u>** **Specific Number: Based on 897 discharges with primary diagnosis and 1904 with a secondary diagnosis of BH/SA from acute medical and psychiatric inpatient services, 2801 total discharges from WRHS. NTCH had 379 discharges with primary diagnosis and 101 discharges with secondary diagnosis, 480 total discharges. Between both hospitals there were 3,281 total discharges meeting the definition of behavioral health/substance abuse.** **Description of Population: Target population is ED and Inpatient discharges from both hospitals meeting these requirements related to Behavioral Health/Substance Abuse for Wise County persons 18 years and older.** **Census for 2011 Estimate - 59,833 for Wise County.** **<u>Baseline data:</u>** **Diagnostic codes specified for primary Behavioral Health / Substance Abuse and second category in which BH/SA secondary diagnosis is present. Baseline will be established in DY3 once programs are in place.**		
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)**

130606006.3.1	*IT-2.4*	Behavioral Health/Substance Abuse (BH/SA) Admission Rate (**Stand-alone measure**)	
Wise Regional Health System			130606006
Related Category 1 or 2 Projects:	**130606006.2.1** Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.		
Starting Point/Baseline:	**<u>Target Population:</u>** **Specific Number: Based on 897 discharges with primary diagnosis and 1904 with a secondary diagnosis of BH/SA from acute medical and psychiatric inpatient services, 2801 total discharges from WRHS. NTCH had 379 discharges with primary diagnosis and 101 discharges with secondary diagnosis, 480 total discharges. Between both hospitals there were 3,281 total discharges meeting the definition of behavioral health/substance abuse.** **Description of Population: Target population is ED and Inpatient discharges from both hospitals meeting these requirements related to Behavioral Health/Substance Abuse for Wise County persons 18 years and older.** **Census for 2011 Estimate - 59,833 for Wise County.** **<u>Baseline data:</u>** **Diagnostic codes specified for primary Behavioral Health / Substance Abuse and second category in which BH/SA secondary diagnosis is present. Baseline will be established in DY3 once programs are in place.**		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $182,022	Year 3 Estimated Outcome Amount: $210,988	Year 4 Estimated Outcome Amount: $338,561	Year 5 Estimated Outcome Amount: $809,604
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,541,175			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Unique RHP outcome identification number(s): 130606006.3.2
Performing Provider Name/TPI: Wise Regional Health System/ 130606006

Outcome Measure Description:
IT-10-1 Quality of Life is also a stand-alone measure and the SF-36, GAF or other standardized tool will be used to evaluate functional status with an overall goal of increasing functional status by 50% of patients as reported by the chosen evidence-based survey methods at the end of DY5.

Process Milestones and Outcome Improvement Targets for each year:
In DY2 will determine the most appropriate tool to be used with this combined target population of Behavioral Health/Substance Abuse single and dually diagnosed persons that will demonstrate evidence-based quality of life scores. This phase includes the training of staff, purchasing software, group materials, establishing data requirements. This involves establishing the method of evaluating quality of life and the protocols around delivery of the method.

In DY3 will establish baseline data. This will be based on surveys showing improvement in quality of life. Baseline data on improvement will be measured by evidence-based assessment tool. Goal is to establish evidence-based services in an Intensive Outpatient Program that will meet the needs of the population and provide positive outcomes[431].

In DY4 and DY5 the improvement targets are implemented, services are maintained and expanded, and data collection will focus on improving quality of life and functions. The improvement target in DY4 will be 33% of patients and 50% in DY5. Completion of substance abuse treatment is strongly associated with improved outcomes, such as long-term abstinence from substance use[432].

Rationale:
The focus in DY2 is project planning and gathering quality of life data of persons with Behavioral Health /Substance Abuse diagnosis in an Intensive Outpatient Program. Develop interventions that promote evidence-based outcomes that produce improved quality of life by reducing symptoms, increase functioning, maintain pre-morbid level of functioning, and engaging the patients in their own care and treatment.[433] In DY3 we will develop baseline data. In DY4 improve quality of life for 33% of patients and in DY5 improve to 50% of patients based upon estimates of 6 discharges per month. These estimates project an increase in functional status of 24 patients at the end of DY4 and 36 patients at the end of DY5. The scope of the

[431] Evidence-Based Effectiveness of a Private Practice Intensive Outpatient Program With Dual Diagnosis Patients. Edward A. Wise *Journal of Dual Diagnosis*, 6:25–45, 2010

[432] http://www.ahrq.gov/qual/nhqr11/nhqr11.pdf. National Health care Quality Report, 2011
[433] Prince PN, Prince CR. Subjective quality of life in the evaluation of programs for people with serious and persistent mental illness. *Clin Psychol Rev* 2001; 21: 1005–1036.

project offers alternative community-based intensive services that provide a continuum of care to persons that will impact and improve their level of functioning, reduce symptoms, decrease recidivism in more costly services, and maintain the patient in the community as functioning citizens. This program would cover a wide age range including person's age 18 years of age up to and including our aging and geriatric population.

Outcome Measure Valuation:

- **Approach/Methodology:** This QALY value suggests a quality-adjusted life year for patients with co-occurring mental health and substance abuse to be a factor of 0.335 X $50,000 for each patient[434]. We used this QALY factor and multiplied it by our anticipated DY5 number of patients showing an improvement in quality of life measures, then multiplied times five years. This results in 0.335 X $50,000 X 36 patients times five years = $3,015,000.

This outcome value represents approximately 26% of the total value of the project and was allocated accordingly.

- **Rationale/Justification:** Valuations should be based on economic evaluation principles which identify, measure, and value the relevant costs and consequences of two or more alternatives. Typically, one alternative is a new program while the second is treatment as usual. Cost-utility analysis measures the cost of the program in dollars and the health consequences in utility-weighted units. This valuation uses quality adjusted life-years (QALYs) which combines health quality (utility) with length of time in a particular health state.

Cost-utility analysis is a useful tool for assessing the value of new health service interventions due to the fact that it provides a standard way of valuing multiple types of interventions and programs. The valuation also incorporates costs averted when known. In order to make the valuations fair across potentially different types of interventions, the common health goal, or outcome, is the number of life-years added.

The benefits of the proposed co-location program are valued based on assigning a monetary value of $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

[434] Katon W, Russo J, Lin EB et al. (2012). Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial. *Arch Gen Psychiatry*. 69(5):506-514.

130606006.3.2	*IT-10.1*	Quality of Life/Functional Status	
Wise Regional Health System			130606006
Related Category 1 or 2 Projects:	**130606006.2.1** Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population.		
Starting Point/Baseline:	**Target Population:** **Specific Number: Based on estimated starting census of 20 for IOP in DY3, 30 in DY4, and 40 in DY5, 33% or 24 patients in DY4 and 50% or 36 patients at the end of DY5.** **Description of Population: Behavioral Health/Substance Abuse for persons 18 years and older in Wise County with Medicaid, Medicare, are dually eligible, are insured or uninsured** **Baseline data:** **Quality of life improvement for Behavioral Health / Substance Abuse patient in IOP over a period of 1 year or at discharge. Baseline data will be collected 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 and establishing appropriate tools for assessing quality of life. Data Source: Documentation showing evidence-based and Standardized tools for assessment. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $62,842	**Process Milestone 2 [P-2]** Establish baseline data Data Source: Survey Results from Evidence-based and Standardized tools for assessment such as SF-36, GAF, or other standardized tools Process Milestone 2 Estimated Incentive Payment: $72,842	**Outcome Improvement Target 1** [IT- 10-1]: Improve quality of life for 33% of patients Data Source: Survey Results from Evidence-based and Standardized tools for assessment such as SF-36, GAF, or other standardized tools Outcome Improvement Target 1 Estimated Incentive Payment*:* $116,886	**Outcome Improvement Target 2** [IT-10-1]: Improve quality of life for 50% of patients Data Source: Survey Results from Evidence-based and Standardized tools for assessment such as SF-36, GAF, or other standardized tools Outcome Improvement Target 2 Estimated Incentive Payment*:* $279,509
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $62,842	Year 3 Estimated Outcome Amount: $72,842	Year 4 Estimated Outcome Amount: $116,886	Year 5 Estimated Outcome Amount: $279,509
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $532,078			

Title of Outcome Measure (Improvement Target): IT-3.1 All cause 30 day readmission rate-NQF 1789

Performing Provider Name: Wise Regional Health System/130606006
Unique RHP outcome identification number(s): 130606006.3.5 (Pass 3)

Outcome Measure Description:
We propose to establish and verify the baseline in DY2. Based upon 2011 data our total all cause 30 day readmissions were 295 over 5,285 total inpatient admissions, giving us a readmission rate of 5.6%. Our goal is to reduce our readmissions by 3%, or 9 total readmissions, by the end of DY3, 6% or 18 total readmissions over baseline in DY4, and have reduced our total readmissions by 10% or 30 total readmissions by the end of the waiver in DY5.

Rationale:
We chose the process milestone of verifying our readmission rates in DY2 so that we can be sure of our starting point on which to improve. We chose to begin improvement in DY3 because we believe a 3% reduction is attainable. We chose goals that have been proven attainable through similar models of care transitions programs for DY4 and DY5.

Outcome Measure Valuation:
In order to value this project we used the combination of the values provided by our RHP for the two measures, all cause 30-day readmissions and CHF admissions. The value of $7,491 per all cause 30 day readmission was chosen by our RHP using data from the Texas Department of State Health Services. The value of $8,252 per CHF admission was chosen by our RHP using data from the Texas Department of State Health Services. Based upon 2011, data our total all cause 30 day readmissions were 295 over 5,285 total inpatient admissions, giving us a readmission rate of 5.6%. Our goal is to reduce our readmissions by 10% over baseline, or 30 total readmissions by the end of the waiver in DY5.

In addition, we wish to reduce CHF admissions by 10% or 14, with regard to the DY1 CHF admission total of 138. The total value of this project is $3,917,887.

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Wise Regional Health System has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

Wise Regional Health System defined the population that will be directly impacted by the project as All Cause 30 day Readmissions. The percentage of the population expected to be positively impacted by the project is 10**%,** which was determined based on studies of similar projects

implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *2***.** We believe this to be the correct number because, when a person is positively impacted, their quality of life is moderately impacted.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 2**.** We believe this to be the correct number because, when a person is positively impacted, their dependence on the community is moderate.

The value of $7,491 per all cause 30 day readmission was chosen by our RHP using data from the Texas Department of State Health Services.

13060606.3.5	*IT-3.1*	All cause 30 day readmission rate- NQF 1789 (**Standalone measure**)	
Wise Regional Health System			*130606006*
Related Category 1 or 2 Projects:	*130606006.2.2*		
Starting Point/Baseline:	*2011 Data shows 295 readmissions over 5,285 inpatient admissions*		
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 (verify) baseline rates Data Source: EMR Reporting System Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $54,467	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate- NQF 1789 (Standalone measure) Improvement Target: 3% or 9 over baseline Data Source: EMR Reporting System Outcome Improvement Target 1 Estimated Incentive Payment*:* $63,134	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate- NQF 1789 (Standalone measure) Improvement Target:6% or 18 over baseline Data Source: EMR Reporting System Outcome Improvement Target 2 Estimated Incentive Payment*:* $101,308	**Outcome Improvement Target 3** [IT-3.1]: All cause 30 day readmission rate- NQF 1789 (Standalone measure) Improvement Target:10% or 30 over baseline Data Source: EMR Reporting System Outcome Improvement Target 3 Estimated Incentive Payment*:* $242,259
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $54,467	Year 3 Estimated Outcome Amount: $63,134	Year 4 Estimated Outcome Amount: $101,308	Year 5 Estimated Outcome Amount: $242,259
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $461,169			

Title of Outcome Measure (Improvement Target): IT-2.1 Congestive Heart Failure Admission rate (CHF)-PQI #8 Standalone measure

Performing Provider Name: Wise Regional Health System/130606006
Unique RHP outcome identification number(s): 130606006.3.6 (Pass 3)

Outcome Measure Description:
We propose to establish and verify the baseline in DY2. Based upon DY1 data our total CHF admissions were 138. Our goal is to reduce our CHF admissions by 10% by the end of DY5.

Rationale:
We chose the process milestone of verifying our admission rates in DY2 so that we can be sure of our starting point on which to improve.

Outcome Measure Valuation:
In order to value this project we used the combination of the values provided by our RHP for the two measures, all cause 30-day readmissions and CHF admissions. The value of $7,491 per all cause 30 day readmission was chosen by our RHP using data from the Texas Department of State Health Services. The value of $8,252 per CHF admission was chosen by our RHP using data from the Texas Department of State Health Services. Based upon 2011, data our total all cause 30 day readmissions were 295 over 5,285 total inpatient admissions, giving us a readmission rate of 5.6%. Our goal is to reduce our readmissions by 10% over baseline, or 30 total readmissions by the end of the waiver in DY5.

In addition, we wish to reduce CHF admissions by 10% or 14, with regard to the DY1 CHF admission total of 138. The total value of this project is $3,917,887.

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Wise Regional Health System has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

Wise Regional Health System defined the population that will be directly impacted by the project as All Cause 30 day Readmissions. The percentage of the population expected to be positively impacted by the project is 10**%,** which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a *2***.** We believe this to be the correct number because, when a person is positively impacted, their quality of life is moderately impacted.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 2**.** We believe this to be the correct number because, when a person is positively impacted, their dependence on the community is moderately.

The value of $8,252 per CHF admission was chosen by our RHP using data from the Texas Department of State Health Services.

130606006.3.6	*IT-2.1*	Congestive Heart Failure Admission rate (CHF)- PQI #8 (**Standalone measure**)	
Wise Regional Health System			*130606006*
Related Category 1 or 2 Projects:	*130606006.2.2*		
Starting Point/Baseline:	*DY1 Data shows 138 CHF admissions*		
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 (verify) baseline rates Data Source: EMR Reporting System Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $28,068	**Outcome Improvement Target 1** [IT-2.1]: Congestive Heart Failure admission rate- PQI #8 (Standalone measure) Improvement Target: 3% over baseline Data Source: EMR Reporting System Outcome Improvement Target 1 Estimated Incentive Payment*:* $32,534	**Outcome Improvement Target 2** [IT-3.1]: Congestive Heart Failure admission rate- PQI #8 (Standalone measure) Improvement Target:6% over baseline Data Source: EMR Reporting System Outcome Improvement Target 2 Estimated Incentive Payment*:* $52,206	**Outcome Improvement Target 3** [IT-3.1]: Congestive Heart Failure admission rate- PQI #8 (Standalone measure) Improvement Target:10% over baseline Data Source: EMR Reporting System Outcome Improvement Target 3 Estimated Incentive Payment*:* $124,841
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $28,068	Year 3 Estimated Outcome Amount: $32,534	Year 4 Estimated Outcome Amount: $52,206	Year 5 Estimated Outcome Amount: $124,841
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $237,649			

Title of Outcome Measure (Improvement Target): IT-9.2 Reduce Pediatric Emergency Department Visits

Unique RHP outcome identification number(s): - 130606006.3.7 (Pass 3b)
Performing Provider Name/TPI: Wise Regional Health System/130606006

Outcome Measure Description:
Decrease inappropriate Emergency Department use by expanding access to pediatric primary care. Specific percentage of reduction will be determined during baseline measurement in DY2 and implemented in DY3. This project estimates a reduction of 13% of ED pediatric visits within Wise County. Data will come from Wise Regional Health System, but other area hospitals will be impacted by this project.

Rationale:
The process milestones selected were chosen top show project planning in DY1 and dissemination of information to help reduce pediatric ED visits for all stakeholders in DY2. The coordination to reduce pediatric ED visits must come from several different sources. Education for providers and patients is required. Education must take place in local primary care clinics as well as the planned pediatric clinic.

Outcome Measure Valuation:
For this category 3 outcome, we took the value of the outcome in relation to the project and applied it evenly across the milestones. The value associated with this outcome was $7,417,271

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Wise Regional Health System has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B. When calculating the total value, this project is valued at $17,177,531.

Wise Regional Health System defined the population that will be directly impacted by the project as pediatric patients receiving care in two separate settings**.** One outcome measure is pediatric ED admissions and the other outcome measures clinic setting visits. The percentage of the population expected to be positively impacted by the project is 13% on the hospital side, which was determined based on studies of similar projects implemented elsewhere. The number of patients impacted by this project are as follows DY1 5600, DY2 5650, DY3 5700, DY4 5800, and DY 5 5905. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

We also estimated the number of pediatric patient visits and calculated value based upon third day next available appointments.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3**.** We believe this to be the correct number because, when a person is positively impacted, their whole family is impacted since this project targets pediatric patients. Not only is the health of the child improved but time efficiency for families is improved.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, when a person is positively impacted, their dependence on the community is decreased.

130606006.3.7	*IT-9.2*	ED appropriate utilization (Stand-alone measure)	
Wise Regional Health System			130606006
Related Category 1 or 2 Projects:	130606006.1.1 Expand Pediatric Primary Care		
Starting Point/Baseline:	Target Population: Specific Number: Pediatric ED Visits Baseline data: Estimated 5900 pediatric ED visits in DY1		
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 implementations plans. Data Source: Documentation of plans Milestone 1 Estimated Incentive Payment *(maximum amount):* $78,126 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Documentation of baseline Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $78,127	**Process Milestone 3** [P-2]: Disseminate findings, including lessons learned and best practices to stakeholders. Data Source: Documentation of program Process Milestone 3 Estimated Incentive Payment: $90,558 **Outcome Improvement Target 1** [IT-9.2]: Pediatric ED visits Improvement Target: -Achieve 3% reduction in Emergency Department use-Data Source: EMR data from WRHS Outcome Improvement Target 1 Estimated Incentive Payment*:* $90,559	**Outcome Improvement Target 2** [IT-9.2]: Pediatric ED visits Improvement Target: -Achieve 8% reduction in Emergency Department use over baseline data. Data Source: EMR data from WRHS Outcome Improvement Target 2 Estimated Incentive Payment*:* $290,6301	**Outcome Improvement Target 3** [IT-9.2]: Pediatric ED visits Improvement Target:-Achieve 13% reduction in Emergency Department use over baseline data. Data Source: EMR data from WRHS Outcome Improvement Target 3 Estimated Incentive Payment*:* $694,987

130606006.3.7	*IT-9.2*	ED appropriate utilization (Stand-alone measure)	
Wise Regional Health System			130606006
Related Category 1 or 2 Projects:	130606006.1.1 Expand Pediatric Primary Care		
Starting Point/Baseline:	Target Population: Specific Number: Pediatric ED Visits Baseline data: Estimated 5900 pediatric ED visits in DY1		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $156,253	Year 3 Estimated Outcome Amount: $181,117	Year 4 Estimated Outcome Amount: $290,631	Year 5 Estimated Outcome Amount: $694,987
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,322,988			

Title of Outcome Measure (Improvement Target): IT-1.1 Third next available appointments

Unique RHP outcome identification number(s): - 130606006.3.8 (Pass 3b)
Performing Provider Name/TPI: Wise Regional Health System/130606006

Outcome Measure Description:
IT-1.1 Third next available appointment. This is a commonly accepted measure used to determine a patient's ability to access care. This measure utilizes the third next available appointment to determine the length of time between when initial contact is made to request an appointment and when the patient is seen. The third appointment is featured because the first and second available appointments may reflect openings created by patients cancelling appointments and thus does not accurately measure true accessibility. This measure is easily obtained and recorded, on a daily or weekly basis, by counting the number of days until an opening for the third next appointment is on the schedule. As this project is implemented, we will use this measure to determine improvements in patients' ability to access pediatric primary care services. The extent of improvement will be determined in during the project planning phase in DY2. It is anticipated that there will be a steady increase in accessibility over DY4 and DY5. It is estimated that the availability of next day appointments will increase by 5% per year over baseline in DYs 4&5, resulting a 10% overall increase.

Rationale:
WRHS has chosen these milestones and metrics based on the goals of the project, to improve access to pediatric primary care, while allowing for the implementation of the project in a logical manner. DY2 will consist of project planning, which involves identifying current capacity and needed resources while establishing timeline for implementation and determining outcome improvement targets. Additionally, stakeholder pediatric patient visits will be measured and accessed. DY3 will be used to determine baseline rates. As the project is implemented, DY4 and DY5 will see improvement in the baseline rate, the extent of this improvement will be determined in DY2, the planning process. It is estimated that the availability of next day appointments will increase by 5% per year over baseline in DYs 4&5, resulting a 10% overall increase.

Outcome Measure Valuation:
For this category 3 outcome, we took the value of the outcome in relation to the project and applied it evenly across the milestones. We estimated 1,645 visits per year. The value associated with this outcome was $9,725,502. This value reflects expanded capacity to 8,225 pediatric patients over 5 years. Using the funding distribution formula, the achievement of this outcome has a 5 year value of $1,734,698.

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Wise Regional Health System has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B. When calculating the total value, this project is valued at $17,177,531.

Wise Regional Health System defined the population that will be directly impacted by the project as pediatric patients receiving care in two separate settings**.** One outcome measure is pediatric ED admissions and the other outcome measures clinic setting visits. The percentage of the population expected to be positively impacted by the project is 13% on the hospital side, which was determined based on studies of similar projects implemented elsewhere. The number of patients impacted by this project are as follows DY1 5600, DY2 5650, DY3 5700, DY4 5800, and DY 5 5905. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project. We also estimated the number of pediatric patient visits and calculated value based upon third day next available appointments.
To determine the value to each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3**.** We believe this to be the correct number because, when a person is positively impacted, their whole family is impacted since this project targets pediatric patients. Not only is the health of the child improved but time efficiency for families is improved.

To determine the value to the community of each individual positively impacted, we concluded that, on a scale of 1 – 5, the value of this project is a 3. We believe this to be the correct number because, when a person is positively impacted, their dependence on the community is decreased.

30606006.3.8	*IT-1.1*	*Third next available appointment*	
Wise Regional Health System			*130606006*
Related Category 1 or 2 Projects:	*130606006.1.1 Expand Pediatric Primary Care*		
Starting Point/Baseline:	*Target Population:* *Specific Number: Pediatric clinic visits* *Baseline data:* *To be determined. Will come from primary care and pediatric clinic visit impact.*		
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 implementations plans. Data Source: Documentation of plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $204,878	**Process Milestone 2** [P-2]: Disseminate findings, including lessons learned and best practices to stakeholders. Data Source: Documentation of program Process Milestone 2 Estimated Incentive Payment: $118,740 **Process Milestone 3** [P-2]: Establish baseline rates Data Source: Documentation of baseline visits Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $118,741	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment Improvement Target: -Achieve 5% increase in third next day available appointments over baseline-Data Source: EMR data Outcome Improvement Target 1 Estimated Incentive Payment*:* $381,074	**Outcome Improvement Target 2** [IT-1.1]: Third next available appointment Improvement Target: -Achieve 10% increase in third next day available appointments over baseline data.-Data Source: EMR data Outcome Improvement Target 2 Estimated Incentive Payment*:* $911,265

30606006.3.8	*IT-1.1*	*Third next available appointment*	
Wise Regional Health System			*130606006*
Related Category 1 or 2 Projects:	*130606006.1.1 Expand Pediatric Primary Care*		
Starting Point/Baseline:	*Target Population:* *Specific Number: Pediatric clinic visits* *Baseline data:* *To be determined. Will come from primary care and pediatric clinic visit impact.*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $204,878	Year 3 Estimated Outcome Amount: $237,481	Year 4 Estimated Outcome Amount: $381,074	Year 5 Estimated Outcome Amount: $911,265
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,734,698			

Title of Outcome Measure (Improvement Target): Primary Care and Chronic Disease Management IT-1.10 Diabetes care: HbA1c poor control (>9.0%)

Unique RHP outcome identification number(s): 130614405.3.1
Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Outcome Measure Description:
By the end of the Waiver, our goal is to decrease the number of diabetes clinic participants whose HbA1c is > 9.0 by 15%.
Process Milestones:

- In DY2, we will:
  - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
  - Develop and test reporting and monitoring process to evaluate
- Establish the baseline for this rate.
- In DY3, our goal is to reduce this rate by 4%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress

Outcome Improvement Targets for each year:

- In DY4, the goal is to reduce number of patients with diabetes patients whose HbA1c is > 9.0 by 10% from baseline.
- In DY5 the goal is to reduce number of patients with diabetes patients whose HbA1c is > 9.0 by 15% from baseline.

Rationale:
The goal of this project is to develop and implement a more comprehensive diabetes education center/medical home to help reduce the rates of uncontrolled diabetes among project participants. Our goal is to improve the health outcomes and diabetes self-management competency of community residents in Tarrant County by forming a multidisciplinary team, including a nurse practitioner run Chronic Care Clinic based on Wagner's model, to more effectively assist and monitor patients in the management of their diabetes.

THAM data indicates that Medicaid and uninsured patients make up about 40% of our payer mix of those treated and released from the ED and approximately 30% of inpatient population. In our service area the Hispanic community makes up approximately 31% of the population and is the fastest growing ethnicity in Arlington. Hispanic people are about 1.5 times more likely to develop diabetes than non-Hispanic, white people. In the current THAM Outpatient Diabetes Education Program, approximately 75% of those served are Caucasian, indicating a need for innovation and creativity to reach this population. By developing a comprehensive diabetes clinic available to unfunded or government-funded members in the community, individuals

previously struggling to obtain medical care will have access to the care they need to more effectively manage their diabetes.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient nurse-practitioner run diabetes clinic, expanding on the existing diabetes self-management education service currently provided to our patients. In DY2, we will also develop a mechanism for identifying and tracking high-risk diabetic patients and monitoring effectiveness of interventions (enhanced education, self-management coaching, closer monitoring of medical condition, postdischarge telephonic case management,…) to begin analysis of our information and determine potential improvement opportunities.

In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project.

In DY4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology:** For every inpatient admission avoided, $8297 in cost is saved by the health care system.[435] Health care costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[435] Based on 2011 historical inpatient diabetes admissions data for Texas Health Arlington Memorial

130614405.3.1	*3.IT-1.10*	*Primary Care and Chronic Disease Management* *1.10 Diabetes care: HbA1c poor control (>9.0%)*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in DY2. Preliminary data indicates approximately 500 patients with diabetes are seen in the Diabetes Clinic, but data related to successful management HbA1c is not available. **Target Population:** Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 1,000 patients with diabetes annually by DY5. **Description of Population:** Individuals with diabetes living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 1 [P- 1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $**2,617** **Milestone 2** [P- 2] Establish baseline rates Data Source: EMR, laboratory data Milestone 2 Estimated Incentive Payment *(maximum amount):* $**2,616** **Milestone 3** [P-3] Develop and test data systems Data Source: Internally developed database using EMR clinic data to monitor project and produce reports. Milestone 3 Estimated Incentive	**Milestone 4** [P- 4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $**4,137** **Milestone 5** [P- 5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment: $**4,136** **Outcome Improvement Target 6** **[IT-1.10]** Diabetes care: HbA1c poor control (>9.0%), Rate of participants	**Outcome Improvement Target 1** **[IT-1.10]** Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Improvement Target: 10% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $**13,274**	**Outcome Improvement Target 2** [**IT-1.10]** Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Improvement Target: 15% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment*:* $**31,743**

130614405.3.1	*3.IT-1.10*	*Primary Care and Chronic Disease Management 1.10 Diabetes care: HbA1c poor control (>9.0%)*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in DY2. Preliminary data indicates approximately 500 patients with diabetes are seen in the Diabetes Clinic, but data related to successful management HbA1c is not available. **Target Population:** Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 1,000 patients with diabetes annually by DY5. **Description of Population:** Individuals with diabetes living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Payment: $ **2,616**	with HbA1c > 9.0 Improvement Target: 4% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment: $**4,136**		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**7,850**	Year 3 Estimated Outcome Amount: $**12,409**	Year 4 Estimated Outcome Amount: $**13,274**	Year 5 Estimated Outcome Amount: $**31,743**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**65,276**			

Title of Outcome Measure (Improvement Target): Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) - IT.3.3 Diabetes 30-day readmission rate

Unique RHP outcome identification number(s): 130614405.3.2
Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Outcome Measure Description:
By the end of the Waiver, our goal is to decrease 30 day readmission (all-cause) for diabetes patients by 15%.
Process Milestones:

- In DY2, we will:
  - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
  - Develop and test reporting and monitoring process to evaluate
- Establish the baseline for this rate.
- In DY3, our goal is to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress

Outcome Improvement Targets for each year:

- In DY4, the goal is to reduce diabetes patient readmissions by 10% from baseline
- In DY5 the goal is to reduce diabetes patient readmissions by 15% from baseline.

Rationale:
The goal of this project is to develop and implement a more comprehensive diabetes education center/medical home to help reduce the rates of uncontrolled diabetes among project participants. Our goal is to improve the health outcomes and diabetes self-management competency of community residents in Tarrant County by forming a multidisciplinary team, including a nurse practitioner run Chronic Care Clinic based on Wagner's model, to more effectively assist and monitor patients in the management of their diabetes.

According to THAM data, diabetes was the fourth highest readmission diagnosis. Data from August 2011 through July 2012 indicate a 30-day readmission rate of over 19%. Additionally, 10% of the THAM service area has been diagnosed with diabetes. Based on THAM outpatient diabetes education data, the program is underutilized in comparison with the service area diabetic population. Our proposed intervention will help individuals who are traditionally underserved and give them access to diabetes education and regular clinical care so they can better manage their diabetes and prevent hospital readmissions.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the

finalization of plans and implementation of an outpatient nurse-practitioner run diabetes clinic, expanding on the existing diabetes self-management education service currently provided to our patients. In DY2, we will also develop a mechanism for identifying and tracking high-risk diabetic patients and monitoring effectiveness of interventions (enhanced education, self-management coaching, closer monitoring of medical condition, postdischarge telephonic case management) to begin analysis of our information and determine potential improvement opportunities.

In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project.

In DY4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology:** For every inpatient readmission avoided, $8297 in cost is saved by the health care system. Healthc are costs are calculated by multiplying $8297 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g., aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

130614405.3.2	*3.IT-3.3*	*Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT-3.3 Diabetes 30-day readmission rate*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in DY2. Preliminary data indicates a 30-day readmission rate at approximately 19%. **Target Population:** Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 1,000 patients with diabetes annually by DY5. **Description of Population:** Individuals with diabetes living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $**2,617** **Milestone 2** [P-2]: Establish baseline rates Data Source: Database including patient administrative and coding/billing information such as Premier Quality Advisor identified and baseline rate confirmed Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $**2,616**	**Milestone 4 [**P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Process Milestone 4 Estimated Incentive Payment: $**6,205** **Milestone 5** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Process Milestone 5 Estimated Incentive Payment: $**6,204**	**Outcome Improvement Target 1 [IT-3.3]** Diabetes 30-day readmission rate (**Stand-alone measure**) Improvement Target: 10% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment*:* $**13,274**	**Outcome Improvement Target 2 [IT-3.3]:** Diabetes 30-day readmission rate (**Stand-alone measure**) Improvement Target: 15% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $**31,743**

130614405.3.2	*3.IT-3.3*	*Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT-3.3 Diabetes 30-day readmission rate*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in DY2. Preliminary data indicates a 30-day readmission rate at approximately 19%. **Target Population:** Low income, disadvantaged community members with a diagnosis of diabetes that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 1,000 patients with diabetes annually by DY5. **Description of Population:** Individuals with diabetes living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 3 [P-3]: Develop and test data systems Data Source: Internally developed database using EMR data to monitor project and produce reports. Process Milestone 3 Estimated Incentive Payment: $**2,616**			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**7,850**	Year 3 Estimated Outcome Amount: $**12,409**	Year 4 Estimated Outcome Amount: $**13,274**	Year 5 Estimated Outcome Amount: $**31,743**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**65,276**			

Title of Outcome Measure (Improvement Target): Potentially Preventable Admissions: 3.IT-2.1 Congestive Heart Failure Admission rate (CHF) - PQI #8

Unique RHP outcome identification number(s): 130614405.3.3
Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Outcome Measure Description:
By the end of the Waiver, our goal is to decrease congestive heart failure patient admission rates will decrease from 0.20% to 0.18% within our community – a 10.5% reduction over the five-year project.

	DY2	DY3	DY4	DY5
Admissions	315	308	290	282
Total Population	159520	159520	159520	159520
Admission Rate	0.20%	0.19%	0.19%	0.18%

Process Milestones:
In DY2, we will:

- Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes, and obtaining necessary supplies, space and equipment
- Develop and test reporting and monitoring process to evaluate effectiveness
- Establish the baseline for this rate. An initial data pull from our database shows that the baseline rate is close to 315 patients annually with principal diagnosis of heart failure.

Outcome Improvement Targets for each year:

- In DY3, our goal is to conduct performance improvement projects, to work towards further reductions and to disseminate information to key stakeholders regarding our progress
- In DY4, to reduce HF patient admissions by 8% from baseline, and in DY5 to reduce HF patient admissions by 10.5% from baseline (from 0.20% to 0.18% of total community members requiring admission with principal diagnosis of heart failure).

Rationale:

The target population includes disadvantaged individuals with HF who are at risk for hospital admission due to lack of access to health care resources. The project's goal is to identify at risk patients presenting in the emergency department or within the community, determine resources needed, and facilitate them obtaining the necessary supplies, medications, education and health care in order to effectively monitor and manage their chronic disease.
* Heart failure is among Texas Health Arlington Memorial hospital's top reasons for admission with 316 patients admitted with a primary diagnosis of heart failure and 1,947

patients admitted with primary/secondary diagnosis of heart failure between June 2011 and May 2012. Readmission rates for these patients are near 22%.
*. There were 13,272 hospitalizations of North Texas HF patients who were followed by a readmission in 2011[436].
Requests for assistance with health care expenses is now among the top 10 unmet needs within the community, with an increase of 42% from last year.[437] The development of a Heart Failure Clinic would provide an option for patients in our community who do not have financial resources to receive care.
The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient nurse-practitioner run heart failure clinic including hiring and training hospital and clinic staff in Wagner's Chronic Care model and processes being implemented to improve care and education of the at risk HF patient. Time will also be spent communicating information to area health care providers and community members about the availability of the HF Clinic to assist at-risk HF patients in maintaining wellness. In DY2, we will also 1) develop a mechanism for identifying and tracking high-risk HF patients, 2) develop a screening tool to assist in identifying needs that put the HF patient at risk for admission 3) monitor effectiveness of interventions (education, medication reconciliation, ability to meet patient's identified health care need – medication, supplies, primary care provider, transportation to health care appointments – telemonitoring, post-discharge telephonic case management, RN home visits, HF Clinic etc.) and begin analysis of our information to determine potential improvement opportunities 4) collaborate with community health care providers to develop protocols to improve health of HF patients.
In DY3, performance improvement initiatives will be implemented based on opportunities identified from information learned through data collection and analysis. A reporting mechanism will be developed to disseminate information to key partners regarding the project.
In DY 4 and 5, the identified outcomes measures will monitor our effectiveness in achieving the desired outcome of preventing HF patient admissions. We will also continue to evaluate for improvement opportunities and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $8,252 in cost is saved by the health care system. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals

[436] Readmissions in North Texas. 2011. retrieved September 20, 2012 from http://www.dfwhcfoundation.org/wp-content/uploads/2012/09/Readmissions-in-North-Texas-2011final-2.pdf
[437] United Way of Tarrant County. 2011 Annual 2-1-1. report retrieved October 13, 2012 from http://www.unitedwaytarrant.org/about-us/2-1-1

affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up healthcare costs, individual costs, and community costs.

- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc.

130614405.3.3	*2.IT-2.1*	*Potentially Preventable Admissions: IT-2.1 Congestive Heart Failure Admission rate*	
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.2 Expand chronic care management models: redesign the outpatient delivery system to coordinate care for patients with chronic disease*		
Starting Point/Baseline:	**Baseline Data:** Preliminary data indicates approximately 315 patient admissions with principal diagnosis of heart failure annually. Another nearly 2,000 patient were admitted with a secondary HF diagnosis. Baseline data to be determined in DY2 **Target Population:** Low income, disadvantaged community members with a diagnosis of heart failure that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 1,000 HF patient contacts annually by DY5. **Description of Population:** Individuals with heart failure living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment: $**4,305** **Milestone 2 [**P-2]: Establish baseline rates Data Source: Database including patient administrative and coding/billing information such as Premier Quality Advisor identified and baseline rate confirmed Milestone 2 Estimated Incentive Payment: $ **4,304**	**Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $**6,804** **Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment: $**6,803**	**Outcome Improvement Target 2** [IT-2.1]: Congestive Heart Failure Admission rate Goal: decrease overall population requiring admission due to HF to 0.19% or by 8% from hospital baseline volume. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $**21,834**	**Outcome Improvement Target 3** [IT-2.1]: Congestive Heart Failure Admission rate Goal: decrease overall population requiring admission due to HF to 0.19% or by 10.5% from hospital baseline volume. Data Source: Identified database determined in DY2 Outcome Improvement Target 3 Estimated Incentive Payment*:* $**52,212**

130614405.3.3	*2.IT-2.1*	*Potentially Preventable Admissions: IT-2.1 Congestive Heart Failure Admission rate*	
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.2 Expand chronic care management models: redesign the outpatient delivery system to coordinate care for patients with chronic disease*		
Starting Point/Baseline:	**Baseline Data:** Preliminary data indicates approximately 315 patient admissions with principal diagnosis of heart failure annually. Another nearly 2,000 patient were admitted with a secondary HF diagnosis. Baseline data to be determined in DY2 **Target Population:** Low income, disadvantaged community members with a diagnosis of heart failure that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 1,000 HF patient contacts annually by DY5. **Description of Population:** Individuals with heart failure living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 3 [P-3]: Develop and test data systems Data Source: Internally developed database using EMR data to monitor project and produce reports. Milestone 3 Estimated Incentive Payment: $ **4,304**	**Outcome Improvement Target 1** [IT-2.1] Congestive Heart Failure admission rate Goal: decrease overall population requiring admission due to HF to 0.19% or by 2% from hospital baseline volume. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment*:* $**6,803**		

130614405.3.3	*2.IT-2.1*	*Potentially Preventable Admissions: IT-2.1 Congestive Heart Failure Admission rate*	
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.2 Expand chronic care management models: redesign the outpatient delivery system to coordinate care for patients with chronic disease*		
Starting Point/Baseline:	**Baseline Data:** Preliminary data indicates approximately 315 patient admissions with principal diagnosis of heart failure annually. Another nearly 2,000 patient were admitted with a secondary HF diagnosis. Baseline data to be determined in DY2 **Target Population:** Low income, disadvantaged community members with a diagnosis of heart failure that do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 1,000 HF patient contacts annually by DY5. **Description of Population:** Individuals with heart failure living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**12,913**	Year 3 Estimated Outcome Amount: $**20,410**	Year 4 Estimated Outcome Amount: $**21,834**	Year 5 Estimated Outcome Amount: $**52,212**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**107,368**			

Title of Outcome Measure (Improvement Target): Potentially Preventable Readmissions – 30 Day Readmission Rates (PPRs)- IT.3.2 Congestive Heart Failure 30-day readmission rate

Unique RHP outcome identification number(s): 130614405.3.4
Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Outcome Measure Description:
By the end of the Waiver, our goal is to decrease 30-day readmission (all-cause) for heart failure (HF) patients by 15%

Process Milestones:
In DY2, we will:

- Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
- Develop plans/protocols for HF Clinic managed by nurse practitioners. Obtain necessary supplies and equipment
- Develop and test reporting and monitoring process to evaluate
- Establish the baseline for this rate. An initial data pull from our database shows that the baseline rate may be as high as 22%;

Outcome Improvement Targets for each year:

- In DY3, our goal is to reduce this rate by 4%; to conduct performance improvement projects towards further reductions and to disseminate information to key stakeholders regarding our progress
- In DY4 and DY5: In DY4 our goal is to reduce HF patient readmissions by 10% from baseline and in DY5 to reduce HF patient readmissions by 15% from baseline.

Rationale:

The target population includes disadvantaged individuals HF who are at risk for readmission due to lack of access to health care resources. The project's goal is to identify at risk patients, determine resources needed, and provide them with the necessary supplies, medications, education and health care in order to effectively monitor and manage their chronic disease.
* Heart failure is among Texas Health Arlington Memorial hospital's top reasons for admission with 316 patients admitted with a primary diagnosis of heart failure and 1,947 patients admitted with primary/secondary diagnosis of heart failure between June 2011 and May 2012. Readmission rates for these patients are near 22%.
* According to a report published in 2011 on readmissions in North Texas, patients admitting for congestive heart failure (HF) had the highest number of readmissions (22.6%). HF was also the number one diagnosis resulting in readmission for both the Medicare and uninsured patients. There were 13,272 hospitalizations of North Texas HF patients who were followed by a readmission in 2011[438].

[438] Readmissions in North Texas. 2011. retrieved September 20, 2012 from http://www.dfwhcfoundation.org/wp-content/uploads/2012/09/Readmissions-in-North-Texas-2011final-2.pdf

Requests for assistance with health care expenses has increased by 42% from last year and is now among the top 10 unmet needs within the community.[439] The development of a Heart Failure Clinic would provide an option for patients in our community who do not have financial resources to receive care.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient nurse-practitioner run heart failure clinic including hiring and training hospital and clinic staff in Wagner's Chronic Care model and processes being implemented to improve care and education of the at risk HF patient. Evaluation of the need for additional Care Transitions coaches and PrimeMedics will also be completed and staff engaged/trained as needed. In DY2, we will also 1) develop a mechanism for identifying and tracking high-risk HF patients, 2) develop a screening tool to assist in identifying needs putting the HF patient at risk for readmission, 3) monitor effectiveness of interventions (education, medication reconciliation, ability to meet patients' identified health care need – medication, supplies, primary care provider, transportation to health care appointments, care transitions coach, telemonitoring, post-discharge telephonic case management, home visits, HF Clinic, etc.) and begin analysis of our information to determine potential improvement opportunities and 4) collaborate with community health care providers to develop protocols to improve health of HF patients post-hospital discharge and along the continuum of care.

In DY3, performance improvement initiatives will be implemented based on opportunities identified from information learned through data collection and analysis. A reporting mechanism will be developed to disseminate information to key partners regarding the project.

In DY4 and 5, the identified outcomes measures will monitor our effectiveness in achieving the desired outcome of preventing HF patient readmissions. We will also continue to evaluate for improvement opportunities and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $8,252 in cost is saved by the health care system. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher

[439] United Way of Tarrant County. 2011 Annual 2-1-1. report retrieved October 13, 2012 from http://www.unitedwaytarrant.org/about-us/2-1-1

incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).

- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

130614405.3.4	*3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.2 Expand chronic care management models: redesign the outpatient delivery system to coordinate care for patients with chronic disease*		
Starting Point/Baseline:	***Baseline Data:*** *Preliminary data indicates approximately 315 patient admissions with principal diagnosis of heart failure annually. Another nearly 2,000 patient were admitted with a secondary HF diagnosis. Baseline data to be determined in DY2 but preliminary data shows 3- day HF patient readmission rate near 21 - 22%* ***Target Population:*** *Low income, disadvantaged community members with a diagnosis of heart failure that do not have access to care.* ***Specific Number:*** *Numbers will vary but anticipate approximately 1,000 HF patients annually by DY5.* ***Description of Population:*** *Individuals with heart failure living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $**4,305** **Milestone 2** [P- 2]: Establish baseline rates Data Source: Database including patient administrative and coding/billing information such as Premier Quality Advisor identified and Baseline rate confirmed Milestone 2 Estimated Incentive Payment *(maximum amount):* $**4,304**	**Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $**10,205** **Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive Payment:	**Outcome Improvement Target 1** [IT-3.2]: Congestive Heart Failure 30-day readmission rate (**Stand-alone measure**) Improvement Target: 10% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment: $**21,834**	**Outcome Improvement Target 2** [IT-3.2]: Congestive Heart Failure 30-day readmission rate (**Stand-alone measure**) Improvement Target: 15% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment: $**52,212**

130614405.3.4	*3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.2 Expand chronic care management models: redesign the outpatient delivery system to coordinate care for patients with chronic disease*		
Starting Point/Baseline:	***Baseline Data:*** *Preliminary data indicates approximately 315 patient admissions with principal diagnosis of heart failure annually. Another nearly 2,000 patient were admitted with a secondary HF diagnosis. Baseline data to be determined in DY2 but preliminary data shows 3- day HF patient readmission rate near 21 - 22%* ***Target Population:*** *Low income, disadvantaged community members with a diagnosis of heart failure that do not have access to care.* ***Specific Number:*** *Numbers will vary but anticipate approximately 1,000 HF patients annually by DY5.* ***Description of Population:*** *Individuals with heart failure living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 3 [P-3]: Develop and test data systems Data Source: Internally developed database using EMR and other internal data to monitor project, track patients and produce reports that will provide information regarding effectiveness of interventions and gaps in meeting patient needs to prevent readmissions. Reports produced. Milestone 3 Estimated Incentive Payment: $**4,304**	$**10,205**		

130614405.3.4	*3.IT-3.2*	*Congestive Heart Failure 30-day readmission rate*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.2 Expand chronic care management models: redesign the outpatient delivery system to coordinate care for patients with chronic disease*		
Starting Point/Baseline:	***Baseline Data:*** *Preliminary data indicates approximately 315 patient admissions with principal diagnosis of heart failure annually. Another nearly 2,000 patient were admitted with a secondary HF diagnosis. Baseline data to be determined in DY2 but preliminary data shows 3- day HF patient readmission rate near 21 - 22%* ***Target Population:*** *Low income, disadvantaged community members with a diagnosis of heart failure that do not have access to care.* ***Specific Number:*** *Numbers will vary but anticipate approximately 1,000 HF patients annually by DY5.* ***Description of Population:*** *Individuals with heart failure living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**12,913**	Year 3 Estimated Outcome Amount: $**20,410**	Year 4 Estimated Outcome Amount: $**21,834**	Year 5 Estimated Outcome Amount: $**52,212**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**107,368**			

Title of Outcome Measure (Improvement Target): Perinatal Outcomes – IT-8.2 Percentage of Low Birth- weight births

Unique RHP outcome identification number(s): 130614405.3.5
Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Outcome Measure Description:

IT-8.2 Percentage of Low Birth- weight births

At the conclusion of the 5-year project, we expect a 10% reduction in the number of low birth weight infants delivered at our hospital.

Process Milestones:

- In DY2, we will:
  - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
  - Develop and test reporting and monitoring process to evaluate
  - Establish the baseline for this rate. An initial data pull from our database shows that the baseline rate may be over 10% of total births at the hospital.
- In DY3, our goal is to reduce this rate by 4%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress

Outcome Improvement Targets for each year:

In DY4, to reduce low birth weight infants by 6% from baseline, and in DY5 to reduce low birth weight infants by 10% from baseline.

Rationale:

There is currently no prenatal clinic available at Texas Health Arlington Memorial to serve these patients. Between January and August 2012, there were 1,382 (2,073 patients annualized) infant deliveries performed. Of these 45.2% (937 annualized) of the women were unfunded or Medicaid funded patients. Estimates indicate approximately 10.2% of the deliveries or over 200 infants at THAM are low birth weight or preterm.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient advanced practice nurse run prenatal clinic, hiring and training staff. In DY2, we will also develop a mechanism for identifying and tracking patients, monitoring the effectiveness of interventions implemented to retain patients in the program and impacting change to healthy behaviors. Analysis of our information will be completed to determine potential improvement opportunities.

In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project.

In DY4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology**: For every low birth-weight birth avoided, $29,000 in cost is saved by the health care system.[440] Health care costs are calculated by multiplying $29,000 by the total individuals affected.

- **Rationale/Justification:** Low birth-weight birth outcome improvement targets are dependent on the target population, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place.

There are no individual and community savings for this outcome.

[440] March of Dimes Foundation. *Data Book for Policy Makers: Maternal, Infant, and Child Health in the United States.* Washington, DC: March of Dimes; 2009.

130614405.3.5	*3.IT-8.2*	*Perinatal Outcomes – IT-8.2 Percentage of Low Birth-weight births*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.3: Implement Evidence-Based Disease Prevention Program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth*		
Starting Point/Baseline:	***Baseline Data:*** *The actual baseline data is not known, however preliminary data indicates that approximately 11% of babies born at THAM are low birth weight or preterm.* ***Target Population:*** *Low income, disadvantaged pregnant women without access to prenatal care.* ***Specific Number:*** *Numbers will vary but anticipate 950 - 1,200 patients annually* ***Description of Population:*** *Pregnant women living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 1 [P- 1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $**16,125** **Milestone 2** [P- 2]: Establish baseline rates Data Source: Database including patient administrative and coding/billing information such as Premier Quality Advisor identified and baseline rate determined	**Milestone 4** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $**38,230** **Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 5 Estimated Incentive	**Milestone 6 [IT-8.2]:** Percentage of Low Birth- weight births (CHIPRA/NQF # 1382) (**Stand-alone measure**)) Improvement Target: 6% reduction over baseline Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment*:* $**81,794**	**Milestone 7 [IT-8.2]:** Percentage of Low Birth- weight births (CHIPRA/NQF # 1382) (**Stand-alone measure**) Improvement Target: 10% reduction over baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $**195,594**

130614405.3.5	*3.IT-8.2*	*Perinatal Outcomes – IT-8.2 Percentage of Low Birth-weight births*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.3: Implement Evidence-Based Disease Prevention Program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth*		
Starting Point/Baseline:	***Baseline Data:*** *The actual baseline data is not known, however preliminary data indicates that approximately 11% of babies born at THAM are low birth weight or preterm.* ***Target Population:*** *Low income, disadvantaged pregnant women without access to prenatal care.* ***Specific Number:*** *Numbers will vary but anticipate 950 - 1,200 patients annually* ***Description of Population:*** *Pregnant women living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 2 Estimated Incentive Payment *(maximum amount):* $**16,124** **Milestone 3** [P- 3]: Develop and test data systems Data Source: Internally developed database using EMR data to monitor project and produce reports. Milestone 3 Estimated Incentive Payment: $ **16,124**	Payment: $**38,229**		

130614405.3.5	*3.IT-8.2*	*Perinatal Outcomes – IT-8.2 Percentage of Low Birth-weight births*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.3: Implement Evidence-Based Disease Prevention Program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth*		
Starting Point/Baseline:	***Baseline Data:*** *The actual baseline data is not known, however preliminary data indicates that approximately 11% of babies born at THAM are low birth weight or preterm.* ***Target Population:*** *Low income, disadvantaged pregnant women without access to prenatal care.* ***Specific Number:*** *Numbers will vary but anticipate 950 - 1,200 patients annually* ***Description of Population:*** *Pregnant women living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**48,373**	Year 3 Estimated Outcome Amount: $**76,459**	Year 4 Estimated Outcome Amount: $**81,794**	Year 5 Estimated Outcome Amount: $**195,594**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:$402,219**			

Title of Outcome Measure (Improvement Target): Perinatal Outcomes – IT-8.3 Early Elective Delivery (Medicaid Adult Core Measure/NQF #469)

Unique RHP outcome identification number(s): 130614405.3.6
Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Outcome Measure Description:

IT-8.3 Early Elective Delivery

At the conclusion of the 5-year project, we expect a 95% reduction in the number of early, elective deliveries.

Process Milestones:

- In DY2, we will:
  - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
  - Develop and test reporting and monitoring process to evaluate
  - Establish the baseline for this rate.
- In DY3, our goal is to reduce this rate by 50%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress

Outcome Improvement Targets for each year:

In DY4, our goal is to reduce low birth weight infants by 75% from baseline and in DY5 to reduce low birth weight infants by 95% from baseline.

Rationale:

There is currently no prenatal clinic available at Texas Health Arlington Memorial to serve these patients. In addition, the clinic run by the county hospital currently serving pregnant women in this area is scheduled to move to a new location outside of the geographic Region easily accessible to our at risk women. This effectively eliminates access to health care for many of these women. Between January and August 2012, there were 1,382 (2,073 patients annualized) infant deliveries performed. Of these 45.2% (937 annualized) of the women were unfunded or Medicaid funded patients. Through effective, ongoing prenatal care and education of the women regarding the risks associated with delivering infants at less than 39 weeks, we hope to decrease the rate of individuals requesting and receiving elective induction of labor for non-medical reasons prior to 39 weeks gestation.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much of the focus in DY2 will be on the finalization of plans and implementation of an outpatient advanced practice nurse run prenatal clinic, hiring and training staff. In DY2, we will also develop a mechanism for 1) identifying and tracking patients, 2) monitoring the effectiveness of interventions

implemented to retain patients in the program and 3) impacting participants to change to healthy behaviors. Analysis of our information will be completed to determine potential improvement opportunities.

In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding the project.

In DY4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology**: For every early elective delivery avoided, $29,000 in cost is saved by the health care system. Health care costs are calculated by multiplying $29,000 by the total individuals affected.

- **Rationale/Justification**: Early elective delivery outcome improvement targets are dependent on the target population, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place.

130614405.3.6	*3.IT-8.3*	*Perinatal Outcomes – IT-8.3 Early Elective Delivery*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.3: Implement Evidence-Based Disease Prevention Program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth*		
Starting Point/Baseline:	***Baseline Data:*** *The actual baseline data is not known, however preliminary data indicates that approximately 6% of babies born at THAM are early, elective deliveries.* ***Target Population:*** *Low income, disadvantaged pregnant women without access to prenatal care.* ***Specific Number:*** *Numbers will vary but anticipate 950 - 1,200 patients annually* ***Description of Population:*** *Pregnant women living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 1 [P- 1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $**16,125** **Milestone 2** [P- 2] Establish baseline rates Data Source: EMR Milestone 2 Estimated Incentive Payment *(maximum amount):* $**16,124**	**Milestone 4** [P- 4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $**38,229** **Milestone 5** [P- 5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings	**Milestone 6** **[IT-8.3]** Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (**Stand-alone measure**) Improvement Target: 75% reduction over baseline Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment*:* $**81,794**	**Milestone 7** **[IT-8.3]** Early Elective Delivery (Medicaid Adult Core Measure/NQF #469) (**Stand-alone measure**) Improvement Target:95% reduction over baseline Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $**195,594**

130614405.3.6	*3.IT-8.3*	*Perinatal Outcomes – IT-8.3 Early Elective Delivery*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.3: Implement Evidence-Based Disease Prevention Program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth*		
Starting Point/Baseline:	***Baseline Data:*** *The actual baseline data is not known, however preliminary data indicates that approximately 6% of babies born at THAM are early, elective deliveries.* ***Target Population:*** *Low income, disadvantaged pregnant women without access to prenatal care.* ***Specific Number:*** *Numbers will vary but anticipate 950 - 1,200 patients annually* ***Description of Population:*** *Pregnant women living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Milestone 3: [P- 3] Develop and test data systems Data Source: Internally developed database using EMR data to monitor project and produce reports. Milestone 3 Estimated Incentive Payment: $**16,124**	Milestone 5 Estimated Incentive Payment: $**38,230**		

130614405.3.6	*3.IT-8.3*	*Perinatal Outcomes – IT-8.3 Early Elective Delivery*	
Texas Health Arlington Memorial			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.3: Implement Evidence-Based Disease Prevention Program: Implement innovative evidence-based strategies to reduce low birth weight and preterm birth*		
Starting Point/Baseline:	***Baseline Data:*** *The actual baseline data is not known, however preliminary data indicates that approximately 6% of babies born at THAM are early, elective deliveries.* ***Target Population:*** *Low income, disadvantaged pregnant women without access to prenatal care.* ***Specific Number:*** *Numbers will vary but anticipate 950 - 1,200 patients annually* ***Description of Population:*** *Pregnant women living within Region 10, particularly those in Arlington or southeast Tarrant 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**48,373**	Year 3 Estimated Outcome Amount: $**76,459**	Year 4 Estimated Outcome Amount: $**81,794**	Year 5 Estimated Outcome Amount: $**195,594**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:$402,219**			

Title of Outcome Measure (Improvement Target): Right Care, Right Setting – IT-9.2 – ED appropriate utilization

Unique RHP outcome identification number(s): 130614405.3.7
Performing Provider Name/TPI: Texas Health Arlington Memorial / 130614405

Outcome Measure Description:

IT-9.2 – ED appropriate utilization

By the end of the Waiver, our goal is to improve appropriate ED utilization for the targeted populations by 18%.

Process Milestones:

- In DY2, we will:
  - Complete project planning including identification and hiring/training of necessary staff, development of policies/procedures and processes
  - Develop/test reporting and monitoring process to evaluate effectiveness of program
  - Develop or identify database for capturing information on targeted populations to understand needs in order to develop interventions to effective meet their needs. This included creating strategies with other community health care providers (skilled nursing facilities, nursing homes, home health agencies, primary care physicians, outpatient clinics and other resources in the community) to facilitate transition of at-risk population to a medical home.
  - Establish the baseline.
- In DY3, we will conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress

Outcome Improvement Targets for each year:

- In DY4 we will reduce ED utilization for the targeted populations by 10% from baseline
- In DY5 we will reduce ED utilization for the targeted populations by 18% from baseline.

Rationale:

An analysis of the 4,936 June 2012 Texas Health Arlington Memorial ED patient visits indicated that 53% of the patients presenting for care in the ED were unfunded or Medicaid. Of this unfunded or Medicaid population, over half (55%) had diagnoses that did not require emergency care, including conditions such as chronic back pain, prescription refills, follow-up exams or dental disorder. Additional diagnoses, such as limb pain or urinary tract infection might have been managed at a lower level of care making the potential avoidable ED admissions even greater. This program provides patients utilizing the ED for non-emergent care needs with a resource (ED-based case manager) to help navigate them to appropriate resources.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2

will be on the finalization of plans and implementation of a process for hiring and training staff, identifying individuals who are frequent users of the ED or who are utilizing the ED for services that might be provided at a lower level of care, and developing a process to navigate the individuals to more appropriate health care venues. In DY2, we will also develop a mechanism for 1) tracking patients, 2) monitoring the effectiveness of interventions and 3) monitoring impact on compliance with care plan. Analysis of our information will be completed to determine potential improvement opportunities.

In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project.

In DY4 and 5, we will continue to monitor our effectiveness to achieve target outcomes and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology:** For every ED visit avoided, $540 in cost is saved by the health care system.[441] The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.

- **Rationale/Justification:** ED visit outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with greater than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.

- Community benefits were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[441] Based on 2011 historical ED visits data for Texas Health Arlington Memorial

130614405.3.7	*3.IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization Reduce Emergency Department visits for target conditions*	
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.4 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Specific Number:** Numbers will vary but anticipate 11,000 - 12,500 annually (10%-15% of annual ED volume) **Description of Population:** Community members with target conditions within Region 10, particularly those living in Arlington or southeast Tarrant 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)**
Milestone 1[P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment: $**56,683** **Milestone 2** [P-2]: Establish baseline rates (Emergency Department (ED) visits rate for target population: Congestive Heart Failure, Diabetes, End-stage Renal Disease, Cardiovascular Disease/Hypertension,	**Milestone 4** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: $**134,392** **Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization Improvement Target: 10% improvement from baseline (all patients). Data Source: Hospital discharge records Outcome Improvement Target 1 Estimated Incentive Payment: **$287,537**	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Improvement Target: 18% improvement from baseline (all patients). Data Source: Hospital discharge records Outcome Improvement Target 2 Estimated Incentive Payment: **$687,588**

130614405.3.7	*3.IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization Reduce Emergency Department visits for target conditions*	
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.4 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Specific Number:** Numbers will vary but anticipate 11,000 - 12,500 annually (10%-15% of annual ED volume) **Description of Population:** Community members with target conditions within Region 10, particularly those living in Arlington or southeast Tarrant 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)**
Behavioral Health/Substance Abuse, Chronic Obstructive Pulmonary Disease and Asthma patients) Data Source: Hospital discharge records Milestone 2 Estimated Incentive Payment: $**56,683** **Milestone 3**:[P- 3]: Develop and test data systems Data Source: Internally developed database using EMR, coding and/or case management data to monitor project and produce reports. Milestone 3 Estimated Incentive	disseminate findings Milestone 5 Estimated Incentive Payment: $**134,392**		

130614405.3.7	*3.IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization Reduce Emergency Department visits for target conditions*	
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.4 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Specific Number:** Numbers will vary but anticipate 11,000 - 12,500 annually (10%-15% of annual ED volume) **Description of Population:** Community members with target conditions within Region 10, particularly those living in Arlington or southeast Tarrant 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)**
Payment: $ **56,683**			

130614405.3.7	*3.IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization Reduce Emergency Department visits for target conditions*	
Texas Health Arlington Memorial Hospital			*130614405*
Related Category 1 or 2 Projects:	*130614405.2.4 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (Emergency Department Care Management)*		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Specific Number:** Numbers will vary but anticipate 11,000 - 12,500 annually (10%-15% of annual ED volume) **Description of Population:** Community members with target conditions within Region 10, particularly those living in Arlington or southeast Tarrant 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)**
Year 2 Estimated Outcome Amount: : **$170,049**	Year 3 Estimated Outcome Amount: **$268,784**	Year 4 Estimated Outcome Amount: **$287,537**	Year 5 Estimated Outcome Amount: **$687,588**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $1,413,957**			

Title of Outcome Measure (Improvement Target): IT-9.2- ED appropriate utilization

Unique RHP outcome identification number(s): 130724106.3.1
Performing Provider Name/TPI: Pecan Valley Centers for Behavioral and Developmental Healthcare / 130724106

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
By the end of the Waiver, our goal is to have 25% reduction in emergency department utilization for behavioral health and substance abuse. Our milestones include the following:

- In DY2, we will meet with stakeholders of emergency departments to establish protocols for data collection and sharing
- In DY3, we will establish a baseline of emergency department utilization for behavioral health and substance abuse
- In DY4, our goal is to reduce ED utilization by 10% so that by the end of the Waiver a significant reduction in ED utilization will occur so that costs will be reduced as a result of expanded access and quicker availability of behavioral services.

Rationale:
Behavioral health conditions, account for increased health care expenditures such as higher rates of potentially preventable inpatient admissions. Texas Medicaid data on potentially preventable inpatient readmissions demonstrates that behavioral health conditions are a significant driver of inpatient costs. Mental health and substance abuse conditions comprise 8% of initial inpatient readmissions to general acute and specialty inpatient hospitals but represent 24% of potentially preventable admissions.[442]

If access to behavioral health services is expanded and individuals are seen quicker for those services, the use if the emergency department should decrease as people are getting their behavioral health needs met. The process milestones will be targeted towards establishing a data collection and sharing process to evaluate the use of the emergency department as compared to individuals receiving behavioral health services, which will in turn help establish the starting point for baseline. Improvement targets will be determined in DY2 and DY 3 as the baseline is set and data collection is established with local emergency departments.

Outcome Measure Valuation:
Improved access to services will engage individuals in treatment sooner and potentially prevent visits to the emergency department and other higher cost services. Based on a review by the

[442] Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal Year 2010, Texas Health and Human Services Commission , 2012.

Indigent Care Collaborative in Central Texas,[443] the average use of the emergency department by people with a behavioral health diagnosis is 7.085 visits per year, with the national average of an emergency department visit by a person with a behavioral health diagnosis is $1,500 per visit,[444] On average, a person with a behavioral health diagnosis will have an annual cost of $10,628 in emergency department visits. On average, it costs $12 per day to provide community mental health services to adults[445] at an annual average cost of $4,380 per year, providing a cost savings of $6,248 per patient year. Utilizing the Region 10 Category 3 pricing Model, Pecan Valley values the reduction in emergency department use by clients with behavioral health at $13,706,550, as related to the priority population for community centers as defined by the Texas Department of State Health services. In addition to health care cost savings, there is an added value to the person suffering with behavioral health issues. According to a study performed for the Center for Health Care Service, access to telemedicine services increases the quality-adjusted life years by 2.45%.[446] Utilizing the cost-utility analysis at a rate of $50,000 per life year, the adjusted value per person is equivalent to $1,225 per year. Based on the Region 10 Category 3 pricing model, Pecan Valley values the impact to the individuals to be served at $2,149,875 over the course of the grant, for a total grant valuation of $15,856,425. This amount does not include a value for the community impact, which would reach across multiple areas and which is not limited to, but would include reducing lost wages and lost productivity in the community, increasing the access to emergency departments due to a reduction in improper utilization, and a reduction in incarceration the behavioral health-affected population. Considering the impact of the improved access, improved quality of life, and potential cost reduction from ED use and other high cost services, Pecan Valley values this project to exceed the $1,460,649 incentive payment for the waiver period.

[443] Impact of proposed budget cuts to community-based mental health. Health Management Associates Services, 2011.

[444] The Durham Center. (n.d.). Community hospital emergency department admissions for individuals with behavioral health disorders in Durham County.

[445] Health Management Associates. Impact of proposed budget cuts to community-based mental health services. 2011.

[446] Shelton Brown H. Hasanat Alamgir P & Bohman, P. Valuing the program to provide integrated care through telemedicine. 2012.

130724106.3.1	***3.IT-9.2***	***ED appropriate utilization (Stand-alone measure)***	
Pecan Valley Centers for Behavioral and Developmental Health Care			*130724106*
Related Category 1 or 2 Projects:	*130724106.1.1 EXPAND SPECIALTY CARE CAPACITY Access Redesign to target quicker access to psychiatric services*		
Starting Point/Baseline:	*(Need data from ED for individuals with MH issues)*		
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 to engage stakeholders, identify current capacity and needed resources. Data Source: EHR/data exchange Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $154,042	**Process Milestone 2** [P-2]: Establish baseline Data Source: Internal data crosschecked with ED usage from hospitals Process Milestone 2 Estimated Incentive Payment: $313,133	**Outcome Improvement Target 1** [IT-1.1]: Reduce Emergency Department visits for behavioral health/substance abuse Improvement Target: 10% Data Source: Data Exchange with hospitals matched with internal data Outcome Improvement Target 1 Estimated Incentive Payment*:* $322,333	**Outcome Improvement Target 2** [IT-1.1]: Reduce Emergency Department visits for behavioral health/substance abuse Improvement Target: 25% Data Source: Data Exchange with hospitals matched with internal data Outcome Improvement Target 2 Estimated Incentive Payment*:* $671,141
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $154,042	Year 3 Estimated Outcome Amount: $313,133	Year 4 Estimated Outcome Amount: $322,333	Year 5 Estimated Outcome Amount: $671,141
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,460,649			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 130724106.3.2
Performing Provider Name/TPI: Pecan Valley Centers for Behavioral and Developmental Healthcare / 130724106

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
By the end of the Waiver project, our goal is to show;

- In DY2- protocols, mechanisms of collection, timeframes and sampling for data collection of the survey will be identified and determined .
- In DY3- we will establish the baseline for patient satisfaction by utilizing the CG-CAHPS survey
- In DY4- patient satisfaction will show 40% of individuals receiving integrated care report satisfaction with overall health and functioning status
- In DY 5-70% of individuals reporting satisfaction with their overall health and functional status

Rationale:
According to a recent study released by the Robert Wood Johnson Foundation, only 33% of patients with BH conditions (24% of the adult population) receive adequate treatment. Patients with BH issues experience higher risk of mortality and poor health outcomes, largely due to a lack of preventive health services and poorly controlled co-morbid medical disease. Risk increases with the severity of the behavioral health diagnoses.[447] Health care systems which successfully integrate behavioral health and primary care services demonstrate improved care, cost savings, increased provider and consumer satisfaction.[448] More importantly for medically indigent populations, which have co-occurring chronic health and mental health conditions, integrated health is even more valuable.

Since behavioral health problems are often cyclical in nature meaning that over a course of months or years a person may experience periods of time when symptoms are well controlled (or in remission) while at other times symptoms can range from moderate to severe, collaborative care is important. In addition to health conditions, psychiatric medications also complicate the problem because they are associated with obesity and high triglyceride levels, known risk factors

[447] Druss BG, Reisinger Walker E., "Mental Disorders and Medical Co-Morbidity." Robert Wood Johnson Foundation, The Synthesis Project: Issue 21 (2011).
[448] Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives, Health Management Associates (2007).

for cardiovascular disease. Adults with serious mental illnesses are known to have poor nutrition, high rates of smoking and a sedentary lifestyle—all factors that place them at greater risk for serious physical disorders, including diabetes, cardiovascular disease, stroke, arthritis and certain types of cancers. Despite such extensive medical needs, adults with serious mental illnesses often do not receive treatment. Among people with schizophrenia, fewer than 70% of those with co-occurring physical problems were currently receiving treatment for 10 of 12 physical health conditions studied.[449]

Outcome Measure Valuation:

The benefit of integrated healthcare will result in a wider continuum of care. Integrating care can impact patient satisfaction because individuals will be able to receive both their primary care and behavioral care in one location resulting in improved satisfaction. The integrated model will result in the "right" treatment being provided at the "right time" By removing barriers to primary care, for individuals with behavioral health issues, an expected overall improvement in health care status and functioning can be expected. The valuation of this project is aimed at assessing patient satisfaction as it relates to patient experiences with integrated health care. In order to retain patients with both physical and behavior health needs, patient satisfaction must be maintained. Utilizing the Region 10 Pricing Model, Pecan Valley Centers' places a value of customer satisfaction to equal $87,427. This calculation is based on a 70% favorable rating of the population at a value of 2% of billing over the five-year period of the Waiver. In addition, Pecan Valley Center's recognizes that integrated health will lead to lower level intervention needed to address the patients' on-going physical needs. . Taking into consideration the impact of the improved access to both primary and behavioral healthcare, improved health outcomes, improved satisfaction and potential cost reduction, Pecan Valley values this project to exceed the $455,126 incentive payment for the waiver period.

[449] "GET IT TOGETHER How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders" Bazelon Center for Mental Health Law, 2004.

130724106.3.2	*3.IT-6.1*	*Patient Satisfaction*	
Pecan Valley Centers for Behavioral and Developmental Health Care			*130724106*
Related Category 1 or 2 Projects:	*130724106.2.1 Integrate Primary and Behavioral Health Care Services- Collaboration with indigent clinics and site-based primary care*		
Starting Point/Baseline:	*Will survey individuals in integrated care after six months to set baseline starting point*		
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: Implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $17,170	**Process Milestone 2** [P-2]: Establish baseline data Data Source: **CAHPS** Patient Survey Process Milestone 2 Estimated Incentive Payment: $83,778	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores Improvement Target :40% Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $102,270	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores Improvement Target: 70% Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $251,908
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $17,170	Year 3 Estimated Outcome Amount: $83,778	Year 4 Estimated Outcome Amount: $102,270	Year 5 Estimated Outcome Amount: $251,908
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $455,126			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores

Performing Provider Name: Pecan Valley Centers for Behavioral and Developmental Healthcare/130724106
Unique RHP outcome identification number(s): 130724106.3.3 (Pass 2)

Outcome Measure Description:
By the end of the Waiver project, our goal is:

DY2: Identify technology needs for survey completion, timelines and protocols to collect sampling.
DY3: Establish the baseline.
DY4: Show 40% improvement in patient satisfaction of individuals with improved access.
DY 5: to show 60% of individuals reporting increased satisfaction with getting timely care, appointments, and information during the extended clinic hours.

Rationale:
Many individuals have difficulty accessing behavioral health services due to multiple barriers. Two of these barriers are the inability to access routine services during normal business hours due to work schedules for family commitments. Another barrier is transportation to these appointments. By addressing these two barriers, the intent is to provide services in a more convenient manner and as a result, individuals will receive quality care and be more satisfied with their treatment. If access to behavioral health services is expanded and individuals have improved access for those services, the potential use of the emergency department should decrease as people get their behavioral health needs met. As individuals receive more accessible treatment, their lives will be impacted in a positive manner and improve patient satisfaction. The process milestones will be to develop technology units and timelines to distribute and collect information from the patient survey hours. The distribution of this survey will help establish the starting point for baseline. Improvement targets will be determined in DYs 4 and 5 as the baseline is set and data collection of survey results are analyzed.

Outcome Measure Valuation:
The project will aim to improve patient satisfaction and the value of this measure. The American Medical Association affiliate Press Ganey reports that positive patient surveys assist in retaining patients for continued care. In addition to serving patients in a lower cost and in the least restrictive environment, the extended hours will be targeted to accommodate employed patients or individuals with other family commitments. The project will also add a transportation component for individuals receiving services after 5 pm. A potential barrier to treatment will be addressed as individuals are able to maintain their employment without interruption, not having the need to make arrangements for dependent care and allowing children to complete the entire

school day without interruption. By providing transportation, access to behavioral health providers will be more readily available and fewer individuals will not have to rely on other's to provide transportation. For those employed, the Federal Minimum Wage of $7.25 (U.S. Department of Labor) Pecan Valley Centers estimates that wages retained by patients attending after-hours behavioral health appointments are calculated at a minimum $35,287 over the life of the grant. In addition to providing services in a lower cost environment and allowing patients to maximize their earning potential, telemedicine services will be offered in at least one location. According to Brown et al.,[450] access to telemedicine improves the quality-adjusted life-years (QALYs) at a value of $1,225 per person who utilizes this service. Pecan Valley Centers expects that this will provide a minimum value of $397,488 over the life of the grant. Taking into consideration the impact of the improved access, improved quality of life, improved satisfaction and potential cost reduction, Pecan Valley values this project to exceed the $642, 489 incentive payment for the waiver period.

[450] Brown HS, Hasanat AP & Bohman TP. Valuing the program to provide integrated care through telemedicine. 2012.

130724106.3.3	*3.IT-6.1*	***Patient Satisfaction***	
Pecan Valley Centers for Behavioral and Developmental Healthcare			*130724106*
Related Category 1 or 2 Projects:	***130724106.1.2 Extending Services Beyond Normal Business Hours***		
Starting Point/Baseline:	*Will survey individuals receiving services in extended services to set baseline starting point*		
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 - identify needed resources (electronic kiosk or other technology agents to be used for survey, determine timelines and protocols for conducting survey and document implementation plans: Data Source: Implementation plan of survey schedule, technology plans and survey timeline Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $57,346	**Process Milestone 2** [P-2]Establish baseline data Data Source: CG- CAHPS Patient Survey Process Milestone 2 Estimated Incentive Payment: $132,.959	**Outcome Improvement Target 1** [IT-6.1] Percent improvement over baseline of patient satisfaction scores Improvement Target :40% Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $142,469	**Outcome Improvement Target 2** [IT-6.1] Percent improvement over baseline of patient satisfaction scores Improvement Target: 60% Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $309,715
Year 2 Estimated Outcome Amount: $57,346	**Year 3 Estimated Outcome Amount: $132,959**	**Year 4 Estimated Outcome Amount: $142,469**	**Year 5 Estimated Outcome Amount: $309,715**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $642,489			

Title of Outcome Measure (Improvement Target): Right Care Right Setting – 9.2 – ED appropriate utilization

Unique RHP outcome identification number(s): 131036903.3.1
Performing Provider Name/TPI: Texas Health Harris Methodist Cleburne / 131036903

Outcome Measure Description:
Process Milestones:
The DY2 process milestone will be (P-1) Project Planning – engage stakeholders, identify current utilization, determine timelines and document implementation plans. In DY3, we will use milestone (P-2) establish baseline rates and conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

Outcome Improvement Targets for each year:
By the end of DY4, there will be a 30% reduction in Medicare, Medicaid and unfunded patients who visit the Emergency Department (ED) for the following target conditions: chronic obstructive pulmonary disease, asthma, hypertension, congestive heart failure and diabetes. This is defined as our intervention population.
In DY5, the goal will be to reduce the ED visits from patients with these target conditions by 40%.

Rationale:
The reason for selecting P-1 is to ensure that the proposed clinic is developed in a way that meets community needs; P-2 will help us establish the current number of target visits diverted from the ED.
For P-4, we will look at how effective we are at reaching out to the intervention population to educate them on the benefits of the clinic versus using the emergency department for primary care services. Another goal for PDSA is to communicate clinic efficacy with the ED physicians and current primary care providers.
Increasing community awareness in terms of the availability of an APRN clinic will also attract patients who have been utilizing other facilities to meet their health care needs. Because of this, we believe that we will realistically be able to decrease 30% of the intervention population coming in through the ED in DY4.
By increasing staffing, we project a decrease of 40% of the intervention population in DY5.

Outcome Measure Valuation:

- **Approach/Methodology**: For every ED visit avoided, $665 in cost is saved by the health care system.[451] The average length of stay per ED visit is multiplied by the number of decreased encounters to determine the total days saved by the individuals affected. Next,

[451] Based on 2011 historical ED visits data for the intervention population for Texas Health Cleburne

we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.

- **Rationale**: The value for each outcome is largely dependent on what outcome improvements are expected as a result of the proposed program. Outcome improvement targets are set, taking into consideration the following factors:
    - Volume capacity of the proposed program, which defines the baseline/ intervention population
    - Clinical literature or historical performance that provide a comparison for expected improvement as a result of the program

The valuation model computes separate values for program impacts on the health care system, the individual and the community. Community benefits took into account lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits considered these factors: lost wages, caretaker expense and extension of life (if applicable).

131036903.3.1	*3.IT-9.2*	*ED appropriate utilization-Reduce ED visits for target conditions*	
Texas Health Harris Methodist Hospital Cleburne			TPI# 1310369-03
Related Category 1 or 2 Projects:	*131036903.1.1 Expand Existing Primary Care Capacity*		
Starting Point/Baseline:	**Baseline/Intervention Population**: As determined by review of the emergency department patients records, there were 781 unfunded/Medicaid and Medicare encounters treated for Chronic Obstructive Pulmonary Disease, Asthma, Cardiac Disease/Hypertension, Congestive Heart Failure, and Diabetes. Baseline data to be validated by 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)**
Milestone 1 [P-1]: Project Planning-engage stakeholders, identify current utilization, determine timelines and document implementation plans. **Data Source:** EHR, Registration data, and claims. Milestone 1 Estimated Incentive Payment: ***$29,658***	**Milestone 2 [P-2]:** Establish baseline rates for ED volumes for target chronic conditions **Data Source:** EHR, Registration data, claims. Milestone 2 Estimated Incentive Payment: **$23,439** **Milestone 3 [P-4]:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. **Data Source:** EHR, Registration data, claims. Milestone 2 Estimated Incentive Payment: **$23,439**	**Milestone 4 [IT-9.2]:** ED appropriate utilization **Goal:** Decrease ED visits for target chronic conditions by 30%. **Data Source:** EHR, Registration data, claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* **$50,148**	**Milestone 5 [IT-9.2]:** ED appropriate utilization **Goal**: Decrease ED visits for target chronic conditions by 40%. **Data Source:** EHR, Registration data, claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* **$119,920**

131036903.3.1	*3.IT-9.2*	*ED appropriate utilization-Reduce ED visits for target conditions*	
Texas Health Harris Methodist Hospital Cleburne			TPI# 1310369-03
Related Category 1 or 2 Projects:	*131036903.1.1 Expand Existing Primary Care Capacity*		
Starting Point/Baseline:	**Baseline/Intervention Population**: As determined by review of the emergency department patients records, there were 781 unfunded/Medicaid and Medicare encounters treated for Chronic Obstructive Pulmonary Disease, Asthma, Cardiac Disease/Hypertension, Congestive Heart Failure, and Diabetes. Baseline data to be validated by 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**29,658**	Year 3 Estimated Outcome Amount: $**46,878**	Year 4 Estimated Outcome Amount: **$50,148**	Year 5 Estimated Outcome Amount: **$119,920**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:$246,604**			

Title of Outcome Measure (Improvement Target): Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 (Stand-alone measure)

Unique RHP outcome identification number(s): 136326908.3.1

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital HEB / 136326908

Outcome Measure Description:
By the end of the Waiver, our goal is to decrease the number of diabetes clinic participants whose HbA1c is > 9.0 by 15%. Our milestones include the following:

Process Milestones:

- In DY2, we will:
  - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
  - Develop and test reporting and monitoring process to evaluate
- Establish the baseline for this rate.
- In DY3, our goal is to reduce this rate by 4%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress

Outcome Improvement Targets for each year:

- In DY4, to reduce number of patients with diabetes patients whose HbA1c is > 9.0 by 10% from baseline
- In DY5 to reduce number of patients with diabetes patients whose HbA1c is > 9.0 by 15% from baseline.

Rationale:

The goal of this project is to develop and implement a more comprehensive diabetes education center/medical home to help reduce the rates of uncontrolled diabetes among project participants. Our goal is to improve the health outcomes and diabetes self-management competency of community residents in Tarrant County. THAM data indicates that Medicaid and uninsured patients make up about 40% of our payer mix of those treated and released from the ED and approximately 30% of inpatient population. In our service area the Hispanic community makes up approximately 31% of the population and is the fastest growing ethnicity in Arlington. Hispanic people are about 1.5 times more likely to develop diabetes than non-Hispanic white people. In the current THAM Outpatient Diabetes Education Program, approximately 75% of those served are Caucasian, thus indicating a need for innovation and creativity to reach this population. By developing a comprehensive diabetes clinic available to unfunded or government-

funded members in the community, individuals previously struggling to obtain medical care will have access to the care they need to more effectively manage their diabetes.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient nurse-practitioner run diabetes clinic, expanding on the existing diabetes self-management education service currently provided to our patients. In DY2, we will also develop a mechanism for identifying and tracking high-risk diabetic patients and monitoring effectiveness of interventions (enhanced education, self-management coaching, closer monitoring of medical condition, post-discharge telephonic case management to begin analysis of our information and determine potential improvement opportunities.

In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project.

In DY4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology:** For every inpatient admission avoided, $11,538 in cost is saved by the health care system.[452] Health care costs are calculated by multiplying $11,538 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inpatient admissions outcome improvement targets are dependent on the target population being enrolled by the respective hospital, size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable inpatient admissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[452] Based on 2011 historical inpatient diabetes admissions data for Texas Health Hurst-Euless-Bedford

136326908.3.1	*IT-1.10*	*Primary Care and Chronic Disease Management – IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 (Stand-alone measure)*	
Texas Health Harris Methodist Hospital HEB			*136326908*
Related Category 1 or 2 Projects:	*136326908.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in DY2, assumed 15% of target population enrolled. **Target Population:** Low income, disadvantaged community members with a diagnosis of diabetes that come in through the emergency department more than twice per year and do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 800 patients with diabetes annually in 2011. **Description of Population:** Individuals with diabetes living within Region 10, particularly those in Hurst, Euless, and/or Bedford		
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]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Milestone 1 Estimated Incentive Payment: $**1,966** **Milestone 2** [P-2]: Establish baseline rates Data Source: EMR, laboratory data Process Milestone 2 Estimated Incentive Payment: $**1,965**	**Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 3 Estimated Incentive Payment: $**2,072** **Milestone 4** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Milestone 4 Estimated Incentive	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Goal: 10% reduction from baseline. Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment: $**6,647**	**Outcome Improvement Target 3** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Goal: 15% reduction from baseline. Data Source: EMR Outcome Improvement Target 3 Estimated Incentive Payment: $**15,895**

136326908.3.1	*IT-1.10*	*Primary Care and Chronic Disease Management – IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 (Stand-alone measure)*	
Texas Health Harris Methodist Hospital HEB			*136326908*
Related Category 1 or 2 Projects:	*136326908.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in DY2, assumed 15% of target population enrolled. **Target Population:** Low income, disadvantaged community members with a diagnosis of diabetes that come in through the emergency department more than twice per year and do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 800 patients with diabetes annually in 2011. **Description of Population:** Individuals with diabetes living within Region 10, particularly those in Hurst, Euless, and/or Bedford		
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)**
	Payment: $**2,071** **Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%), Rate of participants with HbA1c > 9.0 Goal: 4% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment: $**2,071**		

136326908.3.1	*IT-1.10*	*Primary Care and Chronic Disease Management – IT-1.10 Diabetes care: HbA1c poor control (>9.0%) – NQF 0059 (Stand-alone measure)*	
Texas Health Harris Methodist Hospital HEB			*136326908*
Related Category 1 or 2 Projects:	*136326908.2.1 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)*		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in DY2, assumed 15% of target population enrolled. **Target Population:** Low income, disadvantaged community members with a diagnosis of diabetes that come in through the emergency department more than twice per year and do not have access to care. **Specific Number:** Numbers will vary but anticipate approximately 800 patients with diabetes annually in 2011. **Description of Population:** Individuals with diabetes living within Region 10, particularly those in Hurst, Euless, and/or Bedford		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**3,931**	Year 3 Estimated Outcome Amount: $**6,214**	Year 4 Estimated Outcome Amount: $**6,647**	Year 5 Estimated Outcome Amount: $**15,895**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $**32,687**			

Title of Outcome Measure (Improvement Target): Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs)-IT.3.3 Diabetes 30-day readmission rate

Unique RHP outcome identification number(s): 136326908.3.2

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital HEB / 136326908

Outcome Measure Description:
By the end of the Waiver, our goal is to decrease 30 day readmission (all-cause) for diabetes patients by 15%. Our milestones include the following:

Process Milestones:

- In DY2, we will:
  - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
  - Develop and test reporting and monitoring process to evaluate
- Establish the baseline for this rate.

Outcome Improvement Targets for each year:

- In DY3, our goal is to reduce this rate by 4%; to conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress.
- In DY4, to reduce diabetes patient readmissions by 10% from baseline.
- In DY5 to reduce diabetes patient readmissions by 15% from baseline.

Rationale:
The goal of this project is to develop and implement a more comprehensive diabetes education center/medical home to help reduce the rates of uncontrolled diabetes among project participants. Our goal is to improve the health outcomes and diabetes self-management competency of community residents in Tarrant County.
According to THHEB data, diabetes was the fourth highest readmission diagnosis Data from August 2011 – July 2012 indicate a 30 readmission rate of over 19%. Additionally, 10% of the THHEB service area has been diagnosed with diabetes. Based on THHEB outpatient diabetes education data, the program is underutilized in comparison with the service area diabetic population. Our proposed intervention will help individuals who are traditionally underserved and give them access to diabetes education and regular clinical care so they can better manage their diabetes and prevent hospital readmissions.
The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as

the completion of planning for the project key components. Much focus in DY2 will be on the finalization of plans and implementation of an outpatient nurse-practitioner run diabetes clinic, expanding on the existing diabetes self-management education service currently provided to our patients. In DY2, we will also develop a mechanism for identifying and tracking high-risk diabetic patients and monitoring effectiveness of interventions (enhanced education, self-management coaching, closer monitoring of medical condition, postdischarge telephonic case management,…) to begin analysis of our information and determine potential improvement opportunities.
In DY3, performance improvement initiatives will be implemented based on opportunities identified and a reporting mechanism developed to disseminate information regarding project.
In DY4 and 5, we will continue to monitor our effectiveness and take action to improve performance as needs are identified.

Outcome Measure Valuation:

- **Approach/Methodology:** For every inpatient readmission avoided, $9,253 in cost is saved by the health care system.[453] Health care costs are calculated by multiplying $9,253 by the total individuals affected. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** Inpatient readmissions outcome improvement targets are dependent on the target population served (e.g., aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease), and current processes in place that already prevent avoidable readmissions (e.g., keeping lower acuity patients under observation instead of admitting them).
- **Community benefits** were calculated using lost productivity (net of lost wages), work presenteeism, lost in payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

[453] Texas Department of State Health Services with 30% ccr assumption. http://www.dshs.state.tx.us/ph/county.shtm

136326908.3.2	*3.IT-3.3*	*Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT-3.3 Diabetes 30-day readmission rate*	
Texas Health Harris Methodist Hospital HEB			*136326908*
Related Category 1 or 2 Projects:	*136326908.2.1* Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in *number of diabetic patients admitted to THHEB* **Specific Number:** Numbers will vary but anticipate approximately 392 patients admitted in **Description of Population:** Individuals with diabetes living within Region 10, particularly those Hurst, Euless, and/or Bedford.		
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]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* **$1,965** **Milestone 2** [P- 2]: Establish baseline rates Data Source: Database including patient administrative and coding/billing information such as Premier Quality Advisor identified and baseline rate confirmed Process Milestone 2 Estimated Incentive Payment *(maximum amount):* **$1,966**	**Milestone 3** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Process Milestone 4 Estimated Incentive Payment: $**3,107** **Milestone 4** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Process Milestone 4 Estimated Incentive Payment: $**3,107**	**Outcome Improvement Target 1** [IT-3.2]: Diabetes 30-day readmission rate Goal: 10% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment*:* $**6,647**	**Outcome Improvement Target 2** [IT-3.2]: Diabetes 30-day readmission rate Goal: 15% reduction from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 2 Estimated Incentive Payment*:* $**15,895**

136326908.3.2	*3.IT-3.3*	*Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT-3.3 Diabetes 30-day readmission rate*	
Texas Health Harris Methodist Hospital HEB			*136326908*
Related Category 1 or 2 Projects:	*136326908.2.1* Expand Chronic Care Management Models: Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)		
Starting Point/Baseline:	**Baseline Data:** Baseline will be determined in *number of diabetic patients admitted to THHEB* **Specific Number:** Numbers will vary but anticipate approximately 392 patients admitted in **Description of Population:** Individuals with diabetes living within Region 10, particularly those Hurst, Euless, and/or Bedford.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $**3,931**	Year 3 Estimated Outcome Amount: **$6,214**	Year 4 Estimated Outcome Amount: **$6,647**	Year 5 Estimated Outcome Amount: **$15,895**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ **32,687**			

Title of Outcome Measure (Improvement Target): Potentially Preventable Readmissions – 30-Day Readmission Rates (PPRs) – IT.3.2 Congestive Heart Failure 30-day readmission rate

Unique RHP outcome identification number(s): 136326908.3.3

Performing Provider Name/TPI: Texas Health Harris Methodist HEB / 136326908

Outcome Measure Description:

The outcomes measure is to decrease the number of readmissions of the patients with heart failure over the course of the project using a variety of multidisciplinary approaches along the entire continuum of care. The process measures are as follows:

Process Milestones:

- P-1: Project planning-in Year 2 needs to identify current capacity and needed resources, determine timelines, obtain needed resources, develop and approve protocols, and document implementation plan. The goal is to complete P-1 prior to the end of Year 2.
- P-3: Develop and test system – In DY2, we will implement a PharmD-driven HF clinic; enroll identified patients at high risk for HF readmission; and test physician-approved protocols using a PDSA model. We will also develop a program to assist patients to better self-manage their chronic conditions by leveraging an innovative intensive outpatient multidisciplinary psychiatric chronic disease clinic of an associated behavioral health hospital.
- P-5: Disseminate findings, including lessons learned and best practices, to stakeholders in DY3– Based on patients enrolled in the chronic illness program and HF clinic and how well they respond to the program (in terms of readmission rates, etc.), we can make appropriate recommendations for program improvement e.g., how to increase enrollment, improve adherence

Outcome Improvement Targets for each year:

Our baseline CHF readmission rate is 20%. Utilizing the process milestones of planning, implementing, and measuring the targeted interventions and using a PDSA model, our goal is to decrease the readmission rate from:

- 20% to 19% in DY3
- 19% to 18% in DY4
- 18% to 16% in DY5

Rationale:

These process milestones were chosen for measurement because they are the innovative approaches within the entire program that we envision. This program will also include the more conventional transition coaches, dedicated disease management case managers, and ensuring that patients with limited to no financial resources have the tools they need to self-manage their disease.

The concentration of CHF programs focused on the care of the patient postdischarge will impact the readmission rate, thereby helping us reach the goal of Premier's 75-percentile (~16%).

Outcome Measure Valuation:

- **Approach/Methodology:** For every CHF admission avoided, $8,252 in cost is saved by the health care system. The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** CHF outcome improvement targets are dependent on the target population served (aging populations will have increased admissions due to higher incidence rates), size (e.g., if a hospital is at maximum capacity, admission rates can only decrease) and also current processes in place that already prevent avoidable hospitalizations (e.g., keeping lower acuity patients under observation instead of admitting them).
- Community benefits were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax.
  Individual benefits were calculated using wages, caretaker expense and extension of life (if applicable).

136326908.3.3	*IT-3.2*	*Potentially Preventable Readmissions – 30-Day Readmission Rates* *All CHF 30-Day Readmission Rates*	
Texas Health Harris Methodist HEB			*1363269-08*
Related Category 1 or 2 Projects:	*136326908.2.2 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – improving management of heart failure patients and preventing readmissions*		
Starting Point/Baseline:	*30-Day Readmission Rate for Patients with CHF (2011) = 20.6%*		
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] Project Planning: Engage stakeholders, identify current capacity, and needed resources, determine timelines and document implementation plans. Metric 1: Recruit RN project manager, etc.; develop protocols, implement CHF PharmD-driven clinic, enroll patients in PharmD-driven CHF clinic and psychiatric chronic disease clinic Baseline/Goal: Complete recruitment; begin enrolling patients Data Source: Chart abstractions, internal patient database, Premier database Milestone 1 Estimated Incentive Payment *(maximum amount):* **$3,935** **Milestone 2** [P-4]: Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities	**Milestone 3** [P-5]: Disseminate findings including lessons learned at best practices to stakeholders Metric 1: Participate in semiannual face-to-face meetings Baseline/Goal: Participate in two meetings per year Data Source: Registration two learning meetings per year Milestone 3 Estimated Incentive Payment: **$6,220** **Outcome Improvement Target 1** [IT-3.2]: Decrease 30-day readmission rate in patients with CHF Goal: Decrease 30-day HF readmission rate to 19% Data Source: Premier database Outcome Improvement Target 1 Estimated Incentive Payment*:* **$6,220**	**Outcome Improvement Target 2** [IT-3.2]: Decrease 30-day readmission rate in patients with CHF Goal: Decrease 30-dayHF readmission rate to 18% Data Source: Premier database Outcome Improvement Target 2 Estimated Incentive Payment*:* **$13,308**	**Outcome Improvement Target 3** [IT-3.2]:Decrease 30-day readmission rate in patients with CHF Goal: Decrease 30-day HF readmission rate to 16% Data Source: Premier data base Outcome Improvement Target 3 Estimated Incentive Payment*:* **$31,824**

136326908.3.3	*IT-3.2*	*Potentially Preventable Readmissions – 30-Day Readmission Rates* *All CHF 30-Day Readmission Rates*	
Texas Health Harris Methodist HEB			*1363269-08*
Related Category 1 or 2 Projects:	*136326908.2.2 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases – improving management of heart failure patients and preventing readmissions*		
Starting Point/Baseline:	*30-Day Readmission Rate for Patients with CHF (2011) = 20.6%*		
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)**
Metric 1: Record changes made in processes as a result of PDSA Baseline/Goal: N/A Data Source: Patient feedback, chart abstractions, Premier database, internal patient database Milestone 2 Estimated Incentive Payment: **$3,935**			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): **$7,870**	Year 3 Estimated Outcome Amount: **$12,440**	Year 4 Estimated Outcome Amount: **$13,308**	Year 5 Estimated Outcome Amount: **$31,824**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $65,443**			

Title of Outcome Measure (Improvement Target): IT-3.8 Behavioral Health Substance Abuse 30-day readmission rate (Stand-alone measure)
Unique RHP outcome identification number(s): 136326908.3.4

Performing Provider Name/TPI: Texas Health Harris Methodist Hospital HEB/Springwood / 136326908

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:

For this project milestone P-2 will establish a baseline rate for behavioral health readmissions and P-3 develop and test data systems for effectiveness of behavioral health follow up. After the baseline rate is set and systems have been tested we will utilize milestone P-1 to plan the target readmission rates, engage stakeholders, identify current capacity and determine the timeline and implementation plan. Outcome Improvement target IT-3.8 will show the decreases in readmissions by 20% in DY3, 35% in DY4 and 50% in DY5.

Rationale:

Utilizing milestone P-2 establish baseline rate for behavioral health readmissions will allow us to have a starting point of current readmissions. Milestone P-3 develop and test data systems for effectiveness of behavioral health follow ups will allow us to track patients seen in acute care that follow up with the integrated clinic and exchange information that will allow the continuing care provider to address all the issues established by the acute care provider so readmissions are decreased. Milestone P-1 will allow us to set our plan, engage our stakeholders and create our timeline and implementation plan of how to decrease our readmissions. We chose our outcome Improvement target of decreasing readmissions by 25% in DY3, 35% in DY4 and 50% in DY5 based on a current study of readmission targets if chronic medical issues and behavioral issues are captured by behavioral health and medical providers that are integrated.

Outcome Measure Valuation:

- **Approach/Methodology:** For every behavioral health readmission avoided, $7,491 in cost is saved by the health care system.[454] The average length of stay per admission is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale:** Behavioral health outcome improvement targets are dependent on the target population served (aging populations will have increased readmissions due to higher

[454] HCUP

incidence rates), size (e.g., if a hospital is at maximum capacity, readmission rates can only decrease) and also current processes in place that already prevent avoidable readmissions.

- **Community benefits** were calculated using lost productivity (net of lost wages), worker presenteeism, lost payroll taxes and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

136326908.3.4	3.IT-3.8	*Behavioral Health /Substance Abuse 30-day readmission rate*	
Texas Health HEB/Springwood			-136326908
Related Category 1 or 2 Projects:	136326908.2.3 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.		
Starting Point/Baseline:	*Readmission Rate of 10.8%*		
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]: Establish baseline rate for behavioral health readmissions Data Source: Data from mental health coalition readmission rates Milestone 1 Estimated Incentive Payment *(maximum amount):* **$38,548** **Milestone 2** [P-3]: Develop and test data systems for effectiveness of behavioral health follow-up Data Source: Electronic Health Record and claims Milestone 2 Estimated Incentive Payment: **$38,549**	**Milestone 3** [P-1]: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Minutes from stakeholder meetings, capacity from the EHR, timeline and implementation plan Milestone 3 Estimated Incentive Payment*:* **$60,931** **Outcome Improvement Target 1** [IT-3.8]: Goal: Readmissions decrease by 20% Data Source: EHR and claims Outcome Improvement Target 1 Estimated Incentive Payment*:* **$60,931**	**Outcome Improvement Target 2** [IT-3.8]: Goal: Readmissions decrease by 35% Data Source: EHR and claims Outcome Improvement Target 2 Estimated Incentive Payment*:* **$130,364**	**Outcome Improvement Target 3** [IT-3.8]: Goal: Readmissions decreased by 50% Data Source: EHR and claims Outcome Improvement Target 3 Estimated Incentive Payment*:* **$311,739**

136326908.3.4	3.IT-3.8	*Behavioral Health /Substance Abuse 30-day readmission rate*	
Texas Health HEB/Springwood			-136326908
Related Category 1 or 2 Projects:	136326908.2.3 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.		
Starting Point/Baseline:	*Readmission Rate of 10.8%*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): **$77,097**	Year 3 Estimated Outcome Amount: **$121,862**	Year 4 Estimated Outcome Amount: **$130,364**	Year 5 Estimated Outcome Amount: **$311,739**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $641,061**			

Title of Outcome Measure (Improvement Target): Right Care, Right Setting – IT-9.2 – ED appropriate utilization

Unique RHP outcome identification number(s): 136326908.3.5

Performing Provider Name/TPI: Texas Health Harris Methodist Hurst Euless Bedford / 136326908

Outcome Measure Description:
By the end of the Waiver, our goal is to decrease all ED visits for targeted populations 18%. Our milestones include the following

Process Milestones:

- In DY2, we will:
  - Complete project planning including identification and hiring of necessary staff, development of policies/procedures and processes
  - Develop/test reporting and monitoring process to evaluate effectiveness of program
  - Develop or identify database for capturing information on targeted populations to understand needs in order to develop interventions to effective meet their needs. This included creating strategies with other community health care providers (skilled nursing facilities, nursing homes, home health agencies, primary care physicians, outpatient clinics and other resources in the community) to facilitate transition of at-risk population to a medical home.
- In DY3, we will conduct performance improvement projects to work towards further reductions and disseminate information to key stakeholders regarding our progress

Outcome Improvement Targets for each year:

- In DY4 we will reduce ED utilization for the targeted populations by 7% from baseline
- In DY5 we will reduce ED utilization for the targeted populations by 11% from baseline.

Rationale:

There is a shortage of outpatient clinics and services for the poor. Because of our area in the mid-cities we have no public transportation. People simply cannot make it to Ft Worth to the community hospital. We are the local clinic for the poor, undocumented, old and chronically ill with no resources. Internal numbers tell us with the 18% improvement based on 7,534.2 visits 1,356.2 days could be saved. The same research shows avoided inpatient admissions are projected to be 7.98%.

The identified process milestones will assist the organization in developing and implementing the structure needed to complete the project. Process milestones identified in DY2 include the establishment of a baseline rate for measuring our effectiveness in future project years as well as the completion of planning for the project key components. The focus in DY2 will be on the finalization of plans and implementation of the program utilizing case managers,

navigatorsm, support staff and other professionals available in the hospital. Utilizing other services being planned in our community such as the Coumadin clinic here at the hospital and the heart failure clinic in the planning stage will be of great value and will be expanded as needed.

DY3, outcomes will identify issues not working well then plans will be made changes and processes adjusted.

DY4 and 5 we will continue to monitor our effectiveness and take action to improve performance as needs are identified. The two goals identified that will be of the most help to the community and the patients are ED visits pre and post navigation services by individuals identified as ED frequent fliers and then measuring the appropriate utilization by this group. The identified patient conditions are going to be one of the guides utilized for effective measurement.

Outcome Measure Valuation:

- **Approach/Methodology:** For every ED visit avoided, $535 in cost is saved by the health care system. The average length of stay per ED visit is multiplied by the number of avoidable admissions to determine the total days saved by the individuals affected. Next, we use the total days saved to calculate individual and community costs. The total valuation is calculated by summing up health care costs, individual costs, and community costs.
- **Rationale/Justification:** ED visit outcome improvement targets are dependent on the target population served (e.g., the number of frequent flyers, patients with greater than three visits in a year), size (e.g., if a hospital is at maximum capacity, rates can only decrease), and current processes in place that already prevent navigate frequent flyers away from the ED.
- **Community benefits** were calculated using lost productivity (net of lost wages), lost payroll taxes, and lost sales tax. Individual benefits were calculated using lost wages, caretaker expense and extension of life (if applicable).

136326908.3.5	*IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization* *Reduce Emergency Department visits for target conditions*	
Texas Health Harris Methodist Hurst Euless Bedford			*136326908*
Related Category 1 or 2 Projects:	136326908.2.4 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Specific Number:** Numbers will vary but anticipate 11,000 - 12,500 annually (10%-15% of annual ED volume) **Description of Population:** Community m99embers with target conditions within Region 10, particularly those living in Arlington or southeast Tarrant 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)**
Milestone 1[P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Provider documents describing implementation plan Baseline/Goal: Milestone 1 Estimated Incentive Payment (maximum amount): **$ 18,014** **Milestone 2** [P-2]: Establish baseline rates (Emergency Department (ED) visits rate for target population: Congestive Heart Failure, Diabetes, End-stage Renal Disease, Cardiovascular Disease/Hypertension, Behavioral Health/Substance Abuse,	**Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Provider documents demonstrating completion of performance improvement project Milestone 4 Estimated Incentive Payment: **$28,474** **Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports or other communication tools produced to disseminate findings Baseline/Goal: 1 report	**Outcome Improvement Target 2** [IT-9.2]: ED Appropriate Utilization Improvement Target: 9% improvement from baseline. Data Source: Hospital discharge records Outcome Improvement Target 2 Estimated Incentive Payment: **$91,381**	**Outcoedme Improvement Target 3** [IT-9.2]: ED Appropriate Utilization Improvement Target: 131% improvement from baseline. Data Source: Hospital discharge records Outcome Improvement Target 3 Estimated Incentive Payment: **$218,519**

136326908.3.5	*IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization* *Reduce Emergency Department visits for target conditions*	
Texas Health Harris Methodist Hurst Euless Bedford			*136326908*
Related Category 1 or 2 Projects:	136326908.2.4 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Specific Number:** Numbers will vary but anticipate 11,000 - 12,500 annually (10%-15% of annual ED volume) **Description of Population:** Community m99embers with target conditions within Region 10, particularly those living in Arlington or southeast Tarrant 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)**
Chronic Obstructive Pulmonary Disease and Asthma patients) Baseline/Goal: Data Source: Hospital discharge records Milestone 2 Estimated Incentive Payment (maximum amount): **$ 18,014** **Milestone 3** [P- 3]: Develop and test data systems Data Source: Internally developed database using EMR, coding and/or case management data to monitor project and produce reports. Baseline/Goal: Milestone 3 Estimated Incentive	Milestone 5 Estimated Incentive Payment: **$28,473** **Outcome Improvement Target 1**: [IT-9.2] ED Appropriate Utilization Goal: 10% improvement from baseline. Data Source: Identified database determined in DY2 Outcome Improvement Target 1 Estimated Incentive Payment: **$28,473**		

136326908.3.5	*IT-9.2*	*Right Care, Right Setting -IT-9.2: ED appropriate utilization* *Reduce Emergency Department visits for target conditions*	
Texas Health Harris Methodist Hurst Euless Bedford			*136326908*
Related Category 1 or 2 Projects:	136326908.2.4 Establish/Expand a Patient Care Navigation Program – Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care		
Starting Point/Baseline:	**Baseline Data:** The actual baseline data is not known and will be obtained in DY2 year. **Target Population:** Low income, frequent users of the emergency department with target conditions that do not have access to a primary care physician or medical home **Specific Number:** Numbers will vary but anticipate 11,000 - 12,500 annually (10%-15% of annual ED volume) **Description of Population:** Community m99embers with target conditions within Region 10, particularly those living in Arlington or southeast Tarrant 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)**
Payment: **$ 18,014**			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): **$54,042**	Year 3 Estimated Outcome Amount: **$85,421**	Year 4 Estimated Outcome Amount: **$91,381**	Year 5 Estimated Outcome Amount: **$218,519**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:$449,362**			

Title of Outcome Measure (Improvement Target): IT 9.2 – ED Appropriate Utilization

Unique RHP outcome identification number: 138910807.3.1 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/13890807

Outcome Measure Description:
Category 3 – OD-9 Preventive and Primary Care: -IT.9.2 Reduce pediatric emergency department visits
Decrease inappropriate emergency department use by expanding access to pediatric primary care by establishing a 24/7 nurse triage line and expanding primary care hours. Specific percentage of reduction will be determined during baseline measurement in DY2.

Process Milestones:
DY2:
Milestone 1: P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans
Milestone 2: P-2: Establish baseline rates
Milestone 3: P-3: Develop and test data systems

DY3:
Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
Milestone 5: P-5: Disseminate findings, including lessons learned and best practices to stakeholders.

Outcome Improvement Targets:
DY4:
Milestone 6: I-1: Achieve X% reduction in emergency department use, where X will be determined in DY2 based on baseline data. Note: Provider would like to understand the numerator and denominator definitions prior to establishing percentage change goal.

DY5:
Milestone 7: I-1: Achieve Y% reduction in emergency department use, where Y will be determined in DY2 based on baseline data. Note: Provider would like to understand the numerator and denominator definitions prior to establishing percentage change goal.

Rationale:
Improving access to primary care by opening new pediatric primary care offices, offering expanded office hours, using telecommunication to link primary care providers with specialists, providing a medical home for children with complex and chronic medical conditions, expanding hours for urgent care, providing a 24/7 nurse triage telephone service, enhancing/expanding the

medical home, developing patient/family navigation, implementing evidence-based health promotion programs and implementing/expanding care transitions program should reduce inappropriate use as well as overall use of emergency department services.

Outcome Measure Valuation:

This project was valued using the score for Project 1.1 which was valued using the Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals 4
- Addresses Community Needs 2
- Project Investment 1
- Project Scope 1
- Value Weight of the Project 8

Each point of the scale was given a value of $187,500 based on expected savings, improved outcomes and improved satisfaction with the health care system over the life of the project and beyond the life of the project as all patients are pediatric with expected savings to continue into adulthood. The overall project value was then divided between Category 1 and 3 based on HHSC-provided guidelines with Category 4 being allotted the maximum 15% in later years by reporting on Optional Domain 6.

References

Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. *J Am Board Fam Med*. 2011 May-Jun;24(3):240-8.

Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A profile of nonurgent emergency department use in an urban pediatric hospital. *Pediatr Emerg Care*. 2012 Sep 26.

Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low rates of follow-up with primary care providers after pediatric emergency department visits for respiratory tract illnesses. Pediatr Emerg Care. 2012 Sep 26.

Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients. *J Paediatr Child Health*. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

138910807.3.1	*-IT.9.2*	*REDUCE PEDIATRIC EMERGENCY DEPARTMENT VISITS*	
	Children's Medical Center of Dallas		***138910807***
Related Category 1 or 2 Projects:	**138910807.1.1**		
Starting Point/Baseline:	**Emergency Department visits in DY1.**		
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 implementations plans. Goal: Completed by 9/30/2013 Data source: Administrative data Process Milestone 1Estimated Incentive Payment $12,500 **Process Milestone 2 [P-2]:** Establish baseline rates Goal: Completed by 9/30/2013 Data Source: Epic Electronic Health Record and Financial Data derived from Epic Process Milestone 2 Estimated Incentive Payment $12,500 **Process Milestone 3 [P-3]:** Develop and test data systems Goal: Completed by 9/30/2013 Data Source: Epic Electronic Health Record reports Process Milestone 3 Estimated Incentive Payment: $12,500	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Goal: Completed by 9/30/2014 Data source: Administrative data Process Milestone 4: P-4: Estimated Incentive Payment: $18,750 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices to stakeholders. Goal: Completed by 9/30/2014 Data source: Administrative data Process Milestone 5 Estimated Incentive Payment: $18,750	**Outcome Improvement Target 1** [IT-9.2]: Achieve X% reduction in Emergency Department use, where X will be determined in DY2 based on baseline data. Metric 1**:** Documented evidence of performance achieved. Goal: Completed by 9/30/2015 Data source: Administrative data Outcome Improvement Target 1 Estimated Incentive Payment: $56,250	**Outcome Improvement Target 2** [IT-9.2**]:** Achieve Y% reduction in Emergency Department use, where Y will be determined in DY2 based on baseline data. Metric 1: Documented evidence of performance achieved. Goal: Completed by 9/30/2015 Data source: Administrative data Outcome Improvement Target 2 Estimated Incentive Payment: $123,750
Year 2 Estimated Milestone Bundle Amount: $37,500	**Year 3 Estimated Milestone Bundle Amount: $37,500**	**Year 4 Estimated Milestone Bundle Amount: $56,250**	**Year 5 Estimated Milestone Bundle Amount: $ 123,750**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $255,000			

138910807.3.1	*-IT.9.2*	*REDUCE PEDIATRIC EMERGENCY DEPARTMENT VISITS*	
	Children's Medical Center of Dallas		***138910807***
Related Category 1 or 2 Projects:	**138910807.1.1**		
Starting Point/Baseline:	**Emergency Department visits in DY1.**		
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)**

Title of Outcome Measure (Improvement Target): IT 9.3 – Reduce Pediatric and Young Adult Asthma Emergency Visits

Unique RHP outcome identification number: 138910807.3.2 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/13890807

Outcome Measure Description:
Category 3 – OD-9 Preventive and Primary Care: 3.9.3 Reduce Pediatric/Young Adult Asthma Emergency Department visits

Decrease pediatric and young adult asthma emergency department use by expanding access to and enrollment in a disease management program in the medical home settings of MyChildren's in RHP 10. Specific percentage of reduction will be determined during baseline measurement in DY2.

Process Milestones:
Milestone 1: P1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans
Milestone 2: P2: Establish baseline rates
Milestone 3: P3: Develop and test data systems

DY3:
Milestone 4: P4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
Milestone 5: P5: Disseminate findings, including lessons learned

Outcome Improvement Targets:
DY4:
Improvement Target 1: Achieve X% reduction in pediatric/young adult asthma emergency department use, where X will be determined in DY2 based on baseline data. Further understanding on the numerator and denominator are needed before projecting a percentage reduction.
DY5:
Improvement Target 2: Achieve Y% reduction in pediatric/young adult asthma emergency department use, where Y will be determined in DY2 based on baseline data. . Further understanding on the numerator and denominator are needed before projecting a percentage reduction.

Rationale:
Implementing a disease management program targeting patients with asthma in the medical home setting of MyChildren's should reduce pediatric and young adult emergency use as well as overall use of emergency department services.

Outcome Measure Valuation:

This project was valued using the score for Project 1.2, which was based on Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

Each point of the scale was given a value of $187,500 based on expected savings, improved outcomes and improved satisfaction with the health care system over the life of the project and beyond the life of the project as all patients are pediatric with expected savings to continue into adulthood. The overall project value was then divided between Category 1 and 3 based on HHSC-provided guidelines with Category 4 being allotted the maximum 15% in later years by reporting on Optional Domain 6.

References:

Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. *J Am Board Fam Med*. 2011 May-Jun;24(3):240-8.

Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A Profile of Nonurgent Emergency Department Use in an Urban Pediatric Hospital. *Pediatr Emerg Care*. 2012 Sep 26.

Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low rates of follow-up with primary care providers after pediatric emergency department visits for respiratory tract illnesses. *Pediatr Emerg Care*. 2012 Sep 26.

Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients. *J Paediatr Child Health*. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

138910807.3.2	*-IT.9.3*	*REDUCE PEDIATRIC AND YOUNG ADULT ASTHMA EMERGENCY DEPARTMENT VISITS*	
Children's Medical Center of Dallas			*138910807*
RELATED CATEGORY 1 OR 2 PROJECTS	**138910807.1.2**		
Starting Point/Baseline	**Pediatric and Young Adult Asthma Emergency Department Visits in DY1**		
DY2 (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 [P1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. Goal: Completed by 9/30/2013 Data source: Administrative data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $25,000 **Process Milestone 2** [P2]: Establish baseline rates Goal: Completed by 9/30/2013 Data Source: Epic Electronic Health Record and financial data derived from Epic Process Milestone 2: Estimated Incentive Payment *(maximum amount):* $25,000 **Process Milestone 3** [P3]: Develop and test data systems Goal: Completed by 9/30/2013 Data source: Epic Electron Health Record reports Process Milestone 3: Estimated Incentive Payment *(maximum*	**Process Milestone 4** [P4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Goal: Completed by 9/30/2014 Data source: Administrative data Process Milestone 4: Estimated Incentive Payment *(maximum amount):* $37,500 **Process Milestone 5** [P5]: Disseminate findings, including lessons learned and best practices to stakeholders. Goal: Completed by 9/30/2014 Data source: Administrative data Process Milestone 5 Estimated Incentive Payment *(maximum amount):* $37,500	**Outcome Improvement Target 1** [IT-9.3]: Achieve X% reduction in Pediatric and Young Adult Asthma Emergency Department use, where X will be determined in DY2 based on baseline data. Metric 1**:** Documented evidence of performance achieved. Further understanding on the numerator and denominator are needed before projecting a percentage reduction. a. Numerator: Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. b. Denominator: Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary and secondary diagnoses with the dates of service "Begin Date through End Date" equal any consecutive 12 month period with paid dates from "Begin Date through End Date which includes 3 month tail." This is the measurement period. Total period of our pilot initiative was 24 months. We	**Outcome Improvement Target 2** [IT-9.3]: Achieve Y% reduction in Pediatric and Young Adult Asthma Emergency Department use, where Y will be determined in DY2 based on baseline data. Metric 1: Documented evidence of performance achieved. Further understanding on the numerator and denominator are needed before projecting a percentage reduction. a. Numerator: Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period. b. Denominator: Denominator is all patients age two through age 20, diagnosed with asthma during the measurement period. The denominator will include recipients with claims with asthma as primary and secondary diagnoses with the dates of service "Begin Date through End Date" equal any consecutive 12 month period with paid dates from "Begin Date through End Date which includes 3 month tail." This is the measurement period. Total period of

138910807.3.2	*-IT.9.3*	*REDUCE PEDIATRIC AND YOUNG ADULT ASTHMA EMERGENCY DEPARTMENT VISITS*	
Children's Medical Center of Dallas			*138910807*
RELATED CATEGORY 1 OR 2 PROJECTS	**138910807.1.2**		
Starting Point/Baseline	**Pediatric and Young Adult Asthma Emergency Department Visits in DY1**		
DY2 (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)**
amount): $25,000		used Baseline Measurement period of March 1, 2006 through February 28, 2007 with paid dates through May 31, 2007 to provide a 3 month claims tail. Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion. Goal: Completed by 9/30/2015 Data Source: EHR, Claims Outcome Improvement Target 1: Estimated Incentive Payment *(maximum amount):* $112,500	our pilot initiative was 24 months. We used Baseline Measurement period of March 1, 2006 through February 28, 2007 with paid dates through May 31, 2007 to provide a 3 month claims tail. Rationale/Evidence: Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion. Goal: Completed by 9/30/2016 Data Source: EHR, Claims Outcome Improvement Target 2: Estimated Incentive Payment *(maximum amount):* $247,500
DY2 Estimated Milestone Bundle Amount: $ 75,000	**Year 3 Estimated Milestone Bundle Amount:** $ 75,000	**Year 4 Estimated Milestone Bundle Amount:**$112,500	**Year 5 Estimated Milestone Bundle Amount:** $247,500
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 510,000			

Title of Outcome Measure (Improvement Target): IT-1.18 – Follow-up After Hospitalization for Mental Illness

Unique RHP outcome identification number: 138910807.3.3 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807

Outcome Measure Description:
Category 3 – OD-1 Primary and Chronic Disease Management: 3.1.18 Follow-up After Hospitalization for Mental Illness

Increase follow-up within 30 days after hospitalization for mental illness in patients enrolled in the MyChildren's medical home through the expansion of behavioral health services in MyChildren's in RHP 10. Specific percentage of increase will be determined during baseline measurement in DY2.

Process Milestones:

- DY2:
  - P-1: Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems
- DY3:
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement Targets:

- DY4:
  IT-1.18: Achieve X% increase in follow-up after a hospitalization for mental illness, where X will be determined in DY2 based on baseline data. Need additional information on numerator and denominator prior to establishing percentage increase.
- DY5:
  IT-1.18: Achieve Y% increase in follow-up after a hospitalization for mental illness, where Y will be determined in DY2 based on baseline data. Need additional information on numerator and denominator prior to establishing percentage increase.

Rationale:
Expand pediatric behavioral health capacity in CMC primary care settings to align and coordinate care for behavioral and medical illnesses in an attempt to improve patient/family self-management and reduce unnecessary exacerbation of chronic illnesses. Collaborate with

Timberlawn Services and other behavioral health care providers for coordination of care between medical services and behavioral health services.

Implementing a follow-up process for patients postdischarge for a mental illness and enrolled in MyChildren's medical home should reduce readmissions, exacerbation and complications of mental illnesses. By specifically targeting timely outpatient follow-up after an inpatient stay for mental illness, additional processes and resources will be dedicated to provide timely outpatient follow-up.

Outcome Measure Valuation:

This project was valued using the value of Project 1.3, which was developed using the Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

Each point of the scale was given a value of $187,500 based on expected savings, improved outcomes and improved satisfaction with the health care system over the life of the project and beyond the life of the project as all patients are pediatric with expected savings to continue into adulthood. The overall project value was then divided between Category 1 and 3 based on HHSC-provided guidelines with Category 4 being allotted the maximum 15% in later years by reporting on Optional Domain 6.

References

Aalsma MC, Blythe MJ, Tong Y, Harezlak J, Rosenman MB. Insurance status of urban detained adolescents. *Journal of Correct Health care.* 2012 Aug 23. [Epub ahead of print].

Dumont IP, Olson AL, Primary care, depression, and anxiety: exploring somatic and emotional predictors of mental health status in adolescents. *J Am Board Fam Med* 2012 May-Jun;25(3):291-9.

Jacob MK, Larson JC, Craighead WE. Establishing a telepsychiatry consultation practice in rural Georgia for primary care physicians: a feasibility report. *Clin Pediatr (Phila).* 2012 Apr 20.

Smith JP, Long-term economic costs of psychological problems during childhood. *Social Science & Medicine*, v. 71, no. 1, July 2010, p. 110-115.

138910807.3.3	*OD 3.1.18*	*FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS*	
Children's Medical Center of Dallas			*138910807*
Related Category 1 or 2 Projects	*138910807.1.3*		
Starting Point/Baseline	*Follow-up after Hospitalization for Mental Illness 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]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans. Goal: Completed by 9/30/2013 Data source: Administrative data Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $12,500 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Completed by 9/30/2013 Data source: Electronic health record Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $12,500 **Process Milestone 3**[P-3]: Develop and test data systems Goal: Completed by 9/30/2013 Data source: Electronic health record reports Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $12,500	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Goal: Completed by 9/30/2014 Data Source: Administrative data Process Milestone 4 Estimated Incentive Payment *(maximum amount):*$18,750 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices to stakeholders. Goal: Completed by 9/30/2014 Data Source: Administrative data Process Milestone 5 Estimated Incentive Payment *(maximum amount):*$18,750	**Outcome Improvement Target 1** [IT-1.18]: Achieve X% increase in follow-up after hospitalization for mental, where X will be determined in DY2 based on baseline data. a. Numerator: Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. b. Denominator: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is	**Outcome Improvement Target 2** [IT-1.18]**:** Achieve Y% increase in follow-up after hospitalization for mental, where Y will be determined in DY2 based on baseline data. b. Numerator: Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. b. Denominator: Members 6 years and older as of the date of discharge who were discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. The denominator for this measure is

138910807.3.3	*OD 3.1.18*	*FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS*	
Children's Medical Center of Dallas			*138910807*
Related Category 1 or 2 Projects	*138910807.1.3*		
Starting Point/Baseline	*Follow-up after Hospitalization for Mental Illness 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)**
		based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. c. Data Source: EHR, Claims d. Rationale/Evidence: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	based on discharges, not members. Include all discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. c. Data Source: EHR, Claims d. Rationale/Evidence: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.

138910807.3.3	*OD 3.1.18*	*FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS*	
Children's Medical Center of Dallas			*138910807*
Related Category 1 or 2 Projects	*138910807.1.3*		
Starting Point/Baseline	*Follow-up after Hospitalization for Mental Illness 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)**
		Metric 1 [IT-1.18.1]: Documented evidence of performance achieved. Goal: To be determined in DY2 Data source: Electronic Health Record Need additional information on patient cohort before establishing improvement goal. Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount):* $56,250	Metric 1 [IT-1.18.1]: Documented evidence of performance achieved. Goal: To be determined in DY2 Data source: Electronic Health Record Need additional information on patient cohort before establishing improvement goal. Outcome Improvement Target 2 Estimated Incentive Payment *(maximum amount):* $123,750
Year 2 Estimated Milestone Bundle Amount: $37,500	**Year 3 Estimated Milestone Bundle Amount: $37,500**	**Year 4 Estimated Milestone Bundle Amount: $56,250**	**Year 5 Estimated Milestone Bundle Amount: $123,750**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $255,000			

Title of Outcome Measure (Improvement Target): IT 9.2 – ED Appropriate Utilization

Unique RHP outcome identification number: 138910807.3.4 (Pass 2)
Performing Provider Name/TPI: Children's Medical Center of Dallas/13890807

Outcome Measure Description:
Category 3 – OD-9 Preventive and Primary Care: IT.9.2 Reduce pediatric emergency department visits
Decrease inappropriate emergency Department use by expanding access to medical homes. Specific percentage of reduction will be determined during baseline measurement in DY2. All milestones and metrics are based on the relevancy to RPH 10's population, community needs, RHP priorities and the starting point for the project.

Process Milestones:

- DY2:
  - P-1: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementations plans
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems
- DY3:
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5: Disseminate findings, including lessons learned and best practices to stakeholders

Outcome Improvement Targets:

- DY4:

  IT-9.2: Achieve X% reduction in emergency department use, where X will be determined in DY2 based on baseline data. Note: Provider would like to understand the numerator and denominator definitions prior to establishing percentage change goal.
- DY5:

  IT-9.2: Achieve Y% reduction in emergency department use, where Y will be determined in DY2 based on baseline data. Note: Provider would like to understand the numerator and denominator definitions prior to establishing percentage change goal.

Rationale:
Improving access to primary care by enhancing/expanding the medical homes should reduce inappropriate use as well as overall use of emergency department services. Studies have shown a decrease of 25% or more in inappropriate use of the ED by patients enrolled in a medical home as well as a decrease in overall use of the ED patient receiving care in a medical home environment.

Outcome Measure Valuation:

Project Valuation:

This project was valued using the score for Project 2.1, which was valued using the Scoring Criteria Guidance with a 1 to 5 scoring range and the following criteria:

- Meets Waiver Goals
- Addresses Community Needs
- Project Scope
- Project Investment
- Value Weight of the Project

Each point of the scale was given a value of $187,500 based on expected savings, improved outcomes and improved satisfaction with the health care system over the life of the project and beyond the life of the project as all patients are pediatric with expected savings to continue into adulthood. The overall project value was then divided between Category 1 and 3 based on HHSC-provided guidelines with Category 4 being allotted the maximum 15% in later years by reporting on Optional Domain 6.

References:

Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: a practice coaching intervention from the High Plains Research Network. *J Am Board Fam Med*. 2011 May-Jun;24(3):240-8.

Kubicek K, Liu D, Beaudin C, Supan J, Weiss G, Lu Y, Kipke MD. A profile of nonurgent emergency department use in an urban pediatric hospital. *PediatrEmerg Care*. 2012 Sep 26.

Liberman DB, Shelef DQ, He J, McCarter R, Teach SJ. Low rates of follow-up with primary care providers after pediatric emergency department visits for respiratory tract illnesses. *PediatrEmerg Care*. 2012 Sep 26.

Yang C, Chen CM. Effects of post-discharge telephone calls on the rate of emergency department visits in paediatric patients. *J Paediatr Child Health*. 2012 Aug 16. doi: 10.1111/j.1440-1754.2012.02519.x.

138910807.3.4	*IT-9.2*	*REDUCE PEDIATRIC EMERGENCY DEPARTMENT VISITS*	
Children's Medical Center of Dallas			*138910807*
Related Category 1 or 2 Projects:	*138910807.2.1*		
Starting Point/Baseline:	*Emergency Department visits in DY1.*		
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 implementations plans. Goal: Completed by 9/30/2013 Data Source: Administrative data Milestone 1 Estimated Incentive: $12,500 **Process Milestone 2** [P-2]: Establish baseline rates Goal: Completed by 9/30/2013 Data source: Epic Electronic Health Record and financial data derived from Epic. Milestone 2 Estimated Incentive Payment *(maximum amount):* $12,500 **Process Milestone 3** [P-3]: Develop and test data systems Goal: Completed by 9/30/2013 Data source: Epic Electronic Health Record Milestone 3 Estimated Incentive Payment*:* $12,500	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Goal: Completed by 9/30/2014 Data source: Administrative data Milestone 4 Estimated Incentive Payment *(maximum amount):* $18,750 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices to stakeholders. Goal: Completed by 9/30/2014 Data source: Administrative data Milestone 5 Estimated Incentive Payment *(maximum amount):* $18,750	**Outcome Improvement Target 1** [IT-9.2]: Achieve X% reduction in Emergency Department use, where X will be determined in DY2 based on baseline data. Metric 1 [IT-9.2.1]: Documented evidence of performance achieved. Goal: Completed by 9/30/2015 Data source: Administrative data Note: Provider would like to understand the numerator and denominator definitions prior to establishing percentage change goal. Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount):* $56,250	**Outcome Improvement Target 2** [IT-9.2]: Achieve Y% reduction in Emergency Department use, where Y will be determined in DY2 based on baseline data. Metric 1 [IT-9.2.1]: Documented evidence of performance achieved. Goal: Completed by 9/30/2015 Data source: Administrative data Note: Provider would like to understand the numerator and denominator definitions prior to establishing percentage change goal. Outcome Improvement Target 2 Estimated Incentive Payment *(maximum amount):* $123,750

138910807.3.4	*IT-9.2*	*REDUCE PEDIATRIC EMERGENCY DEPARTMENT VISITS*	
Children's Medical Center of Dallas			*138910807*
Related Category 1 or 2 Projects:	*138910807.2.1*		
Starting Point/Baseline:	*Emergency Department visits in DY1.*		
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)**
Year 2 Estimated Milestone Bundle Amount: $37,500	**Year 3 Estimated Milestone Bundle Amount: $37,500**	**Year 4 Estimated Milestone Bundle Amount: $56,250**	**Year 5 Estimated Milestone Bundle Amount: $123,750**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR: $255,000			

Title of Outcome Measure (Improvement Target): IT-1.1 Third next available appointment

Unique RHP outcome identification number(s): 138980111.3.1

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/ 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving time to third next available appointment for the target population. The expected outcome by the end of the Waiver is to improve time to third next available appointment by 10% from baseline.

Process Milestones and Outcome Improvement Targets for each year:
The associated process milestones and improvement targets are:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include the identification, recruitment of staff, equipment acquisition, and collection of baseline data using a Registered Nurse as the Project Lead. Use of Region stakeholders (community and medical composition) will indicate needs and additional scope of the project .
- Establish baseline rates [P-2]. The baseline will be established using quantitative measures of pre and post appointment schedules counting the third next appointment time for New and Established patients appointments.
- Third next available appointment [IT-1.1]. Time to third next available appointment will be measured by Appointment Schedules and comparing DY4 and DY5 to baseline data.

Rationale:
Primary Care and Chronic Disease Management – Third next available appointment was selected as an outcome measure to assess the effectiveness of the project in meeting the needs of the target population, allowing the patients to be seen closer to home and with less time between appointments. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1. This milestone is important as it provides the opportunity to engage children with severe burns in RHP 10 who have received services from Shriners Hospital in Galveston and their families, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patients living in RHP 10 in the target population. Establishing baseline rates will provide the ability to assess the effectiveness of the project.

1. Primary Care and Chronic Disease Management – Third next available appointment [IT-1.1]. This outcome improvement target measures the average length of days between the day a patient makes a request for an appointment and the third available appointment. Patients receiving telemedicine services from this intervention will see a reduction in days to the third next available appointment due to the use of telemedicine services at UNT Health Science Center and the reduced amount of travel time required for an appointment.

Outcome Measure Valuation:

2. **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

3. **Rationale/Justification:** For third next available appointment, UNT Health Science Center defined the population that will be directly impacted by the project as severely burned patients in North Texas requiring burn follow-up care services, which would be approximately 100 patients. We are anticipating that all of the population is expected to be positively impacted by a 10% decrease in time to third next available appointment- -.

   Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,183 (Baylor Health Care System data)-.

   For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which was valued at $237 for each positive outcome realized.

   The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.1	*3.IT-1.1*	*Primary Care and Chronic Disease Management – IT-1.1 Third next available appointment*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.1 Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region – 1.7.1: Telemedicine for Children Recovering From Severe Burns*		
Starting Point/Baseline:	**Baseline data:** There is currently no baseline data available for the project. Severely Burned Children have follow-up visits at 3, 6, 9, and 12 months. Approximately 3-4 patient visits per patient per year per age of child and medical condition. **Target Population:** **Specific Number:** Initial estimate is 100 severely burned patients in North Texas in various phases on follow-up burn care in conjunction with Shriners Hospital for Burns, Galveston Texas. Additional children populations and site locations will be identified **Description of Population:** The initial phase of the project will focus on severely burned patients in North Texas requiring burn follow-up care services.		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program records Process Milestone 2 Estimated Incentive Payment: $8,127	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment Improvement Target: Decrease time to third next available appointment by 5% over baseline Data Source: Program Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $8,964	**Outcome Improvement Target 2** [IT-1.1]**:** Third next available appointment Improvement Target: Decrease time to third next available appointment by 10% over baseline Data Source: Program Records Outcome Improvement Target 2 Estimated Incentive Payment*:* $18,900

138980111.3.1	*3.IT-1.1*	*Primary Care and Chronic Disease Management – IT-1.1 Third next available appointment*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.1 Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region – 1.7.1: Telemedicine for Children Recovering From Severe Burns*		
Starting Point/Baseline:	**Baseline data:** There is currently no baseline data available for the project. Severely Burned Children have follow-up visits at 3, 6, 9, and 12 months. Approximately 3-4 patient visits per patient per year per age of child and medical condition. **Target Population:** **Specific Number:** Initial estimate is 100 severely burned patients in North Texas in various phases on follow-up burn care in conjunction with Shriners Hospital for Burns, Galveston Texas. Additional children populations and site locations will be identified **Description of Population:** The initial phase of the project will focus on severely burned patients in North Texas requiring burn follow-up care services.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $8,127	Year 4 Estimated Outcome Amount: $8,694	Year 5 Estimated Outcome Amount: $18,900
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $35,720			

Title of Outcome Measure (Improvement Target): IT-6.1(Domain 1) Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for a specific tool.

Unique RHP outcome identification number(s): 138980111.3.2

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/ 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving patient satisfaction in getting timely care, appointments, and information for the target population. The expected outcome by the end of the Waiver is to improve time to patient satisfaction in getting timely care, appointments and information for the target population by 10% from baseline. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1].]. Project planning will include the identification, recruitment of staff, equipment acquisition, and collection of baseline data using a Registered Nurse as the Project Lead. Use of Region stakeholders (community and medical composition) will indicate needs and additional scope of the project.
- Establish baseline rates [P-2]. The baseline will be established using quantitative measures of pre- and pos patient and parent satisfaction ratings of project services.
- Patient Satisfaction [IT-6.1] Domain 1. Patient satisfaction will be measured by Program Records and CGCAHPS survey on patient's overall health status/functional status and comparing DY4 and DY5 to baseline.

Rationale:
Patient Satisfaction – percent improvement of patient satisfaction scores in getting timely care, appointments and information was selected to assess the effectiveness of this project in meeting the needs of the target population. Children's burns account for many hours of care and follow-up visits lasting months to years (children under five years of age account for almost 20% of all burn cases in the U.S.). If patients and parents participate in a coordinated multidisciplinary burn care program the patient has the greatest chance of a satisfying long-term outcome. Successful treatment outcomes and patient satisfaction are correlated. When the patient and parent are satisfied with the medical care and service they receive they are more likely to follow treatment plans, complete treatments and not drop out of care. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1. This milestone is important as it provides the opportunity to engage children with severe

burns in RHP 10 who have received services from Shriners Hospital in Galveston and their families, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patients living in RHP 10 in the target population. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Patient Satisfaction – percent improvement of patient satisfaction scores in getting timely care, appointments and information [IT-6.1] Domain 1. This outcome improvement target measures patient satisfaction for patients. Patients receiving telemedicine services from this intervention should see an improvement in patient satisfaction. If patients and parents participate in a coordinated multidisciplinary burn care program the patient has the greatest chance of a satisfying long-term outcome. Successful treatment outcomes and patient satisfaction are correlated. When the patient and parent are satisfied with the medical care and service they receive they are more likely to follow treatment plans, complete treatments and not drop out of care.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For patient satisfaction percent improvement over baseline of patient satisfaction scores, UNT Health Science Center defined the population that will be directly impacted by the project as severely burned patients in North Texas requiring burn follow-up care services, which would be approximately 100 patients. We are anticipating that we will test the entire population, and are expecting to increase the patient satisfaction scores for the project by 10% -.

  Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $13 (per General Services Administration's federal per diem rates, as well as information provided by UNT Health Science Center's Department of Pediatrics), which was based on two percent of the expected reduced cost of each

estimated travel occurrence, in addition to the reduced cost of lost productivity for both school and work-.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which was valued at $11 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.2	*3.IT-6.1(1)*	*Patient Satisfaction – IT-6.1(1) Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for a specific tool.*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.1* Introduce, Expand, or Enhance Telemedicine/Telehealth – *Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region – 1.7.1: Telemedicine for Children Recovering From Severe Burns*		
Starting Point/Baseline:	**Baseline data:** There is currently no baseline data available for the project. Severely Burned Children have follow-up visits at 3, 6, 9, and 12 months. Approximately 3-4 patient visits per patient per year per age of child and medical condition. **Target Population:** **Specific Number:** Initial estimate is 100 severely burned patients in North Texas in various phases on follow-up burn care in conjunction with Shriners Hospital for Burns, Galveston Texas. Additional children populations and site locations will be identified **Description of Population:** The initial phase of the project will focus on severely burned patients in North Texas requiring burn follow-up care services.		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]**:** Establish baseline rates Data Source: Program records Process Milestone 2 Estimated Incentive Payment: $138	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores in getting timely care, appointments, and information Improvement Target: 5% increase in patient satisfaction over baseline Data Source: Patient Survey – Certain supplemental modules for the adult CGCAHPS or The Clinician and Group CAHPS (CGCAHPS) survey will be used as collection instrument Outcome Improvement Target 1 Estimated Incentive Payment*:* $147	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores in getting timely care, appointments, and information Improvement Target: 10% increase in patient satisfaction over baseline Data Source: Patient Survey – Certain supplemental modules for the adult CGCAHPS or The Clinician and Group CAHPS (CGCAHPS) survey will be used as collection instrument Outcome Improvement Target 2 Estimated Incentive Payment*:* $320

138980111.3.2	*3.IT-6.1(1)*	*Patient Satisfaction – IT-6.1(1) Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for a specific tool.*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.1* Introduce, Expand, or Enhance Telemedicine/Telehealth – *Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region – 1.7.1: Telemedicine for Children Recovering From Severe Burns*		
Starting Point/Baseline:	**Baseline data:** There is currently no baseline data available for the project. Severely Burned Children have follow-up visits at 3, 6, 9, and 12 months. Approximately 3-4 patient visits per patient per year per age of child and medical condition. **Target Population:** **Specific Number:** Initial estimate is 100 severely burned patients in North Texas in various phases on follow-up burn care in conjunction with Shriners Hospital for Burns, Galveston Texas. Additional children populations and site locations will be identified **Description of Population:** The initial phase of the project will focus on severely burned patients in North Texas requiring burn follow-up care services.		
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)**

138980111.3.2	*3.IT-6.1(1)*	*Patient Satisfaction – IT-6.1(1) Patient Satisfaction: Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for a specific tool.*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.1* Introduce, Expand, or Enhance Telemedicine/Telehealth – *Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region – 1.7.1: Telemedicine for Children Recovering From Severe Burns*		
Starting Point/Baseline:	**Baseline data:** There is currently no baseline data available for the project. Severely Burned Children have follow-up visits at 3, 6, 9, and 12 months. Approximately 3-4 patient visits per patient per year per age of child and medical condition. **Target Population:** **Specific Number:** Initial estimate is 100 severely burned patients in North Texas in various phases on follow-up burn care in conjunction with Shriners Hospital for Burns, Galveston Texas. Additional children populations and site locations will be identified **Description of Population:** The initial phase of the project will focus on severely burned patients in North Texas requiring burn follow-up care services.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $138	Year 4 Estimated Outcome Amount: $147	Year 5 Estimated Outcome Amount: $320
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $605			

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization

Unique RHP outcome identification number(s): 138980111.3.3

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/ 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing pediatric ED visits for the target population. The expected outcome by the end of the Waiver is to reduce inappropriate ED utilization related to burns in target population receiving intervention by 10% over baseline. The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include the identification, recruitment of staff, equipment acquisition, and collection of baseline data using a Registered Nurse as the Project Lead. Use of Region stakeholders (community and medical composition) will indicate needs and additional scope of the project .
- Establish baseline rates [P-2]. The baseline will be established by determining number of non-urgent ED visits at pre-project implementation and comparing to post project non-urgent ED visits using patient medical records.
- Right Care, Right Setting – ED Appropriate Utilization [IT-9.2]. Reduction in ED use will be measured by using patient medical records and comparing DY4 and DY5 to baseline.

Rationale:
Right Care, Right Setting – ED Appropriate Utilization was selected as an outcome measure to assess the effectiveness of the project in meeting the needs of the target population, allowing the patients to receive specialized care closer to home, with less time between appointments and in providing a resource in the Region for treatment other than the pediatric ED. Additionally, total payor non-urgent ED visits are estimated to be at the 10-40% of all ED visits. Medicaid non-urgent ED visits are at the 25% level based on a national sample of all medical insurance payor types. Shifting ED visits for non-urgent health problems to primary care providers in the community is a necessary step for broader efforts in the health care system to create ―patient-centered medical homes. This would not only improve the quality of care by ensuring that patients have a primary care physician to see for their non-urgent health problems and coordinating care with specialists and other providers, but it is also likely to generate additional cost savings by reducing unnecessary or redundant utilization. To support the achievement of this outcome, specific process milestones and metrics were selected.

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1. This milestone is important as it provides the opportunity to engage children with severe burns in RHP 10 who have received services from Shriners Hospital in Galveston and their families, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.
- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patients living in RHP 10 in the target population. Establishing baseline rates will provide the ability to assess the effectiveness of the project.

4. ED Appropriate Utilization [IT-9.2]. This outcome improvement target measures appropriate utilization of the pediatric ED for patients receiving the intervention. Patients receiving telemedicine services from this intervention will see a reduction in use of the ED due to having an additional resource for care related to severe burns and due to receiving specialized care through the use of telemedicine services at UNT Health Science Center.

Outcome Measure Valuation:

5. **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

6. **Rationale/Justification:** For ED appropriate utilization, UNT Health Science Center defined the population that will be directly impacted by the project as severely burned patients in North Texas requiring burn follow-up care services, which would be approximately 100 patients.. The percentage of improvement expected by the project is 10%, equating to 10 lives positively impacted by this outcome-.

   Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,500 due to the patient population mix -.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $1,200 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved with the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.3	*3.IT-9.2*	*Right Care, Right Setting – IT-9.2 ED Appropriate Utilization*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.1 Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region – 1.7.1: Telemedicine for Children Recovering From Severe Burns*		
Starting Point/Baseline:	**Baseline data:** There is currently no baseline data available for the project. Severely Burned Children have follow-up visits at 3, 6, 9, and 12 months. Approximately 3-4 patient visits per patient per year per age of child and medical condition. **Target Population:** **Specific Number:** Initial estimate is 100 severely burned patients in North Texas in various phases on follow-up burn care in conjunction with Shriners Hospital for Burns, Galveston Texas. Additional children populations and site locations will be identified **Description of Population:** The initial phase of the project will focus on severely burned patients in North Texas requiring burn follow-up care services.		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program records Process Milestone 2 Estimated Incentive Payment: $1,546	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization Measure: Reduce pediatric Emergency Department visits (CHIPRA Core Measure) related to burns in target population Improvement Target: 5% reduction over baseline in inappropriate ED utilization related to burns in target population receiving intervention Data Source: Program Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,654	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization Measure: Reduce pediatric Emergency Department visits (CHIPRA Core Measure) related to burns in target population Improvement Target: 10% reduction over baseline in inappropriate ED utilization related to burns in target population receiving intervention Outcome Improvement Target 2 Estimated Incentive Payment*:* $3,595

138980111.3.3	*3.IT-9.2*	*Right Care, Right Setting – IT-9.2 ED Appropriate Utilization*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.1 Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region – 1.7.1: Telemedicine for Children Recovering From Severe Burns*		
Starting Point/Baseline:	**Baseline data:** There is currently no baseline data available for the project. Severely Burned Children have follow-up visits at 3, 6, 9, and 12 months. Approximately 3-4 patient visits per patient per year per age of child and medical condition. **Target Population:** **Specific Number:** Initial estimate is 100 severely burned patients in North Texas in various phases on follow-up burn care in conjunction with Shriners Hospital for Burns, Galveston Texas. Additional children populations and site locations will be identified **Description of Population:** The initial phase of the project will focus on severely burned patients in North Texas requiring burn follow-up care services.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $1,546	Year 4 Estimated Outcome Amount: $1,654	Year 5 Estimated Outcome Amount: $3,595
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $6,794			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Unique RHP outcome identification number(s): 138980111.3.4

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/ 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving quality of life scores for the target population. The expected outcome by the end of the Waiver is to improve quality of life scores for the target population by 5% from baseline. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include the identification, recruitment of staff, survey instrument review, and collection of baseline data using a Registered Nurse as the Project Lead. Use of Region stakeholders (community and medical composition) will indicate needs and additional scope of the project.

7. Establish baseline rates [P-2]. The baseline will be established by the identification, recruitment of staff, survey instrument review, and collection of baseline data using a Registered Nurse as the Project Lead. Use of Region stakeholders (community and medical composition) will indicate needs and additional scope of the project.
8. Quality of Life/Functional Status – [IT-10.1] Quality of Life will be measured by the Child Health Questionnaire (CHQ) by Landgraf, Abgetz and Ware (1996): CHQ-PF 28 and CHQ-CF 87. The project will use the Child Health Questionnaire's (CHQ) to measure health-related quality of life concepts from the patient's and parent's perspective (specific forms used are based on the specific age of the patient). CHQ measures will be collected for children with severe burns and chronic conditions. Most CHQ information is collected on healthy children and the project allows information to be collected on a different patient population. Measurements will include: physical functioning, performance in physical role, performance in emotional role, vitality, social functioning, bodily pain, general health perceptions, and mental health scores to be collected and used to improve medical care. DY4 and DY5 results will be compared to baseline to measure improvement.

Rationale:
Quality of Life/Functional Status – Quality of Life was selected to assess the effectiveness of this project in meeting the needs of the target population. The ability to measure the project's patient experience is critical to understanding how to improve the quality of health care for severely burned children receive. The project will use the Child Health Questionnaire's (CHQ) to measure health-related quality of life concepts from the patient's and parent's perspective

(specific forms used are based on the specific age of the patient). To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1. This milestone is important as it provides the opportunity to engage children with severe burns in RHP 10 who have received services from Shriners Hospital in Galveston and their families, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.
- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patients living in RHP 10 in the target population. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Quality of Life/Functional Status – [IT-10.1] Quality of Life. This outcome improvement target measures quality of life for patients. Patients receiving telemedicine services from this intervention should see an improvement in quality of life scores because if patients and parents participate in a coordinated multidisciplinary burn care program the patient has the greatest chance of a satisfying long-term outcome. Successful treatment outcomes, improved quality of life and patient satisfaction are correlated. This outcome improvement target measures quality of life for patients. Integrating back into a social and school environment is very difficult after a severe burn injury. The severely burned child will face many changes as they begin their long journey at increasing functionality and aesthetics. quality of life scores allow burn survivors and their caregivers to become integrated back into their community and assures a high quality of life and life success.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For quality of life, UNT Health Science Center defined the population that will be directly impacted by the project as severely burned patients in North Texas requiring burn follow-up care services, which would be approximately 100

patients. We anticipate that we will test the entire population and are expecting to increase the quality of life scores by 5%-.

Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,510 (as cited in the articles, "Relationships between Quality of Life Questionnaire (QLQ) and the SF-36 among young adults burned as children" in the journal, *ScienceDirect* and "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention -. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.4	*IT-10.1*	*Quality of Life/Functional Status – IT-10.1 Quality of Life*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region – 1.7.1: Telemedicine for Children Recovering From Severe Burns*		
Starting Point/Baseline:	**Baseline data:** There is currently no baseline data available for the project. Severely Burned Children have follow-up visits at 3, 6, 9, and 12 months. Approximately 3-4 patient visits per patient per year per age of child and medical condition. **Target Population:** **Specific Number:** Initial estimate is 100 severely burned patients in North Texas in various phases on follow-up burn care in conjunction with Shriners Hospital for Burns, Galveston Texas. Additional children populations and site locations will be identified **Description of Population:** The initial phase of the project will focus on severely burned patients in North Texas requiring burn follow-up care services.		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]**:** Establish baseline rates Data Source: Program records Process Milestone 2 Estimated Incentive Payment: $20,094	**Outcome Improvement Target 1** [IT-10.1] Quality of Life Demonstrate improvement in quality of life (QOL) scores, as measured by the Child Health Questionnaire (CHQ) by Landgraf, Abgetz and Ware (1996): CHQ-PF 28 and CHQ-CF 87. Improvement Target: 2% increase in quality of life scores over baseline Data Source: CHQ-CF 87 and CHQ-PF 28 Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $21,496	**Outcome Improvement Target 2** [IT-10.1] Quality of Life Demonstrate improvement in quality of life (QOL) scores, as measured by the Child Health Questionnaire (CHQ) by Landgraf, Abgetz and Ware (1996): CHQ-PF 28 and CHQ-CF 87. Improvement Target: 5% increase in quality of life scores over baseline Data Source: CHQ-CF 87 and CHQ-PF 28 Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $46,730

138980111.3.4	*IT-10.1*	*Quality of Life/Functional Status – IT-10.1 Quality of Life*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.1 Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the Region – 1.7.1: Telemedicine for Children Recovering From Severe Burns*		
Starting Point/Baseline:	**Baseline data:** There is currently no baseline data available for the project. Severely Burned Children have follow-up visits at 3, 6, 9, and 12 months. Approximately 3-4 patient visits per patient per year per age of child and medical condition. **Target Population:** **Specific Number:** Initial estimate is 100 severely burned patients in North Texas in various phases on follow-up burn care in conjunction with Shriners Hospital for Burns, Galveston Texas. Additional children populations and site locations will be identified **Description of Population:** The initial phase of the project will focus on severely burned patients in North Texas requiring burn follow-up care services.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $20,094	Year 4 Estimated Outcome Amount: $21,496	Year 5 Estimated Outcome Amount: $46,730
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $88,320			

Title of Outcome Measure (Improvement Target): IT-3.1: All-cause 30-day readmission rate – NQF 1789

Unique RHP outcome identification number(s): *138980111.3.6*
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing all-cause 30-day readmission rates for Medicaid patients receiving services from the project Community-Based Primary Care for the Elderly-. The expected outcome by the end of the Waiver is to reduce all-cause 30-day readmission rates for the target population by 10% over baseline (10 readmissions prevented). The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include discussions with local health care providers and hospital administration regarding targeted conditions most strongly related to readmissions. A review of the literature on this topic has already been conducted. The intervention will be planed targeting these risk factors.
- Establish baseline rates [P-2]. Prior work suggests that approximately 20% of Medicaid elders experience readmission within 30 days of hospital discharge. Additional baseline data from our target population will be collected by survey at initial patient encounters.
- Develop and test data systems [P-3]. This will involve setting up methods to track and collect readmission data from our target population and from area hospitals
- Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – [IT-3.1]: All-cause 30-day readmission rate – NQF 1789 will be measured by tracking patients provided services through the community-based medical clinics (mobile teams and community-based clinics).
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Rationale:
Approximately 20% of Medicaid-eligible elders are readmitted to hospitals within 30 days of discharge, which is a significant financial drain that also reduces overall quality of life. Through implementation of our mobile clinics, we propose to reduce Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – All-cause 30-day readmissions by 10% over baseline thereby providing a substantial cost savings. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This

milestone is important as it provides the opportunity to engage primary care physicians and other primary care providers in evidence-based process models, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for this particular population, which is at higher risk for hospital readmissions. Establishing baseline rates for our target population will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect 30-day readmission data from program records and area hospitals.
- Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – [IT-3.1] – All-cause 30-day readmission rate – NQF 1789. This outcome improvement target measures the number of 30-day readmissions among Medicaid elders and near elders receiving care from the project titled Community-Based Primary Care for the Elderly. Participants in this intervention will demonstrate a reduced risk of 30-day readmission by receiving care from the mobile teams and community clinics, particularly though provision of urgent care services.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For All Cause 30 day Readmission Rate, UNT Health Science Center defined the population that will be directly impacted as Patients receiving services from the project titled Community-Based Primary Care for the Elderly who have been admitted to a hospital. It is anticipated that approximately 500 patients will be hospitalized annually. Based on various literature, it is estimated that 20% (or 100) of the target population will be readmitted within 30 days. The percentage of improvement expected by the project - is 10%, equating to 10 lives positively impacted by this outcome.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,491 (TX Dept. of State Health Services data).-The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.6	*3.IT-3.1*	*Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) - IT-3.1– All-cause 30-day readmission rate– NQF 1789*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics – 1.1.3: Community-Based Primary Care for the Elderly*		
Starting Point/Baseline:	**Baseline data:** Actual baseline data will be collected in DY2 and DY3 **Target Population**: Patients receiving services from the project titled "Community-Based Primary Care for the Elderly" who have been admitted to a hospital. It is anticipated that approximately 500 patients will be hospitalized annually. **Specific Number:** Based on various literature, it is estimated that 20% (or 100) of the patients provided services through this project - will be readmitted within 30days. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program Records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $1,731 **Process Milestone 3** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 3 Estimated Incentive Payment: $1,731	**Outcome Improvement Target 1** [IT-3.1]: All-cause 30-day readmission rate for Medicaid-eligible and near elders receiving services from the project titled Community-Based Primary Care for the Elderly. Improvement Target: 5% reduction (5 hospital re-admissions prevented) in all-cause 30-day readmission rate over baseline Data Source: Program Records Outcome Improvement Target 1 Estimated Incentive Payment: $3,704	**Outcome Improvement Target 2** [IT-3.1]: All-cause 30-day readmission rate for Medicaid-eligible elders and near elders receiving services from the project titled Community-Based Primary Care for the Elderly. Improvement Target: 10% reduction (10 hospital re-admission prevented) in all-cause 30-day readmission rate over baseline Data Source: Program Records Outcome Improvement Target 2 Estimated Incentive Payment: $8,051

138980111.3.6	*3.IT-3.1*	*Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) - IT-3.1– All-cause 30-day readmission rate– NQF 1789*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics – 1.1.3: Community-Based Primary Care for the Elderly*		
Starting Point/Baseline:	**Baseline data:** Actual baseline data will be collected in DY2 and DY3 **Target Population**: Patients receiving services from the project titled "Community-Based Primary Care for the Elderly" who have been admitted to a hospital. It is anticipated that approximately 500 patients will be hospitalized annually. **Specific Number:** Based on various literature, it is estimated that 20% (or 100) of the patients provided services through this project - will be readmitted within 30days. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $3,462	Year 4 Estimated Outcome Amount: $3,704	Year 5 Estimated Outcome Amount: $8,051
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $15,217			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores – of patient's involvement in shared decision making.

Unique RHP outcome identification number(s): 138980111.3.7
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving patient satisfaction scores of patient's involvement in shared decision making for those receiving services from the project "Community-Based Primary Care for the Elderly."-The expected outcome by the end of the Waiver is to improve patient satisfaction scores in decision making by 15% (among all 3,071 patients) over baseline. The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include meeting with local primary care providers as well as patients to identify key components required for effective patient participation in medical decision making.
- Establish baseline rates [P-2]. The baseline will be established by providing the survey prior to and after patient encounters with the mobile teams and clinics.
- Develop and test data systems [P-3]. The Consumer Assessment of Health Plans Survey (CAHPS) module on Patient/Caregiver Experience – Shared Decision Making will be incorporated into the computerized patient interview. Beta testing will be conducted to ensure accuracy of data as well as test data analytic systems.
- Patient Satisfaction – [IT-6.1] Percent improvement over baseline of patient satisfaction scores of patient's involvement in decision making will be measured by comparing pre- and post-interviews from patient encounters with the mobile teams and community clinics.

Rationale:
Prior work has shown that patient perception of involvement in medical decision making and medical care is directly related to outcomes (Brody et al 1989). Therefore, we seek improve patient satisfaction scores of patient's involvement in decision making by 15% over baseline (among all 3,071 patients). To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This

milestone is important as it provides the opportunity to engage primary care providers and patients to identify key barriers for patient involvement in medical decision making (e.g., health literacy). Medical team encounters will be designed to specifically address barriers identified.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for this milestone. Baseline rates will be based on patient experience with prior medical providers. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect patient satisfaction measures.
- Patient Satisfaction – [IT-6.1] Percent improvement over baseline of patient satisfaction scores of patient's involvement in decision making. This outcome improvement target measures improvement in patient perception of involvement in medical decision making by participation in the community-based medical model. Participants in this intervention will be actively engaged in medical decision making by the health care teams thereby affording the patients the opportunity to have direct input into his/her health care.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For Patient Satisfaction Percent Improvement Over Baseline of Patient Satisfaction scores, UNT Health Science Center defined the population that will be directly impacted by the project as 3,071 individuals who will receive services through this project. We are anticipating that we will - test the entire population and are expecting to increase the patient satisfaction scores of patient's involvement in shared decision making by 15%.

  Utilizing, - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $16 per article "BMC Medicine Research" in the journal BioMed Central), which is based on two percent of the expected reduced cost of mobile healthcare.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.7	*3.IT-6.1*	*Patient Satisfaction – IT-6.1 Percent improvement over baseline of patient satisfaction scores – of patient's involvement in shared decision making.*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics – 1.1.3: Community-Based Primary Care for the Elderly*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY2 and DY3 **Target Population**: 20,476 Medicaid-eligible elders and near elders residing in RHP 10 are eligible for services within this project **Specific Number:** Overall project target is 15% (3,071) of population. Outcome 3 target is 15% improvement in satisfaction with involvement in shared decision making for **all** 3,071 patients. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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 (Develop and test data systems) Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment:$1,135 **Process Milestone 3** [P-3]: Develop and test data systems for collection and program evaluation. Data Source: Program Records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $1,135	**Outcome Improvement Target 1** [IT 6.1]: 10% improvement over baseline of patient satisfaction scores of patient's involvement in shared decision making. Data Source: Patient survey pre- and postvisit with provider from mobile teams/community clinics Outcome Improvement Target 1 Estimated Incentive Payment*:* $2,429	**Outcome Improvement Target 2** [IT 6.1]: 15% improvement over baseline of patient satisfaction scores of patient's involvement in shared decision making. Data Source: Patient survey pre- and postvisit with provider from mobile teams/community clinics Outcome Improvement Target 2 Estimated Incentive Payment*:* $5,281
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $2,271	Year 4 Estimated Outcome Amount: $2,429	Year 5 Estimated Outcome Amount: $5,281

TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $9,981

Title of Outcome Measure (Improvement Target): IT-10.1- Quality of Life

Unique RHP outcome identification number(s): 138980111.3.8
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving patient quality of life scores as measured by the SF-36 for those receiving services from the project "Community-Based Primary Care for the Elderly.". The expected outcome by the end of the Waiver is to improve quality of life scores by 10% over baseline (among all 3,071 patients). The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include meeting with local health care providers as well as patients to discuss health care barriers to quality of life. The SF-36 will be incorporated into the patient interviews to be developed in DY2-3 with beta testing completed in DY3.
- Establish baseline rates [P-2]. The baseline will be established by pre-medical encounters for each patient receiving services within the target population.
- Develop and test data systems [P-3]. The interview and data collection and analysis system will be developed over DY2-3 and beta tested in DY3. Full implementation of the system will be in DY4.
- Quality of Life/Functional Status- Quality of Life [IT-10.1]. Percent improvement over baseline of patient quality of life scores will be measured by comparing SF-36 scores prior to and after patient encounters by the mobile teams and community clinics.

Rationale:
Prior work shows how quality of life and health status have reciprocal relationships. In fact, the Oregon Health Insurance Experiment (Finkelstein 2011) demonstrated that enrollment in Medicaid had a significant beneficial impact on quality of life, health care utilization (including preventive care measures and hospitalizations), and overall medical expenditures and debt when compared to the control group with no insurance. By implementing this community-based medical model, we propose to improve quality of life by 10% over baseline (among all 3,071 patients). To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage primary care physicians as well as patients in evidence-based process models related to improvement in QOL, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project.
- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patient quality of life. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect QOL measures.
- Quality of Life/Functional Status- Quality of Life [IT-10.1]. Percent improvement over baseline of patient quality of life. This outcome improvement target measures improvement in QOL experienced by participation in the community-based medical model. Participants in this intervention will demonstrate improved QOL owing to the fact that they will receive medical care "where they live" thereby overcoming the significant barrier of "access" to care pointed out by a recent survey of Tarrant County elders.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For Quality of Life, UNT Health Science Center defined the population as the 3,071 individuals who will receive services through the project titled Community-Based Primary Care for the Elderly. We anticipate that we will survey the entire population and expect to increase quality of life scores by 10% for patients receiving services through this project.

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,755(as cited in the article "Cost –effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial", in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a

cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained to the intervention. -This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.8	*3.IT-10.1*	*Quality of Life/Functional Status – Quality of Life (SF36): for Medicaid-eligible elders 65 and older receiving services from the UNTHSC Division of Geriatrics partner hospitals.*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics – 1.1.3: Community-Based Primary Care for the Elderly*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY2 and DY3 **Target Population**: 20,476 Medicaid-eligible elders and near elders residing in RHP 10 are eligible for services within this project **Specific Number:** Overall project target is 15% (3,071) of population. Outcome 3 target is 10% improvement in quality of life (SF-36 scores) for **all** 3,071 patients. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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 (Develop and test data systems) Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment:$266,478 **Process Milestone 3** [P-3]: Develop and test data systems for collection and program evaluation. Data Source: Program Records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $266,478	**Outcome Improvement Target 1** [IT 10.1]: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool, for the target population. Improvement Target: 5% improvement in QOL scores for population receiving intervention Data Source: Data Source: SF-36 Outcome Improvement Target 1 Estimated Incentive Payment*:* $570,139	**Outcome Improvement Target 2** [IT 10.1]: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool, for the target population. Improvement Target: 10% improvement in QOL scores for population receiving intervention Data Source: Data Source: SF-36 Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,239,433
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $532,956	Year 4 Estimated Outcome Amount: $570,139	Year 5 Estimated Outcome Amount: $1,239,433

138980111.3.8	*3.IT-10.1*	*Quality of Life/Functional Status – Quality of Life (SF36): for Medicaid-eligible elders 65 and older receiving services from the UNTHSC Division of Geriatrics partner hospitals.*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics – 1.1.3: Community-Based Primary Care for the Elderly*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY2 and DY3 **Target Population**: 20,476 Medicaid-eligible elders and near elders residing in RHP 10 are eligible for services within this project **Specific Number:** Overall project target is 15% (3,071) of population. Outcome 3 target is 10% improvement in quality of life (SF-36 scores) for **all** 3,071 patients. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,342,529			

Title of Outcome Measure (Improvement Target): IT-3.1: All-cause 30-day readmission rate – NQF 1789

Unique RHP outcome identification number(s): 138980111.3.10

Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:

This outcome measure will assess the effectiveness of the project in reducing all-cause 30-day readmission rates for Medicaid-eligible elders 65 receiving the intervention. The expected outcome by the end of the Waiver is to reduce all-cause 30-day readmission rates for Medicaid-eligible elders 65 and above receiving the intervention by 10% over baseline (3 readmissions prevented). The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include discussions with local health care providers and hospital partners regarding targeted conditions most strongly related to readmissions, which will be targeted in the intervention.
- Establish baseline rates [P-2]. Prior work suggests that 20% of hospitalized Medicaid elders will be readmitted within 30 days of discharge. Additional baseline data from our target population will be collected by survey of patients regarding prior hospital readmission rates.
- Develop and test data systems [P-3]. This will involve setting up methods to track and collect readmission data from program records and partner hospitals.
- Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – IT-3.1: All-cause 30-day readmission rate – NQF 1789 will be measured by survey of patients receiving care from this intervention as well as partnering hospital records. We predict that enhanced access to geriatric primary care services through the UNTHSC Division of Geriatrics will reduce 30-day readmission rates within the target population.

Rationale:

Approximately 20% of Medicaid-eligible elders are readmitted to hospitals within 30 days of discharge, which is a significant financial drain that also reduces overall quality of life. By enhancing access to geriatric primary care for Medicaid-eligible elders receiving services within the UNTHSC Department of Internal Medicine, we propose to reduce Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – All-cause 30-day readmissions by 10% over baseline (3 readmissions prevented). This reduction in readmissions will result in a significant cost savings. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project

planning will include discussions with local health care providers and hospital partners regarding targeted conditions most strongly related to readmissions, which will be targeted in the intervention.

- Establish baseline rates [P-2]. Prior work suggests that 20% of discharged Medicaid elders will be readmitted within 30 days. However, this milestone is necessary as baseline rates within our target population and community have not been established. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect 30-day readmission data from area hospitals.
- Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – [IT-3.1] – All-cause 30-day readmission rate – NQF 1789. This outcome improvement target measures the number of 30-day readmissions among Medicaid-eligible patients receiving services from the UNTHSC Department of Internal Medicine/Division of Geriatrics. Patients in this intervention will demonstrate improved knowledge regarding appropriate use of medical services and disease self-management, which will result in a reduction in 30-day readmissions.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For all cause 30 day readmission rate, the UNT Health Science Center defined the population that will be directly impacted by the project as the number of hospitalized Medicaid-eligible elders of Tarrant Count ages 65 and above, who receive services from the UNTHSC Department of Internal Medicine, which would - be 33 - individuals. - The percentage of improvement - expected - by the project is 10%, equating to 3 lives positively impacted by this outcome -.

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,491 (Texas Department of State Health Services data) -.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $4,495 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $2,996 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.10	*3.IT-3.1*	Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – IT-3.1: All-cause 30-day readmission rate – NQF 1789: for Medicaid eligible elders 65 and older receiving services from the UNTHSC Department of Internal Medicine	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.3 Expand Primary Care Capacity – Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid-Eligible Elders*		
Starting Point/Baseline:	**Baseline data**: Approximately 20% of elderly patients are readmitted within 30 days based on prior data. Actual baseline data will be collected in DY3. **Target Population**: Number of hospitalized Medicaid eligible elders who receive services from UNTHSC Department of Internal Medicine (FY11 baseline data was approx. 750 patients receiving services from UNTHSC Department of Internal Medicine, which this project will increase by 35% – 1,013 patients by DY5). It is anticipated that 16%, or 162, of these patients will be admitted to the hospital. **Specific Number:** It is anticipated that 20%, or 33, of those hospitalized will be readmitted within 30 days. Our goal is reduction in hospital readmission by 10% (3 readmissions prevented). **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program records	**Process Milestone 3** [P-2]: Establish baseline rates -Data Source: Program Records Process Milestone 3 Estimated Incentive Payment: $2,830	**Outcome Improvement Target 1** [IT 3.1]: All-cause 30-day readmission rate – NQF 1789 – for Medicaid-eligible elders 65 and above who receive care from the UNTHSC Department of Internal Medicine. Improvement Target: 5% reduction in all-cause hospitalization rate over baseline (2 readmissions prevented). Data Source: Program records/EMR/Claims records Outcome Improvement Target 1 Estimated Incentive Payment: $3,028	**Outcome Improvement Target 2** [IT 3.1]: All-cause 30-day readmission rate – NQF 1789 – for Medicaid-eligible elders 65 and above who receive care from the UNTHSC Department of Internal Medicine. Improvement Target: 10% reduction in all-cause readmission rate over baseline (3 readmissions prevented) Data Source: Program records/EMR/Claims records Outcome Improvement Target 2 Estimated Incentive Payment: $6,582

138980111.3.10	*3.IT-3.1*	Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – IT-3.1: All-cause 30-day readmission rate – NQF 1789: for Medicaid eligible elders 65 and older receiving services from the UNTHSC Department of Internal Medicine	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.3 Expand Primary Care Capacity – Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid-Eligible Elders*		
Starting Point/Baseline:	**Baseline data**: Approximately 20% of elderly patients are readmitted within 30 days based on prior data. Actual baseline data will be collected in DY3. **Target Population**: Number of hospitalized Medicaid eligible elders who receive services from UNTHSC Department of Internal Medicine (FY11 baseline data was approx. 750 patients receiving services from UNTHSC Department of Internal Medicine, which this project will increase by 35% – 1,013 patients by DY5). It is anticipated that 16%, or 162, of these patients will be admitted to the hospital. **Specific Number:** It is anticipated that 20%, or 33, of those hospitalized will be readmitted within 30 days. Our goal is reduction in hospital readmission by 10% (3 readmissions prevented). **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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 2 Estimated Incentive Payment *(maximum amount):* $0			

138980111.3.10	*3.IT-3.1*	Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – IT-3.1: All-cause 30-day readmission rate – NQF 1789: for Medicaid eligible elders 65 and older receiving services from the UNTHSC Department of Internal Medicine	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.3 Expand Primary Care Capacity – Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid-Eligible Elders*		
Starting Point/Baseline:	**Baseline data**: Approximately 20% of elderly patients are readmitted within 30 days based on prior data. Actual baseline data will be collected in DY3. **Target Population**: Number of hospitalized Medicaid eligible elders who receive services from UNTHSC Department of Internal Medicine (FY11 baseline data was approx. 750 patients receiving services from UNTHSC Department of Internal Medicine, which this project will increase by 35% – 1,013 patients by DY5). It is anticipated that 16%, or 162, of these patients will be admitted to the hospital. **Specific Number:** It is anticipated that 20%, or 33, of those hospitalized will be readmitted within 30 days. Our goal is reduction in hospital readmission by 10% (3 readmissions prevented). **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $2,830	Year 4 Estimated Outcome Amount: $3,028	Year 5 Estimated Outcome Amount: $6,582
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $12,440			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores – of getting timely care, appointments and information

Unique RHP outcome identification number(s): 138980111.3.11
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving patient satisfaction scores of getting timely care, appointments and information for those receiving services within the UNTHSC Department of Internal Medicine. The expected outcome by the end of the Waiver is to improve patient satisfaction scores in getting timely care, appointments and information by 5% over baseline for all 1,013 patients provided services. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include discussions with local health care providers and patients regarding barriers to getting timely care, appointments and information. The intervention will target these barriers.
- Establish baseline rates [P-2]. The baseline will be established by survey of patients prior to and after receiving patient encounters within the UNTHSC Division of Geriatrics.
- Develop and test data systems [P-3]. This will involve setting up methods to collect and analyze survey data.
- Patient Satisfaction – IT-6.1 Percent improvement over baseline of patient satisfaction scores in getting timely care, appointments and information will be measured by survey prior to and after receiving encounters from the UNTHSC Division of Geriatrics.

Rationale:
A sizable literature supports the notion that patient satisfaction with medical care has direct impact on patient outcomes as well as clinical quality and operation performance. The current project targets improvement in patient satisfaction with "getting timely care, appointments and information." In fact, these are related to commonly implemented quality metrics utilized by clinics throughout the U.S. We seek to improve patient satisfaction with getting timely care, appointments and information by 5% over the Waiver period. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage primary care

providers, clinic staff, and patients regarding barriers to receipt of timely appointments and information. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for patient satisfaction with timeliness to appointments and services. However, prior UNTHealth surveys will provide information for comparison regarding timeliness to appointment. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect patient satisfaction surveys.
- Patient Satisfaction – IT-6.1 Percent improvement over baseline of patient satisfaction scores of getting timely care, appointments and information. This outcome improvement target measures change in patient satisfaction prior to and after receiving services from the UNTHSC Division of Geriatrics. Participants in this intervention will demonstrate improved satisfaction with getting timely care, appointments and information.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For patient satisfaction percent improvement over baseline of patient satisfaction scores, UNT Health Science Center defined the population that will be directly impacted by the project as Medicaid-eligible elders of Tarrant County ages 65 and above, who receive services from the UNTHSC Department of Internal Medicine, which would be approximately 1,013 individuals. We are anticipating that we will test the entire population, and - are expecting to increase - the patient satisfaction scores for the project by 5%-.

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $15 (per information provided by the UNT Health Science Center's Division of Geriatrics) -.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $9 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $6 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.11	*3.IT-6.1*	*Patient Satisfaction – IT-6.1 Percent improvement over baseline of patient satisfaction scores – (1) are getting timely care, appointments and information.*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.3: Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid-Eligible Elders*		
Starting Point/Baseline:	**Baseline data**: Baseline data will be collected in DY3. **Target Population:** Medicaid eligible elders of Tarrant County age 65 and above who receive services from the UNTHSC Department of Internal Medicine **Specific Number:** In FY 11, approx. 750 Medicaid-eligible elders received services from UNTHSC Department of Internal Medicine. This project will increase patient pool by 35% – 1,013 patients by DY5. Our goal is improvement in patient satisfaction among all 1013 patients. **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 3 Estimated Incentive Payment: $1,763	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores of getting timely care, appointments and information. Improvement Target: 3% over baseline improvement in patient's satisfaction with getting timely care, appointments and information Data Source: Patient survey pre- and postvisit with provider Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,886	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores of getting timely care, appointments and information. Improvement Target:5% over baseline improvement in patient's satisfaction with getting timely care, appointments and information Data Source: Patient survey pre- and postvisit with provider Outcome Improvement Target 2 Estimated Incentive Payment*:* $4,100

138980111.3.11	*3.IT-6.1*	*Patient Satisfaction – IT-6.1 Percent improvement over baseline of patient satisfaction scores – (1) are getting timely care, appointments and information.*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.3: Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid-Eligible Elders*		
Starting Point/Baseline:	**Baseline data**: Baseline data will be collected in DY3. **Target Population:** Medicaid eligible elders of Tarrant County age 65 and above who receive services from the UNTHSC Department of Internal Medicine **Specific Number:** In FY 11, approx. 750 Medicaid-eligible elders received services from UNTHSC Department of Internal Medicine. This project will increase patient pool by 35% – 1,013 patients by DY5. Our goal is improvement in patient satisfaction among all 1013 patients. **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $1,763	Year 4 Estimated Outcome Amount: $1,886	Year 5 Estimated Outcome Amount: 4,100

138980111.3.11	*3.IT-6.1*	*Patient Satisfaction – IT-6.1 Percent improvement over baseline of patient satisfaction scores – (1) are getting timely care, appointments and information.*
University of North Texas Health Science Center (UNTHSC)		*138980111*
Related Category 1 or 2 Projects::	*138980111.1.3: Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid-Eligible Elders*	
Starting Point/Baseline:	**Baseline data**: Baseline data will be collected in DY3. **Target Population:** Medicaid eligible elders of Tarrant County age 65 and above who receive services from the UNTHSC Department of Internal Medicine **Specific Number:** In FY 11, approx. 750 Medicaid-eligible elders received services from UNTHSC Department of Internal Medicine. This project will increase patient pool by 35% – 1,013 patients by DY5. Our goal is improvement in patient satisfaction among all 1013 patients. **Description of Population:** Elderly patients who are eligible for coverage by Medicaid	

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)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $7,749			

Title of Outcome Measure (Improvement Target): IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)

Unique RHP outcome identification number(s): 138980111.3.12
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
Improving the pneumonia vaccination status for Medicaid-eligible adults aged 65 and over receiving services from the UNTHSC Department of Internal Medicine. The expected outcome by the end of the Waiver is to improve the pneumonia vaccination status for adults aged 65 and over by 15% over baseline (51 new vaccinations). The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include discussions with local health care providers and patients regarding barriers to receiving pneumonia vaccinations. The appropriate evidence-based plan will be developed with timelines generated.
- Establish baseline rates [P-2]. The baseline will be established by survey of patients receiving services from the intervention regarding prior vaccination history.
- Develop and test data systems [P-3]. This involves generation of a method for collecting and analyzing survey data.
- Primary Care and Primary Prevention- Pneumonia vaccination status for older adults (HEDIS 2012) [IT-12.4] will be measured by survey of patients receiving services from the UNTHSC Department of Internal Medicine, Division of Geriatrics.

Rationale:
The risk for developing pneumonia is higher among the elderly owning to chronic (often comorbid) illnesses. Pneumonia is oftentimes cited as the fifth leading cause of death among the elderly. Given the increase medical illnesses and comorbidities among our target population, they are at increased risk for pneumonia. The current project seeks to increase the percentage of elders ever receiving a pneumonia vaccine by 15% over baseline (51 new vaccinations) during the Waiver period. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include discussions with local health care providers and hospital partners regarding barriers to receiving appropriate vaccinations among the target population. The intervention will be designed to address these key barriers.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for patients from the target population and community. It is anticipated that approximately 33% (334) will never have received the target vaccination.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect and analyze survey data regarding patient vaccination history.
- Primary Care and Primary Prevention- Pneumonia vaccination status for older adults (HEDIS 2012) [IT-12.4]. This outcome improvement target measures the percentage of patients receiving pneumonia vaccinations prior to and after intervention. Patients in the intervention will gain understanding of the importance of receiving appropriate vaccinations and the dangers of not doing so, with particular emphasis on pneumonia vaccinations. It is anticipated that this education, as well as targeted interventions regarding key barriers to access, will significantly improve vaccination rates among the target population.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For pneumonia vaccination status for older adults, UNT Health Science Center defined the population that will be directly impacted by the project as Medicaid-eligible elders of Tarrant County ages 65 and above, who receive services from the UNTHSC Department of Internal Medicine is estimated to be 1013 individuals, of which 674 have received the vaccination. It is anticipated that approximately 15 -% or 51 additional patients will receive the vaccination-.

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $15,682 (as cited in the article "Incidence and Cost of Pneumonia in Medicare Beneficiaries" in *Chest* Journal) -.

  For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $6,273 for each positive outcome realized. Also, additional multiplier was applied to determine the

benefit it provided to the community, the resulting additional valuation amount is $6,273 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.12	*3.IT-12.4*	*Primary Care and Primary Prevention- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.3: Expand Primary Care Capacity – Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elder*		
Starting Point/Baseline:	**aseline data**: According to Jackson & Janoff (2008) approximately 33% of elders have never received the pneumonia vaccination. Actual Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County ages 65 and above receiving services from UNTHSC Department of Internal Medicine, Division of Geriatrics **Specific Number:** In FY 11, approx. 750 Medicaid-eligible elders received services from UNTHSC Department of Internal Medicine. This project will increase patient pool by 35% – 1,013 patients by DY5. Therefore, it is anticipated that approximately 33%, or 334, patients will have never received the vaccinations. Our goal is to increase vaccination status of the Medicaid-eligible elders receiving services from UNTHSC Department of Internal Medicine by 15% over baseline rates (51 new vaccinations). **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program records	**Process Milestone 3** [P-2]: Establish baseline rates - Data Source: Program Records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $163,374	**Outcome Improvement Target 1** [IT-12.4]: Pneumonia vaccination status for older adults (HEDIS 2012). Improvement Target: 10% over baseline improvement in patients who have ever received pneumonia vaccinations (33 new vaccinations). Data Source: Program Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $174,772	**Outcome Improvement Target 2** [IT-12.4]: Pneumonia vaccination status for older adults (HEDIS 2012). Improvement Target: 15% over baseline improvement in patients who have ever received pneumonia vaccinations (51 new vaccinations). Data Source: Program Records Outcome Improvement Target 2 Estimated Incentive Payment*:* $379,940

138980111.3.12	*3.IT-12.4*	*Primary Care and Primary Prevention- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.3: Expand Primary Care Capacity – Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elder*		
Starting Point/Baseline:	**aseline data**: According to Jackson & Janoff (2008) approximately 33% of elders have never received the pneumonia vaccination. Actual Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County ages 65 and above receiving services from UNTHSC Department of Internal Medicine, Division of Geriatrics **Specific Number:** In FY 11, approx. 750 Medicaid-eligible elders received services from UNTHSC Department of Internal Medicine. This project will increase patient pool by 35% – 1,013 patients by DY5. Therefore, it is anticipated that approximately 33%, or 334, patients will have never received the vaccinations. Our goal is to increase vaccination status of the Medicaid-eligible elders receiving services from UNTHSC Department of Internal Medicine by 15% over baseline rates (51 new vaccinations). **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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 2 Estimated Incentive Payment *(maximum amount):* $0			

138980111.3.12	*3.IT-12.4*	*Primary Care and Primary Prevention- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.3: Expand Primary Care Capacity – Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elder*		
Starting Point/Baseline:	**aseline data**: According to Jackson & Janoff (2008) approximately 33% of elders have never received the pneumonia vaccination. Actual Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County ages 65 and above receiving services from UNTHSC Department of Internal Medicine, Division of Geriatrics **Specific Number:** In FY 11, approx. 750 Medicaid-eligible elders received services from UNTHSC Department of Internal Medicine. This project will increase patient pool by 35% – 1,013 patients by DY5. Therefore, it is anticipated that approximately 33%, or 334, patients will have never received the vaccinations. Our goal is to increase vaccination status of the Medicaid-eligible elders receiving services from UNTHSC Department of Internal Medicine by 15% over baseline rates (51 new vaccinations). **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $163,374	Year 4 Estimated Outcome Amount: $174,772	Year 5 Estimated Outcome Amount: $379,940
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $718,086			

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization

Unique RHP outcome identification number(s): 138980111.3.13
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing inappropriate ED use among the target population. The expected outcome by the end of the Waiver is to reduce all ED visits in patients of PCPs receiving the training/intervention by 2% from baseline. The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include identification and recruitment of content experts, content development, baseline data analysis and finalization of tracking and analysis methodology, educational plan development and target audience triangulation and assessment strategies.
- Establish baseline rates [P-2]. The baseline will The baseline will be obtained through the Texas Public Use Data File (Hospital Admissions) or data mart.
- ED Appropriate Utilization Rate [IT-9.2]. ED visits for target conditions:
    - Congestive Heart Failure
    - Diabetes
    - End-stage Renal Disease
    - Cardiovascular Disease/Hypertension
    - Chronic Obstructive Pulmonary Disease
    - Asthma

  will be measured by analysis of ED utilization data collected by the DFW Hospital Council.

Rationale:
Right Care, Right Setting – ED Appropriate Utilization was selected as an outcome measure to assess the effectiveness of the project training materials which include training on medical home and chronic care models, disease registry use for population health management. As a result of the training, PCPs should improve the percentage of high-risk populations receiving preventive measures, increase patient self-management, and reduce inappropriate ED utilization. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage primary care

physicians in updated training in emerging and evolving health care delivery models, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been confirmed for the patients of participating PCPs. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Right Care, Right Setting – ED Appropriate Utilization [IT-9.2]. This outcome improvement target measures the number of ED visits for targeted conditions (congestive heart failure, diabetes, end-stage renal disease, cardiovascular disease/hypertension, chronic obstructive pulmonary disease and asthma). Primary care participants receiving education will demonstrate improvement in appropriate management and self-management for targeted conditions, resulting in fewer ED visits. Educational effectiveness will be measured by improvements in knowledge, competence and performance.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

  - **Rationale/Justification**: For ED appropriate utilization, UNT Health Science Center defined the population that will be directly impacted by the project as patients in RHP 10 who visit the ED and receive services from PCPs receiving intervention, which would be approximately 23,612 patients. The percentage of - improvement by the project - is 2%, equating to 472 lives positively impacted by this outcome-.

    Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,200 due to the patient population mix. -For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $480 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $480 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.13	*3.IT-9.2*	*Right Care, Right Setting – ED appropriate utilization*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.4 Increase Training of Primary Care Workforce – "Other" project option: Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement – 1.2.1: Training Primary Care Workforce in Evolving Health Care Delivery Models*		
Starting Point/Baseline:	**Baseline data:** Based on recent literature and ED utilization data, it is estimated that 231,618 ED visits occur for the targeted conditions each year in RHP 10. Actual baseline data will be determined in DY3. **Target Population**: It is estimated that 231,618 ED visits occur for the targeted conditions each year in RHP-10 in 2010. **Specific Number:** Based on 10% of PCPs in RHP 10 receiving the intervention (training), it is estimated that 23,612 ED visits may be impacted. The goal of this project is to reduce ED visits by 2% for patients of PCPs receiving the intervention. **Description of Population:** Patients in RHP 10 who visit the ED and receive services from PCPs receiving intervention		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Develop and test data systems Data Source: Program Records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $29,197 **Process Milestone 3** [P-2]. Establish baseline rates	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization Reduce Emergency Department visits for target conditions • Congestive Heart Failure • Diabetes • End-stage Renal Disease • Cardiovascular Disease/Hypertension • Chronic Obstructive Pulmonary Disease • Asthma Improvement Target: 1% improvement in appropriate ED utilization in patients of PCP receiving the training/intervention	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization Reduce Emergency Department visits for target conditions • Congestive Heart Failure • Diabetes • End-stage Renal Disease • Cardiovascular Disease/Hypertension • Chronic Obstructive Pulmonary Disease • Asthma Improvement Target: 2% improvement in appropriate ED utilization in patients of PCP receiving the training/intervention

138980111.3.13	*3.IT-9.2*	*Right Care, Right Setting – ED appropriate utilization*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.4 Increase Training of Primary Care Workforce – "Other" project option: Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement – 1.2.1: Training Primary Care Workforce in Evolving Health Care Delivery Models*		
Starting Point/Baseline:	**Baseline data:** Based on recent literature and ED utilization data, it is estimated that 231,618 ED visits occur for the targeted conditions each year in RHP 10. Actual baseline data will be determined in DY3. **Target Population**: It is estimated that 231,618 ED visits occur for the targeted conditions each year in RHP-10 in 2010. **Specific Number:** Based on 10% of PCPs in RHP 10 receiving the intervention (training), it is estimated that 23,612 ED visits may be impacted. The goal of this project is to reduce ED visits by 2% for patients of PCPs receiving the intervention. **Description of Population:** Patients in RHP 10 who visit the ED and receive services from PCPs receiving intervention		
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)**
	Data Source: Program Records Process Milestone 3 Estimated Incentive Payment: $29,197	Data Source: North Texas Regional Extension Center and/or North Texas Accountable Healthcare Partnership Outcome Improvement Target 1 Estimated Incentive Payment: $62,469	Data Source: North Texas Regional Extension Center and/or North Texas Accountable Healthcare Partnership Outcome Improvement Target 2 Estimated Incentive Payment: $135,802

138980111.3.13	*3.IT-9.2*	*Right Care, Right Setting – ED appropriate utilization*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.4 Increase Training of Primary Care Workforce – "Other" project option: Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement – 1.2.1: Training Primary Care Workforce in Evolving Health Care Delivery Models*		
Starting Point/Baseline:	**Baseline data:** Based on recent literature and ED utilization data, it is estimated that 231,618 ED visits occur for the targeted conditions each year in RHP 10. Actual baseline data will be determined in DY3. **Target Population**: It is estimated that 231,618 ED visits occur for the targeted conditions each year in RHP-10 in 2010. **Specific Number:** Based on 10% of PCPs in RHP 10 receiving the intervention (training), it is estimated that 23,612 ED visits may be impacted. The goal of this project is to reduce ED visits by 2% for patients of PCPs receiving the intervention. **Description of Population:** Patients in RHP 10 who visit the ED and receive services from PCPs receiving intervention		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $58,395	Year 4 Estimated Outcome Amount: $62,469	Year 5 Estimated Outcome Amount: $135,802
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $256,666			

Title of Outcome Measure (Improvement Target): IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)

Unique RHP outcome identification number(s): 138980111.3.15
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving the pneumonia vaccination status for adults ages 65 and over. The expected outcome by the end of the Waiver is to improve the pneumonia vaccination status for adults aged 65 and over by 3% over baseline. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include identification and recruitment of content experts, content development, baseline data analysis and finalization of tracking and analysis methodology, educational plan development and target audience triangulation and assessment strategies.
- Establish baseline rates [P-2]. The baseline will be obtained through the Texas Public Use Data File (Hospital Admissions) or data mart.
- Primary Care and Primary Prevention- Pneumonia vaccination status for older adults (HEDIS 2012) [IT-12.4] will be measured by data aggregated by the North Texas Regional Extension Center and North Texas Accountable Healthcare Partnership and DY4 and DY5 will be compared to baseline.

Rationale:
Primary Care and Primary Prevention- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012) was selected as an outcome measure because training will specifically addresses gaps in care in primary care, where sub-optimal rates of pneumonia immunizations are administered to older patients. This measure will assess the effectiveness of the project training materials which include modules in pneumonia prevention, including immunization in older adults. Medical home and chronic care models are also included in the training and have been shown to improve immunization status. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage primary care physicians in updated training in emerging and evolving health care delivery models, to identify capacity, to plan and document needed resources, and to implement plans

necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been confirmed for the patients of participating PCPs. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Primary Care and Primary Prevention- Pneumonia vaccination status for older adults (HEDIS 2012) [IT-12.4]. Primary care participants receiving education will demonstrate improvement in pneumonia vaccination status in adults 65 and older. Educational effectiveness will be measured by improvements in knowledge, competence and performance.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification**: For Pneumonia vaccination status for older adults, UNT Health Science Center defined the population that will be directly impacted by the project as patients in RHP 10 who are 65 and older and receive services from PCPs receiving intervention**,** which would be approximately 14,167. The percentage of improvement in pneumonia vaccinations for this population is expected to be 3%, equating to 425 lives positively impacted.

  Utilizing, - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $417 (as cited in the article, "Pneumococcal Vaccination Reduces Mortality and Costs in Elderly" in the internet journal at www.respiratoryreviews.com), -which was based on the average savings per person vaccinated.

  For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $167 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $167 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.15	*3.IT-12.4*	*Primary Care and Primary Prevention- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.4 Increase Training of Primary Care Workforce – "Other" project option: Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement (1.2.1: Training Primary Care Workforce in Evolving Health Care Delivery Models)*		
Starting Point/Baseline:	**Baseline data:** Based on 2010 Census Data, 141,667 ages 65 and older have never received the pneumococcal vaccine. Actual baseline data for providers and corresponding patients will be identified by performing a provider review and ID of impact metrics and baseline in DY2-3 to set baseline data. **Target Population:** Total number of people ages 65 and older who have not ever received the pneumococcal vaccine and are seen by the 12,788 PCPs in the Region. According to 2010 Census Data, n= 141,667. **Specific Number:** Estimated **14,167** based on 10% of PCPs receiving intervention **Description of Population:** Patients in RHP 10 who are considered high risk for infection and receive services from PCPs receiving intervention		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program Records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $28,969 **Process Milestone 3** [P-2]. Establish baseline rates Data Source: Program Records	**Outcome Improvement Target 1 IT-12.4** Pneumonia vaccination status for older adults (HEDIS 2012) Numerator: Number of adults aged 65 and older that have ever received a pneumonia vaccine. Denominator: Number of adults ages 64 and older in the patient or target population Improvement Target: is 2% increase over baseline for patients of PCPs receiving intervention Data Source: EMR, claims Outcome Improvement Target 1 Estimated Incentive Payment*:*	**Outcome Improvement Target 2 IT-12.4** Pneumonia vaccination status for older adults (HEDIS 2012) Numerator: Number of adults aged 65 and older that have ever received a pneumonia vaccine. Denominator: Number of adults ages 64 and older in the patient or target population Improvement Target: is 3% increase over baseline for patients of PCPs receiving intervention Data Source: EMR, claims Outcome Improvement Target 2 Estimated Incentive Payment*:*

138980111.3.15	*3.IT-12.4*	*Primary Care and Primary Prevention- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.4 Increase Training of Primary Care Workforce – "Other" project option: Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement (1.2.1: Training Primary Care Workforce in Evolving Health Care Delivery Models)*		
Starting Point/Baseline:	**Baseline data:** Based on 2010 Census Data, 141,667 ages 65 and older have never received the pneumococcal vaccine. Actual baseline data for providers and corresponding patients will be identified by performing a provider review and ID of impact metrics and baseline in DY2-3 to set baseline data. **Target Population:** Total number of people ages 65 and older who have not ever received the pneumococcal vaccine and are seen by the 12,788 PCPs in the Region. According to 2010 Census Data, n= 141,667. **Specific Number:** Estimated **14,167** based on 10% of PCPs receiving intervention **Description of Population:** Patients in RHP 10 who are considered high risk for infection and receive services from PCPs receiving intervention		
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 3 Estimated Incentive Payment: $28,969	$61,979	$134,738

138980111.3.15	*3.IT-12.4*	*Primary Care and Primary Prevention- IT-12.4 Pneumonia vaccination status for older adults (HEDIS 2012)*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.4 Increase Training of Primary Care Workforce – "Other" project option: Update primary care training programs to include training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement (1.2.1: Training Primary Care Workforce in Evolving Health Care Delivery Models)*		
Starting Point/Baseline:	**Baseline data:** Based on 2010 Census Data, 141,667 ages 65 and older have never received the pneumococcal vaccine. Actual baseline data for providers and corresponding patients will be identified by performing a provider review and ID of impact metrics and baseline in DY2-3 to set baseline data. **Target Population:** Total number of people ages 65 and older who have not ever received the pneumococcal vaccine and are seen by the 12,788 PCPs in the Region. According to 2010 Census Data, n= 141,667. **Specific Number:** Estimated **14,167** based on 10% of PCPs receiving intervention **Description of Population:** Patients in RHP 10 who are considered high risk for infection and receive services from PCPs receiving intervention		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $57,937	Year 4 Estimated Outcome Amount: $61,979	Year 5 Estimated Outcome Amount: $134,738
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $254,654			

Title of Outcome Measure (Improvement Target): IT 6.1 (1) Percent improvement over baseline of patient satisfaction scores – are getting timely care, appointments, and information

Unique RHP outcome identification number(s): 138980111.3.16
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will track and assess the percent improvement over baseline patient satisfaction scores. The expected outcome by the end of the Waiver period is to improve patient satisfaction by 10% over baseline as measured by CGCAHPS survey on patients getting timely care appointments, and information. To support achievement of this outcome, specific process milestones and metrics were selected:

Process Milestones and Outcome Improvement Targets for each year:

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Activities will include expanding the primary care training program and rotations for community health workers/promotoras, hiring additional precepting primary care faculty, and developing a mentoring program with primary care faculty and new CHW trainees.
- Establish baseline rates [P-2]. The baseline rates will be established by assessing and collecting patient satisfaction scores from patients prior to CHW exposure.
- Percent improvement over baseline patient satisfaction scores – (1) are getting timely care, appointments, and information [IT-6.1] Patient satisfaction will be measured using the CGCAHPS module (1) that assesses whether patients are getting timely care, appointments, and information.

Rationale:
Patient satisfaction with getting timely care appointments, and information was selected to assess the impact of placing CHWs/promotoras in performing providers' facilities.

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important to ensure that capacity for CHW training, placement in rotations, and mentoring is available.
- Establish baseline rates [P-2]. This process milestone is necessary as no patient satisfaction baseline data currently exists. Establishing baseline rates will provide the ability to assess the effectiveness of the project.

Percent improvement over baseline of patient satisfaction scores – (1) are getting timely care, appointments, and information [IT-6.1]. The project will add 40 CHWs and place them in

performing providers' facilities throughout RHP 10. This improvement target measures the expected outcome of improved patient satisfaction.

Outcome Measure Valuation:

Approach/Methodology:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:

For Patient Satisfaction Percent Improvement over Baseline of Patient Satisfaction Scores, UNT Health Science Center defined the population that will be directly impacted by the project as patients seen by providers where newly trained CHWs/promotoras are placed, which would be approximately 2,500 individuals. We are anticipating that we will test the entire population, and are expecting to increase the patient satisfaction scores for the project by 10%.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $32 (as cited in the article, "Medicaid Savings Resulted When Community Health Workers Matched Thoses With Needs To Home and Community Care" in the journal, *Health Affairs*), which was based on two percent of the expected reduced annual Medicaid spending per participant.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health

Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.16	*3.IT-6.1*	*Patient Satisfaction – IT-6.1: Percent improvement over baseline of patient satisfaction scores – of patient's overall health status/functional status*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects:	*138980111.1.5 Increase Training of Primary Care Workforce– - Increase the Number of Primary Care Providers – 2.2.2: Community Health Worker Network*		
Starting Point/Baseline:	**Baseline data:** Baseline data to be collected in DY2 and DY3. **Target Population:** Patients seen by providers where newly trained CHWs/promotoras are placed **Specific Number:** 2500 patients based on estimate at least 10 CHWs employed in practices averaging 250 patients **Description of Population:** Low income, racial or ethnic minority or uninsured patients of RHP 10 providers.		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,290 **Process Milestone 3** [P-2]: Establish baseline rates Data Source: Program records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $2,290	**Outcome Improvement Target 1** [IT-6.1] (Domain (5)): Percent improvement over baseline of patient satisfaction scores of patient's timely care, appointments, and information Goal: 5% increase over baseline by DY4 Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $4,899	**Outcome Improvement Target 2** [IT-6.1] (Domain (5)): Percent improvement over baseline of patient satisfaction scores of timely care, appointments, and information Goal: 10% increase over baseline by DY5 Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $10,651

138980111.3.16	*3.IT-6.1*	*Patient Satisfaction – IT-6.1: Percent improvement over baseline of patient satisfaction scores – of patient's overall health status/functional status*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects:	*138980111.1.5 Increase Training of Primary Care Workforce– - Increase the Number of Primary Care Providers – 2.2.2: Community Health Worker Network*		
Starting Point/Baseline:	**Baseline data:** Baseline data to be collected in DY2 and DY3. **Target Population:** Patients seen by providers where newly trained CHWs/promotoras are placed **Specific Number:** 2500 patients based on estimate at least 10 CHWs employed in practices averaging 250 patients **Description of Population:** Low income, racial or ethnic minority or uninsured patients of RHP 10 providers.		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $4,580	Year 4 Estimated Outcome Amount: $4,899	Year 5 Estimated Outcome Amount: $10,651
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $20,130			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of life

Unique RHP outcome identification number(s): 138980111.3.17
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will track and assess the percent improvement over baseline quality of life scores. The expected outcome by the end of the Waiver period is to improve quality of life scores by 10% over baseline as measured by SF-36. To support achievement of this outcome, specific process milestones and metrics were selected:

Process Milestones and Outcome Improvement Targets for each year:

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Activities will include expanding the primary care training program and rotations for community health workers/promotoras, hiring additional precepting primary care faculty, and developing a mentoring program with primary care faculty and new CHW trainees.
- Establish baseline rates [P-2]. The baseline rates will be established by assessing and collecting patient quality of life scores from patients prior to CHW exposure.
- Percent improvement over baseline in quality of life scores [IT-10.1] Patient quality of life will be measured by using the SF-36.

Rationale:
Demonstrate improvement in quality of life scores, as measured by evidence-based and validated assessment tool (SF-36), for the target population was selected to assess the impact of placing CHWs/promotoras in performing providers' facilities.

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important to ensure that capacity for CHW training, placement in rotations, and mentoring is available.
- Establish baseline rates [P-2]. This process milestone is necessary as no patient satisfaction baseline data currently exists. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Quality of Life [IT-10.1]. This outcome improvement target measures quality of life scores of the patients served by community health workers assigned to providers' facilities. Quality of life is a critical part of a person's health. Appraisals of quality of life may be an early indicator of changes in health, as they are often more malleable than traditional health indicators such as cholesterol levels or hemoglobin A1c. Further, assessments of quality of life provide great insight into how a patient

perceives the effect of his or her own health and its subsequent effect on overall life. This project proposes to achieve measurable improvements in quality of life scores among patients working with RHP 10 providers employing CHWs to enhance patient care. Part of each trainee's work will include assessing quality of life at baseline and at the end of working with each patient. It is very likely that patients working with CHWs will enjoy better health outcomes and better health care system encounters when compared with the health and care they received prior to working with CHWs. It is expected that these improvements will be evidenced in improvements in appraisals of quality of life.

Outcome Measure Valuation:

Approach/Methodology:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:

For Quality of Life, UNT Health Science Center defined the population that will be directly impacted by the project as Patients seen by providers where newly trained CHWs/promotoras are placed, which would be approximately 2,500 individuals. We anticipate that we will test the entire population and are expecting to increase the quality of life scores by 10%,

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome would be $3,755 (as cited in the article, "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Control Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention. - This threshold has been a standard way of valuing life-terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved

by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.17	*3.IT-10.1*	*Quality of Life/Functional Status – IT-10.1: Qualtiy of Life*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects:	*138980111.1.5 Increase Training of Primary Care Workforce – Increase the Number of Primary Care Providers – 1.2.2: Community Health Worker Network*		
Starting Point/Baseline:	**Baseline data:** Baseline data to be collected in DY2 and DY3. **Target Population:** Patients seen by providers where newly trained CHWs/promotoras are placed **Specific Number:** 2500 patients based on estimate at least 10 CHWs employed in practices averaging 250 patients **Description of Population:** Low income, racial or ethnic minority or uninsured patients of RHP 10 providers.		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $537,413	**Outcome Improvement Target 1** [IT-10.1]: Demonstrate improvement in quality of life scores, as measured by evidence-based and validated assessment tool (SF-36), for the target population Goal: 5% improvement in SF-36 scores over baseline quality of life scores Data Source: SF-36 Outcome Improvement Target 1 Estimated Incentive Payment*:* $574,906	**Outcome Improvement Target 2** [IT-10.1]: Demonstrate improvement in quality of life scores, as measured by evidence-based and validated assessment tool (PedsQL), for the target population Goal: 10% improvement in SF-36 scores over baseline quality of life scores Data Source: SF-36 Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,249,797
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $537,413	Year 4 Estimated Outcome Amount: $574,906	Year 5 Estimated Outcome Amount: $1,249,797
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,362,116			

Title of Outcome Measure (Improvement Target): IT-10.1: Quality of Life/Functional Status

Unique RHP outcome identification number(s): 138980111.3.18
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Performing Provider Name: University of North Texas Health Science Center (UNTHSC)
Texas Provider Identifier: 138980111

Outcome Measure Description:
This outcome measure would track and measure quality of life for at-risk, underserved African-American pre-teen girls in Tarrant County. The expected outcome by the end of the Waiver is to improve quality of life, as measured by a 5% increase in the PedsQL score by DY5. The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This will include development and implementation of the project plan, execution and documentation of the learning and diffusion strategy, execution and documentation of the evaluation process, tools, and analytics, and identification of 40 African-American pre-teen girls to participate in the program.
- Establish baseline rates [P-2]. The baseline will be established by administering the PedsQL to project participants upon enrollment into the program.
- Quality of Life/Functional Status [IT-10.1]. We will measure quality of life using PedsQL, an evidence-based and validated assessment tool. The PedsQL Measurement Model is a modular approach to measuring health-related quality of life (HRQOL) in healthy children and adolescents and those with acute and chronic health conditions. The PedsQL Measurement Model integrates seamlessly both generic core scales and disease-specific modules into one measurement system. The 23-item PedsQL Generic Core Scales were designed to measure the core dimensions of health as delineated by the World Health Organization, as well as role (school) functioning. The 4 Multidimensional Scales and 3 Summary Scores are:

Scales	**Summary Scores**
Physical Functioning (8 items)	Total Scale Score (23 items)
Emotional Functioning (5 items)	Physical Health Summary (8 items)
Social Functioning (5 items)	Psychosocial Health Summary
School Functioning (5 items)	(15 items)

Rationale:
Quality of life was selected as an outcome improvement target to assess changes in physical, emotional, social, and school functioning as a result of African-American pre-teen girls having participated in the project. To support achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important to ensure engagement by stakeholder organizations providing evidence-based youth services, and to ensure stakeholder organizations are prepared for data reporting.
- Establish baseline rates [P-2]. This process milestone is necessary as no baseline data currently exists. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Quality of Life [IT-10.1]. This outcome improvement target measures quality of life scores of the at-risk, underserved African-American pre-teen girls, as measured by evidence-based and validated assessment tool (PedsQL) for the target population. The PedsQL is a complex measure that includes indicators of physical functioning, emotional functioning, social functioning, and school functioning. The broad based intervention that is used by youth serving organizations may have different impacts on each factor, although a generally positive impact. Hence, in the absence of baseline data, the projected 5% increase indicates a general positive effect, while effects in each subarea may be greater or less. In addition, there are confounding factors such as age and family SES that may influence the effect.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:**
  For quality of life, UNT Health Science Center defined the population that will be directly impacted by the project as Pre-teen African-American girls who are at risk for poor birth outcomes, which would be approximately 40 patients. We are anticipating that we will test the entire population, and are expecting to increase the quality of life scores for the project by 3%-.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $25,000 (as cited in the article, "Mapping the EQ-5D Index from the SF-12: US General Population Preference in a Nationally Representative Sample" in the journal, Medical Decision Making and "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's School of Public Health), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention. -This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.18	*3.IT-10.1*	*Quality of Life/Functional Status – IT-10.1: Quality of Life*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.1 Implement Evidence-based Disease Prevention Programs – Implement Evidence-Based Disease Prevention Programs: "Other Project Option" – 2.7.6: Promoting Physical and Mental Health Among At-risk, Underserved African-American Pre-teen Girls in Tarrant County*		
Starting Point/Baseline:	**Baseline Data:** This is a new project. Baseline data will be collected in DY3. **Target Population:** **Specific Number: 40** **Description of Population:** Pre-teen African-American girls who are at risk for poor birth outcomes		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-1]: Project Planning – Implement intervention through established partnerships with youth serving organizations. Data Source: Program records Process Milestone 2 Estimated Incentive Payment: $28,624 **Process Milestone 3** [P-2]: Establish baseline rates Data Source: Program records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $28,624	**Outcome Improvement Target 1** [IT-10.1]: Demonstrate improvement in quality of life scores, as measured by evidence-based and validated assessment tool (PedsQL), for the target population Improvement Target: By DY4, 2% improvement in PedsQL score over baseline Data Source: PedsQL Outcome Improvement Target 1 Estimated Incentive Payment*:* $61,242	**Outcome Improvement Target 2** [IT-10.1]: Demonstrate improvement in quality of life scores, as measured by evidence-based and validated assessment tool (PedsQL), for the target population Improvement Target: By DY5, additional 3% improvement in PedsQL score over baseline Data Source: PedsQL Outcome Improvement Target 2 Estimated Incentive Payment*:* $133,134
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $57,248	Year 4 Estimated Outcome Amount: $61,242	Year 5 Estimated Outcome Amount: $133,134

138980111.3.18	*3.IT-10.1*	*Quality of Life/Functional Status – IT-10.1: Quality of Life*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.1 Implement Evidence-based Disease Prevention Programs – Implement Evidence-Based Disease Prevention Programs: "Other Project Option" – 2.7.6: Promoting Physical and Mental Health Among At-risk, Underserved African-American Pre-teen Girls in Tarrant County*		
Starting Point/Baseline:	**Baseline Data:** This is a new project. Baseline data will be collected in DY3. **Target Population:** **Specific Number: 40** **Description of Population:** Pre-teen African-American girls who are at risk for poor birth outcomes		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $251,624			

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Title of Outcome Measure (Improvement Target): IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5

Unique RHP outcome identification number(s): 138980111.3.19
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing potentially preventable admissions for COPD among the target population. The expected outcome by the end of the Waiver is to reduce Chronic Obstructive Pulmonary Disease Admission Rate – PQI 5 by 3% from baseline. The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include identification and recruitment of content experts, content development, baseline data analysis and finalization of tracking and analysis methodology, educational plan development and target audience triangulation and assessment strategies.
- Establish baseline rates [P-2]. The baseline will be obtained through the Texas Public Use Data File (Hospital Admissions) or data mart. These data from the process milestones will be analyzed to create the PQI composite score, as defined by the AHRQ. Similar data will be collected over DY3-5.
- Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5 [IT-2.5]. COPD Admission Rate will be measured by using the THCIC – Inpatient and Outpatient Data Public Use Data File (PUDF) or comparable current data set from a data mart or other data aggregator.

Rationale:
Potentially Preventable Admissions Chronic Obstructive Pulmonary Disease (COPD) Admission Rate was selected as an outcome measure to assess the effectiveness of the project in training materials which specifically address clinical processes in effective COPD patient management and education on self-management . To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1. This milestone is important as it provides the opportunity to engage primary care physicians in evidence-based process models, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project.

Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patients of participating PCPs. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5 [IT-2.5]. This outcome improvement target measures the number of non-maternal admissions with a principal diagnosis of COPD among patients in RHP 10 from hospitals in RHP 10. Primary care participants receiving education will demonstrate improved competence and performance related to clinical processes in effective patient management and education on self-management of COPD, resulting in fewer admissions. Educational effectiveness will be measured by improvements in knowledge, competence and performance.

Outcome Measure Valuation:

Approach/Methodology: Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification: For Chronic Obstructive Pulmonary Disease (COPD) Admission Rate, UNT Health Science Center defined the population that will be directly impacted by the project as patients in RHP 10 who have been discharged with a principal diagnosis code for COPD and receive services from PCPs receiving intervention, which would be approximately 330 patients. We are anticipating a reduction of admission rates with a principal diagnosis code for COPD in the target population by 3%, equating to 10 lives positively impacted by this outcome.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it is determined that the valuation amount for each positive outcome realized would be $7,931 (TX Dept. of State Health Services data)

For the selected outcome, an additional multiplier was applied to determine the benefit provided to the community, the resulting additional valuation amount is $4,759 for each positive outcome realized. Also, an additional multiplier was applied to determine the

benefit provided to the individual, the resulting additional valuation amount is $3,172 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.19	*3.IT- 2.5*	*Potentially Preventable Admissions – IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.2 Apply Process Improvement Methodology to Improve Quality/Efficiency – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency – 2.8.1: Improving Primary Care Clinical Processes to Reduce Hospitalization Risk*		
Starting Point/Baseline:	**Baseline data:** Baseline data to be established in DY3. Estimated numbers are based on 2010 Census Data **Target population:** Total number of people seen by the 12,788 PCPs in the Region discharged with code for COPD – estimated 3,300 **Specific number:** Estimated 330 based on 10% of PCPs receiving intervention **Description of population:** Patients in RHP 10 who have been discharged with a principal diagnosis code for COPD and receive services from PCPs receiving intervention		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment: $8,990	**Outcome Improvement Target 1** [IT-2.5]: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5 Improvement Target: 1% over baseline Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $9,617	**Outcome Improvement Target 2** [IT-2.5]: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5 Improvement Target: 3% over baseline Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $20,907
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $8,990	Year 4 Estimated Outcome Amount: $9,617	Year 5 Estimated Outcome Amount: $20,907

138980111.3.19	*3.IT- 2.5*	*Potentially Preventable Admissions – IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate – PQI 5*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.2 Apply Process Improvement Methodology to Improve Quality/Efficiency – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency – 2.8.1: Improving Primary Care Clinical Processes to Reduce Hospitalization Risk*		
Starting Point/Baseline:	**Baseline data:** Baseline data to be established in DY3. Estimated numbers are based on 2010 Census Data **Target population:** Total number of people seen by the 12,788 PCPs in the Region discharged with code for COPD – estimated 3,300 **Specific number:** Estimated 330 based on 10% of PCPs receiving intervention **Description of population:** Patients in RHP 10 who have been discharged with a principal diagnosis code for COPD and receive services from PCPs receiving intervention		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $39,513			

Title of Outcome Measure (Improvement Target): IT-2.6 Adult Asthma Admission Rate – PQI 15

Unique RHP outcome identification number(s): 138980111.3.20
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing potentially preventable admissions for adult asthma among the target population. The expected outcome by the end of the Waiver is to reduce Adult Asthma Admission Rate – PQI 15 by 3% from baseline. The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include identification and recruitment of content experts, content development, baseline data analysis and finalization of tracking and analysis methodology, educational plan development and target audience triangulation and assessment strategies.
- Establish baseline rates [P-2]. The baseline will be obtained through the Texas Public Use Data File (Hospital Admissions) or data mart. These data from the process milestones will be analyzed to create the PQI composite score, as defined by the AHRQ. Similar data will be collected over DY3-5.
- Adult Asthma Admission Rate – PQI 15 [IT-2.6]. Adult Asthma Admission Rate will be measured by using the THCIC – Inpatient and Outpatient Data Public Use Data File (PUDF) or comparable current data set from a data mart or other data aggregator.

Rationale:
Potentially Preventable Admissions Adult Asthma Admission Rate was selected as an outcome measure to assess the effectiveness of the project in training materials which specifically address clinical processes in effective adult asthma patient management and education on self-management . To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1. This milestone is important as it provides the opportunity to engage primary care physicians in evidence-based process models, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project.

Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patients of participating PCPs. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Adult Asthma Admission Rate – PQI 15 [IT-2.6]. This outcome improvement target measures all discharges with a principal diagnosis code of asthma among patients in RHP 10 from hospitals in RHP 10. Primary care participants receiving education will demonstrate improved competence and performance related to clinical processes in effective patient management and education on self-management of asthma, resulting in fewer admissions. Educational effectiveness will be measured by improvements in knowledge, competence and performance.

Outcome Measure Valuation:

Approach/Methodology: Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification: For Adult Asthma Admission Rate –PQI 15, UNT Health Science Center defined the population that will be directly impacted by the project as patients in RHP 10 who have been discharged with a principal diagnosis code for adult asthma and receive services from PCPs receiving intervention, which would be approximately 156 patients. We are anticipating a reduction of admission rates with a principal diagnosis code for adult asthma in the target population by 3%, equating to 5 lives positively impacted by this outcome. -.

Utilizing - the pricing matrix developed by Regional providers to determine the value to the health care system, it was determined that the value amount for each positive outcome realized would be $6,285 (TX Dept. of State Health Services data).

For the selected outcome, an additional multiplier was applied to determine the benefit provided to the community, the resulting additional valuation amount is $3,771 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit provided to the individual, the resulting additional valuation amount is $2,514 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.20	*3.IT- 2.6*	*Potentially Preventable Admissions – IT-2.6 Adult Asthma Admission Rate – PQI 15*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.2 Apply Process Improvement Methodology to Improve Quality/Efficiency – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency – 2.8.1: Improving Primary Care Clinical Processes to Reduce Hospitalization Risk*		
Starting Point/Baseline:	**Baseline data:** Baseline data to be established in DY3. Estimated numbers are based on 2010 Census Data **Target population**: Total number of people seen by the 12,788 PCPs in the Region discharged with code for adult asthma – estimated 1,558 **Specific number:** Estimated 156 based on 10% of PCPs receiving intervention **Description of population:** Patients in RHP 10 who have been discharged with a principal diagnosis code for asthma and receive services from PCPs receiving intervention		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment: $3,368	**Outcome Improvement Target 1** [IT-2.6]: Adult Asthma Admission Rate – PQI 15 Improvement Target: 1% over baseline Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $3,603	**Outcome Improvement Target 2** [IT-2.6]: Adult Asthma Admission Rate – PQI 15 Improvement Target: 3% over baseline Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $7,832
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $3,368	Year 4 Estimated Outcome Amount: $3,603	Year 5 Estimated Outcome Amount: $7,832

138980111.3.20	*3.IT- 2.6*	*Potentially Preventable Admissions – IT-2.6 Adult Asthma Admission Rate – PQI 15*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.2 Apply Process Improvement Methodology to Improve Quality/Efficiency – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency – 2.8.1: Improving Primary Care Clinical Processes to Reduce Hospitalization Risk*		
Starting Point/Baseline:	**Baseline data:** Baseline data to be established in DY3. Estimated numbers are based on 2010 Census Data **Target population**: Total number of people seen by the 12,788 PCPs in the Region discharged with code for adult asthma – estimated 1,558 **Specific number:** Estimated 156 based on 10% of PCPs receiving intervention **Description of population:** Patients in RHP 10 who have been discharged with a principal diagnosis code for asthma and receive services from PCPs receiving intervention		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $14,802			

Title of Outcome Measure (Improvement Target): IT-2.10 Flu and Pneumonia Admission Rate

Unique RHP outcome identification number(s): 138980111.3.21
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing potentially preventable admissions for flu and pneumonia among the target population. The expected outcome by the end of the Waiver is to reduce Flu and Asthma Admission Rate by 3% from baseline. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include identification and recruitment of content experts, content development, baseline data analysis and finalization of tracking and analysis methodology, educational plan development and target audience triangulation and assessment strategies.
- Establish baseline rates [P-2]. The baseline will be obtained through the Texas Public Use Data File (Hospital Admissions) or data mart. These data from the process milestones will be analyzed to create the PQI composite score, as defined by the AHRQ. Similar data will be collected over DY3-5.
- Flu and pneumonia Admission Rate [IT-2.10]. Flu and pneumonia Admission Rate will be measured by using the THCIC – Inpatient and Outpatient Data Public Use Data File (PUDF) or comparable current data set from a data mart or other data aggregator.

Rationale:
Potentially Preventable Admissions Flu and pneumonia Admission Rate was selected as an outcome measure to assess the effectiveness of the project in training materials which specifically address clinical processes in effective adult asthma patient management and education on self-management . To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1. This milestone is important as it provides the opportunity to engage primary care physicians in evidence-based process models, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project.

Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patients of participating PCPs. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Flu and Pneumonia Admission Rate – [IT-2.10]. This outcome improvement target measures all discharges with a principal diagnosis code of flu or pneumonia. among patients in RHP 10 from hospitals in RHP 10. Primary care participants receiving education will demonstrate improved competence and performance related to clinical processes in effective patient management and education on self-management of asthma, resulting in fewer admissions. Educational effectiveness will be measured by improvements in knowledge, competence and performance.

Outcome Measure Valuation:

Approach/Methodology: Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification: For Flu and Pneumonia Admission Rate, UNT Health Science Center defined the population that will be directly impacted by the project as patients in RHP 10 who have been discharged with a principal diagnosis code for flu or pneumonia and receive services from PCPs receiving intervention, which would be approximately 463 patients. We are anticipating a reduction of admission rates with a principal diagnosis code for flu or pneumonia in the target population by 3%, equating to 14 lives positively impacted by this outcome.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $8,047 (TX Dept. of State Health Services data).

For the selected outcome, an additional multiplier was applied to determine the benefit provided to the community, the resulting additional valuation amount is $4,828 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit provided to the individual, the resulting additional valuation amount is $3,219 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.21	*3.IT- 2.10*	*Potentially Preventable Admissions – Flu and Pneumonia Admission Rate*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.2 Apply Process Improvement Methodology to Improve Quality/Efficiency – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency – 2.8.1: Improving Primary Care Clinical Processes to Reduce Hospitalization Risk*		
Starting Point/Baseline:	**Baseline data**: Baseline data to be established in DY3. Estimated numbers are based on 2010 Census Data **Target population**: Total number of people seen by the 12,788 PCPs in the Region discharged with code for flu or pneumonia – Estimated 4,628 **Specific number**: Estimated 463 based on 10% of PCPs receiving intervention **Description of population**: Patients in RHP 10 who have been discharged with a principal diagnosis code for flu or pneumonia and receive services from PCPs receiving intervention		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Metric: Documentation of baseline data Data Source: Program Records Process Milestone 2 Estimated Incentive Payment: $12,797	**Outcome Improvement Target 1** [IT-2.10]: Flu and Pneumonia Admission Rate Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia Denominator: Population in Metro Area or county, age 18 years and older Improvement Target: 1% over baseline Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $13,690	**Outcome Improvement Target 2** [IT-2.10]: Flu and Pneumonia Admission Rate Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia Denominator: Population in Metro Area or county, age 18 years and older Improvement Target: 3% over baseline Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $29,762

138980111.3.21	*3.IT- 2.10*	*Potentially Preventable Admissions – Flu and Pneumonia Admission Rate*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.2 Apply Process Improvement Methodology to Improve Quality/Efficiency – Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency – 2.8.1: Improving Primary Care Clinical Processes to Reduce Hospitalization Risk*		
Starting Point/Baseline:	**Baseline data**: Baseline data to be established in DY3. Estimated numbers are based on 2010 Census Data **Target population**: Total number of people seen by the 12,788 PCPs in the Region discharged with code for flu or pneumonia – Estimated 4,628 **Specific number**: Estimated 463 based on 10% of PCPs receiving intervention **Description of population**: Patients in RHP 10 who have been discharged with a principal diagnosis code for flu or pneumonia and receive services from PCPs receiving intervention		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $12,797	Year 4 Estimated Outcome Amount: $13,690	Year 5 Estimated Outcome Amount: $29,762
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $56,249			

Title of Outcome Measure (Improvement Target): IT-3.11: Pediatric Asthma 30-Day Readmission Rate

Unique RHP outcome identification number(s): 138980111.3.22
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing potentially preventable readmissions among the target population. The expected outcome by the end of the Waiver is to reduce the pediatric asthma 30-day readmission rate by 5% from baseline. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1. Project planning will include creating partnerships with school districts in RHP 10, identifying and documenting children with asthma, and developing implementation plans for participating school districts.
- Establish baseline rates [P-2]. The baseline will be established by determining pediatric asthma 30-day readmission rates among students participating in the project.
- Develop and test data systems [P-3]. This will involve setting up methods to track and collect readmission data from area hospitals.
- Pediatric Asthma 30-Day Readmission Rate [IT-3.11]. Pediatric asthma 30-day readmission rate will be measured by obtaining pediatric asthma 30-day readmissions data from local hospitals and comparing number of readmissions in DY4 and DY5 to baseline data.

Rationale:
Potentially preventable readmissions – 30-day readmission rates (PPR) was selected as an outcome measure to assess the effectiveness of the project in helping students develop asthma action plans and avoiding being readmitted to the hospital. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1. This milestone is important as it provides the opportunity to engage participating school districts, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the participating school districts. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect 30-day readmission data from area hospitals.
- Pediatric Asthma 30-Day Readmission Rate [IT-3.11]. This outcome improvement target measures the number of 30-day readmissions among students participating in the project which is a direct measure of the effectiveness of implementing asthma action plans for students with asthma. The outcome improvement target to reduce readmission rates by 5% is determined as a conservative estimate based on a similar proven approach used in the St. Louis metropolitan area. Using data from Cook Children's Hospital for 2011 it is estimated there are up to 28 readmits annually due to asthma (data for all causes is not known at this time) (CCHAPS 2011), with an estimated 6 of these children from Fort Worth Independent School District (FWISD) alone (FWISD Annual Report 2011-2012).

Outcome Measure Valuation:

Approach/Methodology:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:

For Pediatric Asthma 30-day Readmission Rates, UNT Health Science Center defined the population that will be directly impacted by the project as school age children (K-12) identified by school health services as having asthma in FWISD. We estimate that 20 school age children will be readmitted due to asthma-related illness. The percentage of the population expected to be positively impacted by the project is 5%, equating to 1 life positively impacted by this outcome.

Utilizing - the pricing matrix developed by Region-10 providers to determine the value to the health care system , it was determined that the valuation amount for each positive outcome realized would be $7,491 (TX Dept. of State Health Services data).

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $2,996 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $4,495 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.22	*3.IT-3.11*	*Potentially Preventable ReAdmissions – 30-Day Readmission Rates (PPRs) – IT-3.11: Pediatric Asthma 30-Day Readmission Rate*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111. 2.3 Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School-Based Asthma Program*		
Starting Point/Baseline:	**Baseline data:** The actual number of ED readmissions due to asthma from Fort Worth, TX schools is not available. This information will be obtained longitudinally for the DY2 year. **Target Population:** School age children (K-12) identified by school health services as having asthma in Forth Worth Independent School District (FWISD) **Specific Number:** 6000 students with asthma, with an estimated 20 readmissions annually **Description of Population:** Students in grades K-12 attending FWISD and KISD		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-2]: Establish baseline rates (pediatric asthma) Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Program records	**Process Milestone 4** [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program records Process Milestone 4 Estimated Incentive Payment: $429 **Process Milestone 5** [P-2]: Establish baseline rates (pediatric asthma ED visits and readmissions) Data Source: Program records Process Milestone 5 Estimated Incentive Payment *(maximum amount):* $429	**Outcome Improvement Target 1** [IT-3.11]: Pediatric Asthma 30-Day Readmission Rate (Age group defined as those attending grades K-12 in the participating school districts) Improvement Target: Reduce the number of readmissions over baseline by 2% (estimated as .4 readmissions) in DY4 Data Source: Hospital discharge data Outcome Improvement Target 1 Estimated Incentive Payment*:* $918	**Outcome Improvement Target 2** [IT-3.11]: Pediatric Asthma 30-Day Readmission Rate (Age group defined as those attending grades K-12 in the participating school districts) Improvement Target: Reduce the number of readmissions over baseline by 5% (estimated as 1 readmission) by DY5 Data Source: Hospital discharge data Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,995

138980111.3.22	*3.IT-3.11*	*Potentially Preventable ReAdmissions – 30-Day Readmission Rates (PPRs) – IT-3.11: Pediatric Asthma 30-Day Readmission Rate*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111. 2.3 Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School-Based Asthma Program*		
Starting Point/Baseline:	**Baseline data:** The actual number of ED readmissions due to asthma from Fort Worth, TX schools is not available. This information will be obtained longitudinally for the DY2 year. **Target Population:** School age children (K-12) identified by school health services as having asthma in Forth Worth Independent School District (FWISD) **Specific Number:** 6000 students with asthma, with an estimated 20 readmissions annually **Description of Population:** Students in grades K-12 attending FWISD and KISD		
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 3 Estimated Incentive Payment *(maximum amount):* $0			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $858	Year 4 Estimated Outcome Amount: $918	Year 5 Estimated Outcome Amount: $1,995
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $3,770			

Title of Outcome Measure (Improvement Target): IT-9.3(Age group defined as those attending grades K-12 and are sent to the ED from school)

Unique RHP outcome identification number(s): 138980111.3.23
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing pediatric/young adult asthma emergency department visits among the target population. The expected outcome by the end of the Waiver is to reduce pediatric/young adult asthma emergency department visits by 20% from baseline. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include creating partnerships with school districts in RHP 10, identifying and documenting children with asthma, and developing implementation plans for participating school districts. As new school districts are added, these processes will be repeated.
- Establish baseline rates [P-2]. The baseline will be established by determining pediatric/young adult asthma emergency department visits among students participating in the project. As new school districts are added, baseline data collection will be ongoing.
- Develop and test data systems [P-3]. This will include setting up methods to track and collect pediatric/young adult emergency department visit data.
- Pediatric//Young Adult Asthma Emergency Department Visits [IT-9.3]. Pediatric/young adult asthma emergency department visits will be measured by tracking the number of 911 calls for students with asthma from participating schools.

Rationale:
Pediatric/young adult asthma emergency department visits was selected as an outcome measure to assess the effectiveness of the project in helping students develop asthma action plans and avoiding having to visit the emergency department. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage participating school districts, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and

documentation of implementation are necessary components to assess the process and establish improvement metrics.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the participating school districts. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect 30-day readmission data from area hospitals.
- Pediatric/Young Adult Asthma Emergency Department Visits [IT-9.3]. This outcome improvement target measures the number of emergency department visits among students participating in the project. The outcome improvement target of reduction of school-based ED visits due to asthma by 20% is determined as a conservative estimate from reduction rates seen from the implementation in the St. Louis metropolitan area over a similar time period, where the reduction was ~35%.

Outcome Measure Valuation:

Approach/Methodology:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:

For Pediatric/Young Adult Asthma Emergency Department Visits, UNT Health Science Center defined the population that will be directly impacted by the project as 138 school-age children (K-12) identified by school health services as having asthma in FWISD. The percentage of the population expected to be positively impacted by the project is 20%, equating to 28 lives positively impacted by this outcome.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,200. -For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $480 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $720 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.23	*3.IT-9.3*	*Right Care, Right Setting – IT-9.3: Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.3 Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School-Based Asthma Program*		
Starting Point/Baseline:	**Baseline data:** The number of ED admits due to asthma from Fort Worth, TX schools is not available. This information will be obtained during DY2 through review of 911 documentation for the prior year and longitudinally for the DY2 year. **Target Population:** School age children (K-12) identified by school health services as having asthma **Specific Number:** 6,000 students with ED utilization of 2.3% **Description of Population:** Students in grades K-12 attending FWISD and KISD		
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]: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-2]: Establish baseline rates) Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 3 [P-3]:** Develop and test data systems	**Process Milestone 4** [P-1]: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Program records Process Milestone 4 Estimated Incentive Payment: $1,896 **Process Milestone 5** [P-2]: Establish baseline rates) Data Source: Program records Process Milestone 5 Estimated Incentive Payment *(maximum amount):* $1,896	**Outcome Improvement Target 1** [IT-9.3]: Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381 Improvement Target: 10% reduction over baseline in ED visits from school for asthma by DY4 (based on 60 ED visits annually, estimated as a reduction of 6) Data Source: School District Health Services Records Outcome Improvement Target 1 Estimated Incentive Payment: $4,057	**Outcome Improvement Target 2** [IT-9.3]: Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381 Improvement Target: 20% reduction over baseline in ED visits from school for asthma by DY5 (based on 60 ED visits annually, estimated as a reduction of 12) Data Source: School District Health Services Records Outcome Improvement Target 2 Estimated Incentive Payment: $8,819

138980111.3.23	*3.IT-9.3*	*Right Care, Right Setting – IT-9.3: Pediatric/Young Adult Asthma Emergency Department Visits – NQF 1381*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.3 Expand Chronic Care Management Models – Apply evidence-based care management model to patients identified as having high-risk health care needs – 2.2.2: ASTHMA 411 – A Sustainable School-Based Asthma Program*		
Starting Point/Baseline:	**Baseline data:** The number of ED admits due to asthma from Fort Worth, TX schools is not available. This information will be obtained during DY2 through review of 911 documentation for the prior year and longitudinally for the DY2 year. **Target Population:** School age children (K-12) identified by school health services as having asthma **Specific Number:** 6,000 students with ED utilization of 2.3% **Description of Population:** Students in grades K-12 attending FWISD and KISD		
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)**
Data Source: Program records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $0			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $3,792	Year 4 Estimated Outcome Amount: $4,057	Year 5 Estimated Outcome Amount: $8,819
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $16,668			

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Title of Outcome Measure (Improvement Target): IT-8.2 Percentage of Low Birth-weight Births (CHIPRA/NQF #1382)

Unique RHP outcome identification number(s): 138980111.3.25
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure would track percentage of low birth-weight births among women giving birth in the target population. The expected outcome by the end of the Waiver is to reduce the rate of low birth-weight by 10% over baseline. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This will include development and implementation of the project plan, program curriculum, and evaluation tools.
- Establish baseline rates [P-2]. The program baseline will be established during enrollment into the program. Because of targeted recruitment, at least 50 program participants will have delivered a previous low birth weight infant.
- Percentage of low birth-weight births [IT-8.2]. Low birth-weight births will be measured by tracking the percentage of babies weighing <2,500 grams born to women enrolled in the interconception intervention.

Rationale:

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. For program success there must be significant collaboration between social services and health care providers. This process milestone was selected because of the necessity to mobilize resources and create a feasible implementation plan.
- Establish baseline rates [P-2]. Women with previous low birth weight births will be recruited in the intervention.
- Percentage of low birth-weight births [IT-8.2]. The - interconception interventions proposed in the Tarrant County - Perinatal Health Promotion Initiative will target risk factors that are known to affect low birth weight/prematurity among enrolled women who become pregnant (i.e, chronic diseases, preconception check-up, multivitamin use, smoking cessation, postpartum care, early prenatal care, social and mental wellness, etc.) For program success there must be significant collaboration between social services and health care providers. The improvement target for low birth weight reduction is a decrease by 10% in low birth weight infants born to women enrolled in the intervention compared to pre-intervention births. This is consistent with the success of similar interconception programs.

Outcome Measure Valuation:

Approach/Methodology:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:

For Percentage of Low Birth-weight Births, UNT Health Science Center defined the population that will be directly impacted by the project as women with previous low weight births, which would be approximately 50 patients. The percentage of improvement by the project is 10%, equating to 5 lives positively impacted by this outcome-.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $44,482. -For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $26,689 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $26,689 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.25	*3.IT-8.2*	*Perinatal Outcomes – IT-8.2: Percentage of Low Birth-weight Births (CHIPRA/NQF #1382)*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.4 Implement Evidence-based Disease Prevention Programs – Implement innovative evidence-based strategies to reduce low birth weight and preterm births – 2.7.4: Tarrant County - Perinatal Health Promotion Initiative*		
Starting Point/Baseline:	**Baseline data**: Evidence suggests that women who have had a low birth weight birth are at increased risk of having a low birth weight birth in subsequent pregnancies. The project baseline will be established during enrollment into the program during DY3 as women are enrolled, at least 50 women with previous low birth weight infants will be recruited. **Target Population:** Women with previous low birth weight birth **Specific Number:** 50 **Description of Population:** Women with previous - low birth weight		
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 Goal: Document innovational strategy and plan Data Source: Program records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish Baseline Rates Goal: Document baseline data Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $-$23,166	**Outcome Improvement Target 1** [IT-8.2]: Percentage of Low Birth-weight Births Improvement Target: Reduce percentage of low birth weight births among enrolled participants compared to pre-intervention low birth weight percentages by 5% over baseline. Data Source: program service records, EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $24,783	**Outcome Improvement Target 2** [IT-8.2]: Percentage of Low Birth-weight Births Improvement Target: Reduce percentage of low birth weight births among enrolled participants compared to pre-intervention low birth weight percentages by 10% over baseline. Data Source: program service records, EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $53,875
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $23,166	Year 4 Estimated Outcome Amount: $24,783	Year 5 Estimated Outcome Amount: $53,875

138980111.3.25	*3.IT-8.2*	*Perinatal Outcomes – IT-8.2: Percentage of Low Birth-weight Births (CHIPRA/NQF #1382)*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.4 Implement Evidence-based Disease Prevention Programs – Implement innovative evidence-based strategies to reduce low birth weight and preterm births – 2.7.4: Tarrant County - Perinatal Health Promotion Initiative*		
Starting Point/Baseline:	**Baseline data**: Evidence suggests that women who have had a low birth weight birth are at increased risk of having a low birth weight birth in subsequent pregnancies. The project baseline will be established during enrollment into the program during DY3 as women are enrolled, at least 50 women with previous low birth weight infants will be recruited. **Target Population:** Women with previous low birth weight birth **Specific Number:** 50 **Description of Population:** Women with previous - low birth weight		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** - $101,824			

Title of Outcome Measure (Improvement Target): IT-8.9 Other Outcome Improvement Target: Interpregnancy interval/birth spacing

Unique RHP outcome identification number(s): 138980111.3.26
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure would track pregnancy intervals among women enrolled in the interconception care intervention. The expected outcome by the end of the Waiver is to achieve a pregnancy interval of at least - 9 months of a previous birth among 65% (98) of the women enrolled in the interconception. The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This will include development and implementation of the project plan, program curriculum, and evaluation tools.
- Establish baseline rates [P-2]. The program baseline will be established during enrollment into the program.
- Other Outcome Improvement Target: Interpregnancy interval/birth spacing [IT-8.9]. Pregnancy interval will be calculated for each woman by subtracting the reported date of the last live birth from the start date of the last normal self-reported menses among women who become pregnant.

Rationale:
The - interconception intervention- proposed in the Tarrant County - Perinatal Health Initiative will target risk factors that are known to affect infant mortality among enrolled women who become pregnant (i.e, unintended pregnancy, short pregnancy intervals, chronic diseases, preconception check-up, multivitamin use, smoking cessation, postpartum care, early prenatal care, social and mental wellness, etc.) Women with adverse outcomes, including infant mortality, are intentionally targeted for this intervention.

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. For program success there must be significant collaboration between social services and health care providers. This process milestone was selected because of the necessity to mobilize resources and create a feasible implementation plan.
- Establish baseline rates [P-2]. In 2009, the percentage of births among the highest risk Tarrant County women that were less than 18 months from previous birth was 34.7%. However, the previous pregnancy interval baseline will be calculated among the target population during enrollment in DY3 for this project because it may vary from this baseline.
- Other Outcome Improvement Target: Interpregnancy interval/birth spacing - [IT-8.9]. The improvement target is for 60% in DY4 and 65% in DY5 to achieve a

pregnancy interval of at least - 9 months of a previous birth or avoid pregnancy among - the women enrolled in the interconception intervention. This target was chosen because spacing of less than six months is highly predictive of a subsequent poor birth outcome and pregnancy intervals of 12-18 months are associated with high rates of uterine rupture, maternal morbidities, preterm birth, low birth weight, and small for gestational age infants.

Outcome Measure Valuation:

Approach/Methodology:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:

For Other Outcome Improvement Target: Interpregnancy Interval/Birth Spacing , UNT Health Science Center defined the population that will be directly impacted by the project as women with previous adverse birth outcome, including infant mortality, which would be approximately 150 women. The improvement target is to achieve a pregnancy interval of at least - 9 months of a previous birth among 65% of the women enrolled in the interconception intervention, equating to 98 lives positively impacted. -.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $51,589 (as cited in the article, "Preterm Birth: Causes, Consequences, and Prevention, Chapter 12: Societal Costs of Preterm Birth" in the journal *National Academies Press*) due to the reduction in the cost for care of infants born preterm. -For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $30,953 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $30,953 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.26	*3.IT-8.9*	*Perinatal Outcomes – IT-8.9:Other Outcome Improvement Target: Interpregnancy Interval/Birth Spacing*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.4 Implement Evidence-based Disease Prevention Programs – Implement innovative evidence-based strategies to reduce low birth weight and preterm births – 2.7.4: Tarrant County - Perinatal Health Promotion Initiative*		
Starting Point/Baseline:	**Baseline data:** The program baseline will be established during enrollment into the program **Target Population:** **Specific Number:** 150 **Description of Population:** women with previous adverse birth outcome, including low birth weight infants		
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 Goal: Document innovational strategy and plan Data Source: Program records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish Baseline Rates Goal: Document baseline data Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* - $523,919	**Outcome Improvement Target 1** [IT-8.9]: Other Outcome Improvement Target: Interpregnancy Interval/Birth Spacing Improvement Target: 60% of women will achieve a pregnancy interval of at least - 9 months of a previous birth; or will not become pregnant in DY4 Data Source: Program service records, EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $560,471	**Outcome Improvement Target 2** [IT-8.9]: Other Outcome Improvement Target: Interpregnancy Interval/Birth Spacing Improvement Target: 65% of women achieve a pregnancy interval of at least - 9 months of a previous birth; or will not become pregnant in DY5 Data Source: Program service records, EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,218,416
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $523,919	Year 4 Estimated Outcome Amount: $560,471	Year 5 Estimated Outcome Amount: $1,218,416

138980111.3.26	*3.IT-8.9*	*Perinatal Outcomes – IT-8.9:Other Outcome Improvement Target: Interpregnancy Interval/Birth Spacing*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.4 Implement Evidence-based Disease Prevention Programs – Implement innovative evidence-based strategies to reduce low birth weight and preterm births – 2.7.4: Tarrant County - Perinatal Health Promotion Initiative*		
Starting Point/Baseline:	**Baseline data:** The program baseline will be established during enrollment into the program **Target Population:** **Specific Number:** 150 **Description of Population:** women with previous adverse birth outcome, including low birth weight infants		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** - $2,302,806			

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Title of Outcome Measure (Improvement Target): IT-3.1: All-cause 30-day readmission rate- NQF 1789

Unique RHP outcome identification number(s): 138980111.3.28
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing all-cause 30-day readmission rates for Medicaid-eligible elders 65 receiving the intervention. The expected outcome by the end of the Waiver is to reduce all-cause 30-day readmission rates for Medicaid-eligible elders 65 and above receiving the intervention by 10% (15 readmissions prevented) over baseline. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include discussions with hospital partners regarding best practices to reduce readmissions.
- Establish baseline rates [P-2]. Prior work suggests that approximately 20% of Medicaid elders experience readmission within 30 days of hospital discharge. Additional baseline data from our target population will be collected by survey at initial patient encounters.
- Develop and test data systems [P-3]. This will involve setting up methods to track and collect readmission data from hospital partners
- Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – [IT-3.1] – All-cause 30-day readmission rate- NQF 1789 will be measured by tracking patients provided services and hospital records.

Rationale:
Approximately 20% of Medicaid-eligible elders are readmitted to hospitals within 30 days of discharge, which is a significant financial drain that also reduces overall quality of life. Through implementation of our discharge planning and care coordination model, we propose to reduce Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – All-cause 30-day readmissions by 10% (15 readmissions prevented) over baseline thereby providing a substantial cost savings. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This

milestone is important as it provides the opportunity to engage hospital and community partners necessary to design and implement the targeted implementation from best-practice guidelines.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the particular target population though prior data suggest a 20% readmission rate can be expected. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect 30-day readmission data from area hospitals.
- Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) – [IT-3.1] – All-cause 30-day readmission rate – NQF 1789. This outcome improvement target measures the number of 30-day readmissions among Medicaid-eligible patients discharged from UNTHSC Division of Geriatrics hospital partners. Participants in this intervention will demonstrate improved health management and reduced readmission rates.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B

- **Rationale/Justification:** For 30-Day Readmission Rates, UNT Health Science Center defined the population that will be directly impacted by the project as elderly patients who are eligible for coverage by Medicaid and receive care from UNTHSC Division of Geriatrics physicians – which was 750 patients in FY 2011. It is anticipated that 20% of these patients (150) will be readmitted within 30 days of discharge. Our goal is to reduce hospitalization rates by 10% (15 readmissions prevented) -.

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,491 (TX Dept. of State Health Services data).-.

  For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $5,993 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved with the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.28	*3.IT-3.1*	*Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) - IT-3.1: All-cause 30-day readmission rate – NQF 1789: for Medicaid eligible elders 65 and older receiving services from the UNTHSC Division of Geriatrics hospital partners.*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.5 – Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid Eligible elders*		
Starting Point/Baseline:	**Baseline data:** Approximately 20% of elderly patients are readmitted within 30 days based on prior data. Actual baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 discharged from hospital partners. Approximately 750 Medicaid-eligible elders are discharged annually from existing hospital partners who receive care from UNTHSC Division of Geriatrics physicians. **Specific Number:** It is anticipated that 20% of these patients (150) will be readmitted within 30 days of discharge. Our goal is to reduce hospitalization rates by 10% (15 readmissions prevented) -. **Description of Population:** Elderly patients who are eligible for coverage by both Medicaid		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program records	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: Program records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $11,579	**Outcome Improvement Target 1** [IT 3.1]: All-cause 30-day readmission rate for Medicaid-eligible elders 65 and above who receive care from the UNTHSC Division of Geriatrics hospital partners. Improvement Target: 5% reduction in all-cause hospitalization (8 readmissions prevented) rate over baseline. Data Source: Program records/EMR/Claims records Outcome Improvement Target 1 Estimated Incentive Payment*:*	**Outcome Improvement Target 2** [IT 3.1]: All-cause 30-day readmission rate for Medicaid eligible elders 65 and above who receive care from the UNTHSC Division of Geriatrics hospital partners. Improvement Target: 10% reduction in all-cause readmission (15 readmissions prevented) rate over baseline Data Source: Program records/EMR/Claims records Outcome Improvement Target 2 Estimated Incentive Payment*:*

138980111.3.28	*3.IT-3.1*	*Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) - IT-3.1: All-cause 30-day readmission rate – NQF 1789: for Medicaid eligible elders 65 and older receiving services from the UNTHSC Division of Geriatrics hospital partners.*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.5 – Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid Eligible elders*		
Starting Point/Baseline:	**Baseline data:** Approximately 20% of elderly patients are readmitted within 30 days based on prior data. Actual baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 discharged from hospital partners. Approximately 750 Medicaid-eligible elders are discharged annually from existing hospital partners who receive care from UNTHSC Division of Geriatrics physicians. **Specific Number:** It is anticipated that 20% of these patients (150) will be readmitted within 30 days of discharge. Our goal is to reduce hospitalization rates by 10% (15 readmissions prevented) -. **Description of Population:** Elderly patients who are eligible for coverage by both Medicaid		
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 2 Estimated Incentive Payment *(maximum amount):* $0		$12,387	$26,927

138980111.3.28	*3.IT-3.1*	*Potentially Preventable Readmissions – 30-day Readmission Rates (PPRs) - IT-3.1: All-cause 30-day readmission rate – NQF 1789: for Medicaid eligible elders 65 and older receiving services from the UNTHSC Division of Geriatrics hospital partners.*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.5 – Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid Eligible elders*		
Starting Point/Baseline:	**Baseline data:** Approximately 20% of elderly patients are readmitted within 30 days based on prior data. Actual baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 discharged from hospital partners. Approximately 750 Medicaid-eligible elders are discharged annually from existing hospital partners who receive care from UNTHSC Division of Geriatrics physicians. **Specific Number:** It is anticipated that 20% of these patients (150) will be readmitted within 30 days of discharge. Our goal is to reduce hospitalization rates by 10% (15 readmissions prevented) -. **Description of Population:** Elderly patients who are eligible for coverage by both Medicaid		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $11,579	Year 4 Estimated Outcome Amount: $12,387	Year 5 Estimated Outcome Amount: $26,927
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $50,893			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Unique RHP outcome identification number(s): 138980111.3.29
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving quality of life scores for Medicaid-eligible elders receiving the intervention. The expected outcome by the end of the Waiver is to improve quality of life scores for patients receiving the intervention by 10% for all 750 patients over baseline. The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include meeting with local hospital partners, health care providers, and patients to discuss barriers to quality of life. The SF-36 will be utilized for measurement of OQL.
- Establish baseline rates [P-2]. The baseline will be established during initial encounters by medical teams.
- Develop and test data systems [P-3]. The interview and data collection will be developed over DY2-3 and beta tested in DY3.
- Quality of Life/Functional Status- Quality of Life [IT-10.1]. Percent improvement over baseline of patient quality of life scores will be measured by comparing SF-36 scores prior to and after patient encounters.

Rationale:
If improvement targets are not determined, please indicate that outcome improvement targets will be determined in DY2 for DY3 implementation.
QOL is related to a range of diseases as well as health status, which in turn can be utilized to guide interventions (CDC). Higher QOL is related to improved utilization of medical services and reduced overall health costs. Through implementation of this discharge planning and care coordination model, we will significantly improve quality of life, which will be associated with reduced readmissions. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage local hospital partners, primary care physicians as well as patients in evidence-based process models related

to improvement in QOL, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patient quality of life. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect QOL measures.
- Quality of Life/Functional Status- Quality of Life [IT-10.1]. This outcome improvement target measures improvement in QOL experienced by patients receiving the enhanced discharge planning and care coordination services.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification**: For Quality of Life- UNT Health Science Center defined the population that will be directly impacted by the project as Elderly patients who are eligible for coverage by Medicaid, which we have estimated to be 750 individuals. We are anticipating that we will test the entire population, and are expecting to increase the quality of life scores for the project by 10%-.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,755 (as cited in the aricle "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal Arch Gen Psychiatry, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention -. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value.

Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.29	*3.IT-10.1*	Quality of Life/Functional Status – Quality of Life (SF36): for Medicaid eligible elders 65 and older receiving services from the UNTHSC Division of Geriatrics partner hospitals.	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.5 – Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid-Eligible elders*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 who are discharged from UNTHSC Division of Geriatrics hospital partners (n=750 annually). The goal is improvement in QOL for **all** 750 patients. **Specific Number:** 750 Medicaid-eligible elders age 65 and above who receive services from UNTHSC Division of Geriatrics partner hospitals **Description of Population:** Elderly patients who are eligible for coverage by both Medicaid		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 3** [P-2]: Establish baseline rates - Data Source: Program records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $161,224	**Outcome Improvement Target 1** [IT 10.1]: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool, for the target population. Improvement Target: 5% improvement in QOL scores for population receiving intervention Data Source: Data Source: SF-36 Outcome Improvement Target 1 Estimated Incentive Payment*:* $172,472	**Outcome Improvement Target 2** [IT 10.1]: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool, for the target population. Improvement Target:10% improvement in QOL scores for population receiving intervention Data Source: Data Source: SF-36 Outcome Improvement Target 2 Estimated Incentive Payment*:* $374,939

138980111.3.29	*3.IT-10.1*	Quality of Life/Functional Status – Quality of Life (SF36): for Medicaid eligible elders 65 and older receiving services from the UNTHSC Division of Geriatrics partner hospitals.	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.5 – Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid-Eligible elders*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 who are discharged from UNTHSC Division of Geriatrics hospital partners (n=750 annually). The goal is improvement in QOL for **all** 750 patients. **Specific Number:** 750 Medicaid-eligible elders age 65 and above who receive services from UNTHSC Division of Geriatrics partner hospitals **Description of Population:** Elderly patients who are eligible for coverage by both Medicaid		
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)**

138980111.3.29	*3.IT-10.1*	Quality of Life/Functional Status – Quality of Life (SF36): for Medicaid eligible elders 65 and older receiving services from the UNTHSC Division of Geriatrics partner hospitals.	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.2.5 – Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid-Eligible elders*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 who are discharged from UNTHSC Division of Geriatrics hospital partners (n=750 annually). The goal is improvement in QOL for **all** 750 patients. **Specific Number:** 750 Medicaid-eligible elders age 65 and above who receive services from UNTHSC Division of Geriatrics partner hospitals **Description of Population:** Elderly patients who are eligible for coverage by both Medicaid		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $161,224	Year 4 Estimated Outcome Amount: $172,472	Year 5 Estimated Outcome Amount: $374,939
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $708,635			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Unique RHP outcome identification number(s): 138980111.3.31
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome will assess the effectiveness of the project in improving the quality of life for program participants. The expected outcome by the end of the Waiver is to improve the mean quality of life scores by 10% over baseline. The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Activities to support project planning will include: conducting a needs assessment of complex behavioral health populations who are frequent users of community public health resources; designing community-based specialized interventions for the target population (a targeted behavioral health population focused on reducing substance abuse, depression symptomatology, and improving quality of life among dually-diagnosed patients residing in the PSH programs-); and enrolling and serving individuals with targeted complex needs (a group of dually-diagnosed patients residing in the PSH programs).
- Establish baseline rates [P-2]. The baseline will be established by administering a pre-test of the Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q). Since this is a new project, the process milestone is necessary to establish baseline rates in order to be able to assess the effectiveness of the project.
- Quality of Life [IT-10.1]. Demonstrate improvement in quality of life (QOL) scores. as measured by the Q-LES-Q.

Rationale:
Quality of life was selected as an outcome measure to assess the effectiveness of the project in assisting participants to improve their life enjoyment and functioning.

a. Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to assess the size, characteristics, and needs of the target population, review the literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes, develop a project evaluation plan using qualitative and quantitative metrics to determine outcomes, and design models which include an appropriate range of community-based services and residential supports.

b. Establish baseline rates [P-2]. Since this is a new project, this process milestone is necessary to establish baseline rates in order to be able to assess the effectiveness of the project.

Quality of Life [IT-10.1]. Given the strong connection between substance abuse, mental health and quality of life, the improvement milestone of improving quality of life by at least 10% is justified based on published research with similar community populations (Lundahl & Burke, 2009).

Outcome Measure Valuation:

Approach/Methodology:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. - *(See Section V.B. for a full explanation of the model.)*

For Quality of Life, UNT Health Science Center defined the population that will be directly impacted by the project as 300 dually-diagnosed patients enrolled in the Ft. Worth permanent supportive housing (PSH) program. We are anticipating that we will test the entire population, and are expecting to increase quality of life scores by 10%.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $16,750 (as cited in the article, "Cost- effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total

DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.31	*3.IT-10.1*	*Quality of Life/Functional Status – IT-10.1: Quality of Life*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.6 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population – 2.13.1: Health Navigation and Incentives for Dual Diagnosis Patients*		
Starting Point/Baseline:	**Baseline data:** Baseline data to be collected in DY3 **Target Population:** Medicaid-eligible dually-diagnosed patients **Specific Number:** 300 **Description of Population:** Medicaid-eligible dually-diagnosed patients enrolled in the Ft. Worth permanent supportive housing (PSH) programs		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2 [P-2]:** Establish Baseline Rates Data Source: Initial Q-LES-Q survey Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $287,670	**Outcome Improvement Target 1 [IT-10.1]:** Quality of Life Goal: Increase QOL scores by 5% over baseline Data Source: Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) Outcome Improvement Target 1 Estimated Incentive Payment*:* $307,740	**Outcome Improvement Target 2** [IT-10.1]: Quality of Life Goal: Increase QOL scores by 10% over baseline Data Source: Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q) Outcome Improvement Target 2 Estimated Incentive Payment*:* $668,999
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $287,670	Year 4 Estimated Outcome Amount: $307,740	Year 5 Estimated Outcome Amount: $668,999
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,264,408			

Title of Outcome Measure (Improvement Target): IT-1.9 Depression Management: Depression Remission at 12 Months (NQF #0710)

Unique RHP outcome identification number(s): 138980111.3.32
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome will assess the effectiveness of the project in managing depression for program participants. The expected outcome by the end of the Waiver is depression remission for at least 10% of patients who report moderate to severe depression, as evidenced by a reduction of PHQ-9 scores greater than 9 (i.e., at least moderate depression) to less than 5 (i.e., minimal or no depression). The total number of people impacted will depend on baseline scores of enrolled participants on the PHQ-9.
The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Activities to support project planning will include: conducting a needs assessment of complex behavioral health populations who are frequent users of community public health resources; designing community-based specialized interventions for the target population (a targeted behavioral health population focused on reducing substance abuse, depression symptomatology, and improving quality of life among dually-diagnosed patients residing in the PSH programs); and enrolling and serving individuals with targeted complex needs (a group of dually-diagnosed patients residing in the PSH programs).
- -Establish baseline rates [P-2]. The baseline will be established by administering a pre-test of the PHQ-9.
- Depression management: Depression remission at twelve months [IT-1.9]. Depression remission for at least 10% of patients, as evidenced by a reduction of PHQ-9 scores greater than 9 (i.e., at least moderate depression) to less than 5 (i.e., minimal or no depression).

Rationale:
Reduction in depression symptomatology was selected as an outcome measure to assess the effectiveness of the project in assisting participants to improve their overall functioning.

a. Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to assess the size, characteristics, and needs of the target population, review the literature/experience with populations similar to target population to determine community-based interventions that are effective in averting negative outcomes, develop a project

evaluation plan using qualitative and quantitative metrics to determine outcomes, and design models which include an appropriate range of community-based services and residential supports.

b. Establish baseline rates [P-2]. The baseline will be established by administering a pre-test of the PHQ-9. Since this is a new project, the process milestone is necessary to establish baseline rates in order to be able to assess the effectiveness of the project.

Depression management: Depression remission at 12 months [IT-1.9]. Given the strong connection between substance abuse and mental health, the improvement milestone of reducing depression symptomatology for at least 10% of patients is justified based on past work with similar community populations (Baker et al., 2012; Westra, et al., 2011).

Outcome Measure Valuation:

Approach/Methodology:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Rationale/Justification:

For Depression Management: Depression Remission at Twelve Months, UNT Health Science Center defined the population that will be directly impacted by the project as 300 dually-diagnosed patients enrolled in the Ft. Worth permanent supportive housing (PSH) program. We are expecting to decrease depression symptomatology for at least 10% of patients, equating to 30 lives positively impacted by this outcome. - -.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,759.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the “halo effect”, due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center’s project’s values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center’s project’s values were computed,

the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.32	*3.IT-1.9*	*Primary Care and Chronic Disease Management – IT-1.9: Depression Management: Depression remission at twelve months (NQF# 0710)*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.6 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population – 2.13.1: Health Navigation and Incentives for Dual Diagnosis Patients*		
Starting Point/Baseline:	**Baseline data:** Between one-third and one-half of PSH residents reported regular frequency of depression and related symptoms such as: stopping enjoying things they used to enjoy (36.4%), difficulty concentrating, having racing thoughts or feeling out of control (37.8%) and having periods of intense unease or anxiety (48%). **Target Population:** Dually-diagnosed patients residing in the Ft. Worth PSH programs **Specific Number:** 300 **Description of Population:** Dually-diagnosed patients enrolled in the Ft. Worth permanent supportive housing (PSH) programs		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2 [P-2]:** Establish Baseline Rates Data Source: Initial PHQ-9 survey Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $3,021	**Outcome Improvement Target 1 [IT-1.9]:** Depression management Goal: Remission of depression symptoms for 5% of patients as evidenced by a reduction of PHQ-9 scores greater than 9 (i.e., at least moderate depression) to less than 5 (i.e., minimal or no depression). The total number of people impacted will depend on baseline scores of enrolled participants on the PHQ-9. Data Source: PHQ-9 Outcome Improvement Target 1 Estimated Incentive Payment*:* $3,232	**Outcome Improvement Target 2 [IT-1.9]:** Depression management Goal: Remission of depression symptoms for 10% of patients as evidenced by a reduction of PHQ-9 scores greater than 9 (i.e., at least moderate depression) to less than 5 (i.e., minimal or no depression). The total number of people impacted will depend on baseline scores of enrolled participants on the PHQ-9. Data Source: PHQ-9 Outcome Improvement Target 2 Estimated Incentive Payment*:* $7,025

138980111.3.32	*3.IT-1.9*	*Primary Care and Chronic Disease Management – IT-1.9: Depression Management: Depression remission at twelve months (NQF# 0710)*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.6 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting – Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population – 2.13.1: Health Navigation and Incentives for Dual Diagnosis Patients*		
Starting Point/Baseline:	**Baseline data:** Between one-third and one-half of PSH residents reported regular frequency of depression and related symptoms such as: stopping enjoying things they used to enjoy (36.4%), difficulty concentrating, having racing thoughts or feeling out of control (37.8%) and having periods of intense unease or anxiety (48%). **Target Population:** Dually-diagnosed patients residing in the Ft. Worth PSH programs **Specific Number:** 300 **Description of Population:** Dually-diagnosed patients enrolled in the Ft. Worth permanent supportive housing (PSH) programs		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $3,021	Year 4 Estimated Outcome Amount: $3,232	Year 5 Estimated Outcome Amount: $7,025
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $13,278			

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Title of Outcome Measure (Improvement Target): IT-10.1-Quality of Life

Unique RHP outcome identification number(s): 138980111.3.33 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving patient quality of life scores as measured by the SF-36 for those receiving services from the project Community Based Behavioral Healthcare for Depressed Medicaid Elders and Near Elders. The expected outcome by the end of the waiver is to improve quality of life scores by 10% over baseline. The associated process milestones and improvement targets are:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include meeting with local behavioral health care providers as well as patients to discuss health care barriers to quality of life. The SF-36 will be incorporated into the patient interviews to be developed in DYs 2 and 3 with beta testing completed in DY3.
- Establish baseline rates [P-2]. The baseline will be established by pre-mobile behavioral health care team encounters for each patient receiving services within the target population.
- Develop and test data systems [P-3]. The interview and data collection and analysis system will be developed over DY2-3 and beta tested in DY3. Full implementation of the system will be in DY4.
- Quality of Life/Functional Status – Quality of Life [IT-10.1]. Percent improvement over baseline of patient quality of life scores will be measured by comparing SF-36 scores prior to and after patient encounters by the mobile behavioral health care team.

Rationale:
Prior work shows how quality of life and health status have reciprocal relationships. In fact, the Oregon Health Insurance Experiment (Finkelstein 2011) demonstrated that enrollment in Medicaid had a significant beneficial impact on quality of life, health care utilization (including preventive care measures and hospitalizations), and overall medical expenditures and debt when compared to the control group with no insurance. Prior work also demonstrates a positive impact of depression behavioral health services on patient quality of life. By implementing this community-based depression health care program per the IMPACT model, we propose to improve quality of life by 10% over baseline. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important, as it provides the opportunity to engage behavioral health care physicians as well as patients in evidence-based process models related to improvement in QOL, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project.
- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the patient quality of life. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect QOL measures.
- Quality of Life/Functional Status – Quality of Life [IT-10.1]. Percent improvement over baseline of patient quality of life. This outcome improvement target measures improvement in QOL experienced by participation in the mobile behavioral health care team program for depressed elders. Participants in this intervention will demonstrate improved QOL by owing to the fact that they will receive community-based behavioral health care services for depression.

Outcome Measure Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

For Quality of Life, UNT Health Science Center defined the population that will be directly impacted by the project as 1,500 dually-diagnosed patients enrolled in the Ft. Worth permanent supportive housing (PSH) program. We are anticipating that we will test the entire population, and are expecting to increase quality of life scores by 10%.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $16,750 (as cited in the article, "Cost- effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to $50,000 per life-year gained due to the intervention. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.33	*3.IT-10.1*	*IT-10.1 Quality of Life/Functional Status –IT-10.1 Quality of Life (SF36): for Medicaid eligible elders 65 and older receiving services from the mobile behavioral health care teams*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects:	*1-38980111.1.6 Enhance service availability of appropriate levels of behavioral health care – "Other" project option: Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above -– 1.12.4: Community-Based Behavioral Healthcare for Depressed Medicaid Elders and Near Elders*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY2 and DY3 **Target Population**: Approximately 18,000 elders and near elders residing in Tarrant. At least 5,000 experience symptoms of depression at any given time, all of which are eligible for services within this project **Specific Number:** Overall project target is 30% (1,500) of population. Outcome 3 target is 10% improvement in quality of life (SF-36 scores) for **all** 1,500 patients. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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 (Develop and test data systems) Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment:- $216,849 **Process Milestone 3**[P-3]: Develop and test data systems for collection and program evaluation. Data Source: Program Records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* - $216,850	**Outcome Improvement Target 1** [IT-10.1]: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool, for the target population. Improvement Target: 5% improvement in QOL scores for population receiving intervention Data Source: Data Source: SF-36 Outcome Improvement Target 1 Estimated Incentive Payment*:* $475,436	**Outcome Improvement Target 2** [IT-10.1]: Demonstrate improvement in quality of life (QOL) scores, as measured by evidence-based and validated assessment tool, for the target population. Improvement Target: 10% improvement in QOL scores for population receiving intervention Data Source: Data Source: SF-36 Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,033,555
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: -$443,699**	**Year 4 Estimated Outcome Amount: - $475,436**	**Year 5 Estimated Outcome Amount: - $1,033,555**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$2,403,392			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores – of patients' involvement in shared decision making.

Unique RHP outcome identification number(s): 138980111.3.34 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving patient satisfaction scores of patients' involvement in shared decision making for those receiving services from the project "Community Based Behavioral Healthcare for Depressed Elders and Near Elders." The expected outcome by the end of the Waiver is to improve patient satisfaction scores in decision making by 5% over baseline. The associated process milestones and improvement targets are:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include meeting with local behavioral health care providers as well as patients to identify key components required for effective patient participation in medical decision making.
- Establish baseline rates [P-2]. The baseline will be established by providing the survey prior to and after patient encounters with the mobile behavioral health care team.
- Develop and test data systems [P-3]. The Consumer Assessment of Health Plans Survey (CAHPS) module on Patient/Caregiver Experience – Shared Decision Making will be incorporated into the computerized patient interview. Beta testing will be conducted to ensure accuracy of data as well as test data analytic systems.
- Patient Satisfaction – [IT-6.1] Percent improvement over baseline of patient satisfaction scores of patients' involvement in decision making will be measured by comparing pre- and post-interviews from patient encounters with the mobile behavioral health care team.

Rationale:
Prior work has shown that patient perception of involvement in medical decision making and medical care is directly related to outcomes (Brody et al. 1989). Involvement in decision making is also an essential component of behavioral health care for depression. Therefore, we seek to improve patient satisfaction scores of patients' involvement in decision making by 5% over baseline. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage behavioral health care providers and patients to identify key barriers for patient involvement in medical decision making (e.g., health literacy). Mobile behavioral health care team encounters will be designed to specifically address barriers identified.
- Establish baseline rates [P-2]. This process milestone is necessary, as baseline rates have not been established for this milestone. Baseline rates will be based on patient experience with prior mental health providers. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect patient satisfaction measures.

Patient Satisfaction – [IT-6.1] Percent improvement over baseline of patient satisfaction scores of patients' involvement in decision making. This outcome improvement target measures improvement in patient perception of involvement in decision making by implementation of the mobile behavioral health care team. Participants in this intervention will be actively engaged in decision making by the behavioral health care teams, thereby affording patients the opportunity to have direct input into their health care.

Outcome Measure Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

For Patient Satisfaction Percent Improvement over Baseline of Patient Satisfaction scores, UNT Health Science Center defined the population that will be directly impacted by the project as 1,500 individuals who will receive services through this project. We are anticipating that we will test the entire population and are expecting to increase the patient satisfaction scores of patient's involvement in shared decision making by 5%.

Utilizing, - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $16 (per article "BMC Medicine Research" in the journal BioMed Central), which is based on two percent of the expected reduced cost of mobile healthcare.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.34	*3.IT-6.1*	*Patient Satisfaction – IT-6.1 Percent improvement over baseline of patient satisfaction scores – of patients' involvement in shared decision making.*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects:	*138980111.1.6 Enhance service availability of appropriate levels of behavioral health care – "Other" project option: Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above -– 1.12.4: Community-Based Behavioral Healthcare for Depressed Medicaid Elders and Near Elders*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY2 and DY3 **Target Population**: Approximately 18,000 elders and near elders residing in Tarrant. At least 5,000 experience symptoms of depression at any given time, all of which are eligible for services within this project **Specific Number:** Overall project target is 30% (1,500) of population. Outcome 3 target is 5% improvement in quality of life (SF-36 scores) for **all** 1,500 patients. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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 (Develop and test data systems) Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment:- $213 **Process Milestone 3**[P-3]: Develop and test data systems for collection and program evaluation. Data Source: Program Records Process Milestone 3 Estimated Incentive Payment *(maximum amount): - $214*	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores of patients' involvement in shared decision making. Improvement Target: 3% improvement in patient satisfaction score over baseline Data Source: Patient survey pre- and post-visit with provider from mobile teams/community clinics Outcome Improvement Target 1 Estimated Incentive Payment*:* - $458	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores of patients' involvement in shared decision making. Improvement Target: 5% improvement in patient satisfaction score over baseline Data Source: Patient survey pre- and post-visit with provider from mobile teams/community clinics Outcome Improvement Target 2 Estimated Incentive Payment*:*-$994
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: - $427**	**Year 4 Estimated Outcome Amount: - $458**	**Year 5 Estimated Outcome Amount: - $994**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**- $1,879			

Title of Outcome Measure (Improvement Target): IT-14.6: Percent of trainees who have spent at least five years living in a health professional shortage area (HPSA) or medically underserved area (MUA)

Unique RHP outcome identification number(s): 138980111.3.35 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in expanding the family medicine residency with trainees who have spent at least five years living in a health professional shortage area (HPSA) or medically underserved area (MUA). The expected outcome by the end of the Waiver is to increase the percent of trainees from HPSA/MUA's by 10% over baseline. The associated process milestones and improvement targets are:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include development of data collection and identification process that will allow us to identify residents from HPSA/MUAs, target trainee applicants from these areas, and identify graduates from residency who practice in HPSA/MUAs after graduation from program. Currently this process does not exist.
- Establish baseline rates [P-2]. Currently the residency does not collect data identifying residents who have spent at least five years living in a health professional shortage area (HPSA) or medically underserved area (MUA). This data will be collected early in DY3, establishing the baseline for outcome improvement targets.
- Percent of trainees who have spent at least five years living in a health professional shortage area (HPSA) or medically underserved area (MUA) [IT – 14.6]. The number of residents from HPSA/MUAs will be tracked in DY4 and DY5 with the goal of increasing the percentage of residents from these areas by 10% by the end of DY5.

Rationale:
This outcome measure is a priority for the RHP. RHP community needs as supported by Stakeholder Survey, Texas CHS, County 2010 Health Rankings, Providers Readiness Assessments, and Health Professional Shortage Areas have identified a lack of provider capacity, particularly Medicaid providers who provide primary care services. Five of the Region's counties are recognized as medically underserved areas and four of the nine counties have a shortage in primary care providers.

In a 2011 Survey of Final-Year Medical Residents performed by Merritt Hawkins, "geographic location" was rated as a "most important" factor by 81% of residents when assessing practice opportunities. The preference may override more practical considerations. Residents often pursue

a location for practice where they trained, grew up, or where their spouse or significant other grew up. Recruitment of trainees from HPSA/MUAs will increase the likelihood that they will return to their communities upon graduation. The expected outcome by the end of the Waiver is to increase the percentage of trainees from HPSA/MUAs by 10% over baseline. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Currently, this process does not exist. Engaging stakeholders and needed resources will allow us to expand the residency program in the most efficient manner.
- Establish baseline rates [P-2]. Currently the residency does not collect data identifying residents who have spent at least five years living in a health professional shortage area (HPSA) or medically underserved area (MUA). This data is necessary to show improvement and will be collected early in DY3, establishing the baseline for outcome improvement targets.
- Percent of trainees who have spent at least five years living in a health professional shortage area (HPSA) or medically underserved area (MUA) [IT-14.6]. This improvement target measures the effectiveness of the programs in targeting residents in HPSA/MUAs and should increase primary care providers serving in these areas.

Outcome Measure Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(Section V.B for a full explanation of the model.)*

For percentage of trainees who have spent at least five years living in a HPSA or MUA, UNT Health Science Center expects to increase the number of family medicine residency trainees by six, which will increase the overall number of residency trainees from 12 to 18. It is anticipated that increasing the number of trainees will allow us to increase the number of patient visits by 2,000 for the project period. In addition, it is anticipated this project will increase the percentage of residents who have spent at least five years living in a health professional shortage area (HPSA) or medically underserved area (MUA) by 10%.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,131 (as cited by Agency for Healthcare Research and Quality (AHRQ). Mean Expenses per Person with Care for Selected Conditions by Type of Service: United States, 2010. Medical Expenditure Panel Survey Household Component Data, along with

recommendations provided by UNT Health), as the result- of decreasing per capita cost per patient case by increasing primary care services, prevention, and chronic disease management to patients who currently lack access.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $1,878 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $1,878 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.35	*IT-14.6*	*IT 14.6 Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.7 Increase Training of Primary Care Workforce – Increase the number of primary care providers (i.e., physicians, residents, nurse practitioners, physician assistants) and other clinicians/staff (such as health coaches and community health workers/promotoras) – 1.2.2: Expansion of Plaza/UNTHSC/TCOM Family Medicine Residency Program*		
Starting Point/Baseline:	*Baseline data: Actual baseline data will be collected in early DY3* *Target Population: Family Medicine Resident trainees* *Specific Number: 12 at baseline, 18 at end of project* *Description of Population: Family Medicine Residency trainees*		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2**[P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment: $107,780	**Outcome Improvement Target 1** [IT-14.6]: Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA) Improvement Target: Increase the percent of residents who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA) by 5% over DY3 baseline Data Source: Program Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $115,490	**Outcome Improvement Target 2** [IT-14.6]:Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA) Improvement Target: Increase the percent of residents who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA) by 10% over DY3 baseline Data Source: Program Records Outcome Improvement Target 2 Estimated Incentive Payment*:* $251,064
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: $107,780**	**Year 4 Estimated Outcome Amount: $115,490**	**Year 5 Estimated Outcome Amount: $251,064**

138980111.3.35	*IT-14.6*	*IT 14.6 Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.7 Increase Training of Primary Care Workforce – Increase the number of primary care providers (i.e., physicians, residents, nurse practitioners, physician assistants) and other clinicians/staff (such as health coaches and community health workers/promotoras) – 1.2.2: Expansion of Plaza/UNTHSC/TCOM Family Medicine Residency Program*		
Starting Point/Baseline:	*Baseline data: Actual baseline data will be collected in early DY3* *Target Population: Family Medicine Resident trainees* *Specific Number: 12 at baseline, 18 at end of project* *Description of Population: Family Medicine Residency trainees*		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$474,334			

Title of Outcome Measure (Improvement Target): IT- 14.7- Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

Unique RHP outcome identification number(s): 138980111.3.36 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in expanding the family medicine residency with trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey. The expected outcome by the end of the Waiver is to increase the percentage of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey by 10% over baseline. The associated process milestones and improvement targets are:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include development of a survey that will allow residency to identify residents who report that they plan to practice in HPSAs or MUAs upon graduation from the program. Currently this process does not exist.
- Establish baseline rates [P-2]. Currently the residency does not collect data identifying residents who plan to practice in HPSAs or MUAs upon graduation from the program. This data will be collected early in DY3, establishing the baseline for outcome improvement targets.
- Percentage of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey [P-14.7]. The number of residents who plan to practice in HPSAs or MUAs upon graduation from the program will be tracked in DY4 and DY5, with the goal of increasing the percentage of residents who plan to practice in HPSAs or MUAs upon graduation from the program by 10% by the end of DY5.

Rationale:
This outcome measure is a priority for the RHP. RHP community needs as supported by Stakeholder Survey, Texas CHS, County 2010 Health Rankings, Providers Readiness Assessments, and Health Professional Shortage Areas have identified a lack of provider capacity, particularly Medicaid providers who provide primary care services. Five of the Region's counties are recognized as medically underserved areas and four of the nine counties have a shortage in primary care providers.

In a 2011 Survey of Final-Year Medical Residents performed by Merritt Hawkins, "geographic location" was rated as a "most important" factor by 81% of residents when assessing practice opportunities. The preference may override more practical considerations. Residents often pursue

a location for practice where they trained, grew up, or where their spouse or significant other grew up. Since the residency is located within a mile of MUC census tracts 1045.03 and 1046.05 and within four miles of HPSA tracts 1046.01, 1046.04, 1062.01 and 1062.02 and serves patients from these areas, residents are more likely to remain in this geographical area serving patients with similar demographics. This project aims to increase the percentage of residents who plan to practice in HPSAs or MUAs upon graduation from the program by 10% by the end of DY5. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Currently, this process does not exist. Engaging stakeholders and needed resources will allow us to expand the residency program in the most efficient manner
- Establish baseline rates [P-2]. Currently the residency does not collect data identifying residents who plan to practice in HPSAs or MUAs upon graduation from the program. This data is necessary to show improvement and will be collected early in DY3, establishing the baseline for outcome improvement targets.
- Percentage of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey [IT-14.8]. This improvement target measures the effectiveness of the programs in increasing the percentage of residents who plan to practice in HSPAs and MUAs, thereby increasing primary care access to this population.

Outcome Measure Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

For percentage of trainees who report that they plan to practice in HPSAs or MUAs, UNT Health Science Center expects to increase the number of family medicine residency trainees by six, which will increase the overall number of residency trainees from 12 to 18. It is anticipated that increasing the number of trainees will allow us to increase the number of patient visits by 2,000 for the project period. In addition, it is anticipated this project will increase the percentage of trainees who report that they plan to practice in HPSAs or MUAs based on systematic survey by 10%.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,131 (as cited by Agency for Healthcare Research and Quality (AHRQ). Mean Expenses per Person with Care for Selected Conditions by Type of Service: United States,

2010. Medical Expenditure Panel Survey Household Component Data, along with recommendations provided by UNT Health), as the result- of decreasing per capita cost per patient case by increasing primary care services, prevention, and chronic disease management to patients who currently lack access.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $1,878 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $1,878 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.36	*3.IT-14.7*	*IT- 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.7 Increase Training of Primary Care Workforce – Increase the number of primary care providers (i.e., physicians, residents, nurse practitioners, physician assistants) and other clinicians/staff (such as health coaches and community health workers/promotoras) – 1.2.2: Expansion of Plaza/UNTHSC/TCOM Family Medicine Residency Program*		
Starting Point/Baseline:	*Baseline data: Actual baseline data will be collected in early DY3* *Target Population: Family Medicine Resident trainees* *Specific Number: 12 at baseline, 18 at end of project* *Description of Population: Family Medicine Residency trainees*		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2**[P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment: $107,780	**Outcome Improvement Target 1**[IT- 14.7]: Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey Improvement Target: Increase the percent of trainees who report that they plan to practice in HPSAs or MUAs based on systematic survey by 5% over DY3 baseline Data Source: Program Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $115,490	**Outcome Improvement Target 2**[IT- 14.7]: Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey Improvement Target: Increase the percent of trainees who report that they plan to practice in HPSAs or MUAs based on systematic survey by 10% over DY3 baseline Data Source: Program Records Outcome Improvement Target 2 Estimated Incentive Payment*:* $251,064
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: $107,780**	**Year 4 Estimated Outcome Amount: $115,490**	**Year 5 Estimated Outcome Amount: $251,064**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$474,334			

Title of Outcome Measure (Improvement Target): IT-14.8 - Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Unique RHP outcome identification number(s): 138980111.3.37 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center/138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in expanding the family medicine residency with trainees who report that they plan to serve Medicaid populations based on a systematic survey. The expected outcome by the end of the waiver is to increase the percentage of trainees who report that they plan to serve Medicaid populations based on a systematic survey by 10% over baseline. The associated process milestones and improvement targets are:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include development of a survey that will allow residency to identify residents who report that they plan to serve Medicaid populations upon graduation from the program. Currently this process does not exist.
- Establish baseline rates [P-2]. Currently the residency does not collect data identifying residents who plan to serve Medicaid populations based upon graduation from the program. This data will be collected early in DY3, establishing the baseline for outcome improvement targets.
- Percentage of trainees who report that they plan to serve Medicaid populations based on a systematic survey [IT-14.8]. The number of residents who plan to serve Medicaid populations upon graduation from the program will be tracked in DY4 and DY5 with the goal of increasing the percentage of residents who plan to serve Medicaid populations upon graduation from the program by 10% by the end of DY5.

Rationale:
This outcome measure is a priority for the RHP. RHP community needs as supported by Stakeholder Survey, Texas CHS, County 2010 Health Rankings, Providers Readiness Assessments, and Health Professional Shortage Areas have identified a lack of provider capacity, particularly Medicaid providers who provide primary care services. Five of the Region's counties are recognized as medically underserved areas and four of the nine counties have a shortage in primary care providers.

In a 2011 Survey of Final-Year Medical Residents performed by Merritt Hawkins, "geographic location" was rated as a "most important" factor by 81% of residents when assessing practice opportunities. The preference may override more practical considerations. Residents often pursue a location for practice where they trained, grew up, or where their spouse or significant other

grew up. Since the residency is located within a mile of MUC census tracts 1045.03 and 1046.05 and within four miles of HPSA tracts 1046.01, 1046.04, 1062.01 and 1062.02 and serves patients from these areas, residents are more likely to remain in this geographical area serving patients with similar demographics. In addition the current residency clinic has a 36% Medicaid payer mix. This project aims to increase the percentage of residents who plan to serve Medicaid populations upon graduation from the program by 10% by the end of DY5. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Currently, this process does not exist within the program. Engaging stakeholders and needed resources will allow us to expand the residency program in the most efficient manner.
- Establish baseline rates [P-2]. Currently the residency does not collect data identifying residents who plan to serve Medicaid populations upon graduation from the program. This data is necessary to show improvement and will be collected early in DY3 establishing the baseline for outcome improvement targets.
- Percentage of trainees who report that they plan to serve Medicaid populations based on a systematic survey [IT-14.8].This improvement target measures the effectiveness of the program in increasing the percentage of residents who plan to serve the Medicaid population.

Outcome Measure Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

For percentage of trainees who report that they plan to serve Medicaid populations, UNT Health Science Center expects to increase the number of family medicine residency trainees by six, which would increase the overall number of residency trainees from 12 to 18. It is anticipated that increasing the number of trainees will allow us to increase the number of patient visits by 2,000 for the project period. In addition, it is anticipated this project will increase the percentage of trainees who report that they plan to serve Medicaid populations based on systematic survey by 10%.

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,131 (as cited by Agency for Healthcare Research and Quality (AHRQ). Mean Expenses per Person with Care for Selected Conditions by Type of Service: United States,

2010. Medical Expenditure Panel Survey Household Component Data, along with recommendations provided by UNT Health), as the result- of decreasing per capita cost per patient case by increasing primary care services, prevention, and chronic disease management to patients who currently lack access.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $1,878 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $1,878 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.37	*3.IT-14.8*	*IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey*	
UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.7 Increase Training of Primary Care Workforce – Increase the number of primary care providers (i.e., physicians, residents, nurse practitioners, physician assistants) and other clinicians/staff (such as health coaches and community health workers/promotoras) – 1.2.2: Expansion of Plaza/UNTHSC/TCOM Family Medicine Residency Program*		
Starting Point/Baseline:	*Baseline data: Actual baseline data will be collected in early DY3* *Target Population: Family Medicine Resident trainees* *Specific Number: 12 at baseline, 18 at end of project* *Description of Population: Family Medicine Residency trainees*		
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 Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment: $107,780	**Outcome Improvement Target 1**[IT-14.8]: Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey Improvement Target: Increase the percent of trainees who report that they plan to serve Medicaid populations based on systematic survey by 5% over DY3 baseline Data Source: Program Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $115,490	**Outcome Improvement Target 2**[IT-14.8]: Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey Improvement Target: Increase the percent of trainees who report that they plan to serve Medicaid populations based on systematic survey by 10% over DY3 baseline Data Source: Program Records Outcome Improvement Target 2 Estimated Incentive Payment: $251,064
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: $107,780**	**Year 4 Estimated Outcome Amount: $115,490**	**Year 5 Estimated Outcome Amount: $251,064**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$474,334			

Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Unique Project ID: 138980111.3.38 (Pass 3)
Performing Provider Name/TPI: University of North Texas Health Science Center / 138980111

Outcome Measure Description:
The outcome measure selected is quality of life, which will be measured using the widely used and validated SF-12 quality of life instrument. The expected goal is to improve quality of life by 5% over baseline by the end of the waiver. The specific process milestones and the selected improvement targets for each year are:

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This will include conducting a needs assessment to identify needed specialties that can be provided via telemedicine, identify the types of personnel needed to implement the program, hiring of the respective personnel, and identifying needed services that can be delivered via telehealth. We will implement remote patient monitoring program based on evidence-based models and adapted to fit the needs of the population and local context and document program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.
- Develop and Test Data Systems [P-2]. This will include creating a plan to monitor and enhance technical properties, bandwidth, of telemedicine/telehealth program. We will document bandwidth capacity in relationship to program needs and determine technical properties needed to implement program effectively.
- Percent improvement over baseline in quality of life scores [IT-10.1] Patient quality of life will be measured by using the SF-12. Patients will be in the proposed patient monitoring program for an average of six months and the goal is to improve quality of life scores (SF-12 main summary scores) by 5% from the first baseline measurement to the last measurement collected towards the end of program participation for each Medicaid beneficiary.

Rationale:
Demonstrate improvement in quality of life scores as measured by the SF-12 for the target population was chosen to assess the impact of remote patient monitoring on quality of life.

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to conduct the needs assessment and to identify needed specialties and needs that can be met via telemedicine. It also allows for the implementation of the remote patient monitoring program.
- Develop and Test Data Systems [P-3]. This process milestone is necessary to ensure that appropriate capacity is available to transmit health information efficiently and effectively.
- Percent improvement over baseline in quality of life scores [IT-10.1]. Remote patient monitoring has been shown to lower the risk of hospitalization for Medicare and Medicare/Medicaid dual eligible patients with chronic health conditions. These reductions in hospitalization rates are a direct consequence of better care coordination and chronic disease stabilization resulting from intensive patient

monitoring. The SF-12 is a general survey instrument designed to capture different dimensions of health and quality of life. The instrument allows for the measurement of not only general physical and mental health but also other important health domains (physical functioning, role functioning, bodily pain, vitality, and social functioning). These health outcomes are expected to improve for our targeted low-income population as a result of better care coordination and chronic disease management achieved by our interventional telehealth program.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

For Quality of Life, UNT Health Science Center defined the population that will be directly impacted by the project as patients selected for remote patient monitoring, which would be approximately 700 patients. We anticipate that we will remotely monitor the entire population using interventional telehealth and are expecting to increase the quality of life (SF-12) scores by 5%.

Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $3,755 (as cited in the article, "Cost-effectiveness of a Multicondition Collaborative Care Intervention: A Randomized Controlled Trial" in the journal *Arch Gen Psychiatry*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which was based on a cost-utility analysis that applied an incremental quality-adjusted life-year to the customary $50,000 per life-year gained due to the intervention -. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.38	*3.IT-10.1*	*Quality of Life/Functional Status – IT-10.1: Quality of Life*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	**138980111.1.8 Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement remote patient monitoring programs for diagnosis and/or management of care – 1.7.2: Managing Chronically Ill Medicaid Patients using Interventional Telehealth**		
Starting Point/Baseline:	**Baseline Data:** The project baseline will be established in DY2 and DY3 **Target Population:** Chronically ill Medicaid patients **Specific Number:** 700 (300 in DY4 and 400 in DY5) **Description of Population:** Chronically ill Medicaid patients discharged from RHP 10 hospitals and enrolled in the telehealth monitoring program		
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. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program records. Process Milestone 2 Estimated Incentive Payment: $328,156	**Outcome Improvement Target 1** [IT-10.1]: Quality of Life as measured by SF-12 survey instrument. Improvement Target: 3% increase in SF-12 scores over baseline (average improvement in patient SF-12 summary scores from beginning to end of program participation) Data Source: SF-12. Outcome Improvement Target 1 Estimated Incentive Payment*:* $351,628	**Outcome Improvement Target 2** [IT-10.1]: Quality of Life as measured by SF-12 survey instrument. Improvement Target: 5% increase in SF-12 scores over baseline (average improvement in patient SF-12 summary scores from beginning to end of program participation) Data Source: SF-12. Outcome Improvement Target 2 Estimated Incentive Payment*:* $764,409
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $328,156	Year 4 Estimated Outcome Amount: $351,628	Year 5 Estimated Outcome Amount: $764,409
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,444,192			

Title of Outcome Measure (Improvement Target): IT-10.2 Activities of Daily Living

Unique Project ID: 138980111.3.39 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center / 138980111

Outcome Measure Description:

The outcome measure selected is activities of daily living (functional independence), which will be measured using the widely used and validated Barthel Index of ADLs. The expected goal is to improve functional independence by 5% over baseline by the end of the waiver. The specific process milestones and the selected improvement targets for each year are:

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This will include conducting a needs assessment to identify needed specialties that can be provided via telemedicine, identify the types of personnel needed to implement the program, hiring of the respective personnel, and identifying needed services that can be delivered via telehealth. We will implement remote patient monitoring program based on evidence-based models and adapted to fit the needs of the population and local context and document program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.
- Develop and Test Data Systems [P-2]. This will include creating a plan to monitor and enhance technical properties, bandwidth, of telemedicine/ telehealth program. We will document bandwidth capacity in relationship to program needs and determine technical properties needed to implement program effectively.
- Percent improvement over baseline in activities of daily living [IT-10.2]. Patient improvement in activities of daily living will be measured by using the Barthel Index. Patients will be in the proposed patient monitoring program for an average of six months and the goal is to improve the Barthel Index scores by 5% from the first baseline measurement to the last measurement collected towards the end of program participation for each Medicaid beneficiary.

Rationale:

Demonstrate improvement in ADL scores, as measured by the Barthel Index for the target population was chosen to assess the impact of remote patient monitoring on activities of daily living.

- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to conduct the needs assessment and to identify needed specialties and needs that can be met via telemedicine. It also allows for the implementation of the remote patient monitoring program.
- Develop and Test Data Systems [P-3]. This process milestone is necessary to ensure that appropriate capacity is available to transmit health information efficiently and effectively.
- Percent improvement over baseline in activities of daily living [IT-10.2]. Remote patient monitoring has been shown to lower the risk of hospitalization for Medicare and Medicare/Medicaid dual eligible patients with

chronic health conditions. These reductions in hospitalization rates are a direct consequence of better care coordination and chronic disease stabilization resulting from intensive patient monitoring. The Barthel Index is a general assessment score of functional independence that includes ten items (bathing, grooming, feeding, dressing, bowels, bladder, toilet use, stairs, transfers, and mobility). The overall index score ranges from 0 to 100, with a higher number indicating more independence. Functional independence is expected to improve for our targeted low-income population as a result of better care coordination and chronic disease management achieved by our interventional telehealth program.

Outcome Measure Valuation:

Approach/Methodology:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B.

Rationale/Justification:
For Activities in Daily Living (ADLs), UNT Health Science Center defined the population that will be directly impacted by the project as Patients selected for remote patient monitoring, which would be approximately 700 patients.. We anticipate that we will remotely monitor the entire population using interventional telehealth and are expecting to increase the Barthel Index of ADLs (functional independence) scores by 5%.

Utilizing -the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $2,500 (as cited in the article, "Assessment of post-stroke quality of life in cost-effectiveness studies: The usefulness of the Barthel Index and the EuroQoL-5D" from the journal *Quality of Life Research*, along with recommendations provided by UNT Health Science Center's Department of Health Management and Policy), which used the Barthel Index to assess the impact of the target population as a means to calculate an incremental quality-adjusted life-year and applied it to the customary $50,000 per life-year gained due to the intervention -. This threshold has been a standard way of valuing life-years in terms of whether the cost of the intervention exceeds this standard.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a

reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.39	3.IT-10.2	Quality of Life/Functional Status – IT-10.2: Activities of Daily Living	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	**138980111.1.8 Introduce, Expand, or Enhance Telemedicine/Telehealth – Implement remote patient monitoring programs for diagnosis and/or management of care – 1.7.2: Managing Chronically Ill Medicaid Patients using Interventional Telehealth**		
Starting Point/Baseline:	**Baseline Data:** The project baseline will be established in DY2 and DY3 **Target Population:** Chronically ill Medicaid patients **Specific Number:** 700 (300 in DY4 and 400 in DY5) **Description of Population:** Chronically ill Medicaid patients discharged from RHP 10 hospitals and enrolled in the telehealth monitoring program		
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. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program records. Process Milestone 2 Estimated Incentive Payment: $218,479	**Outcome Improvement Target 1** [IT-10.2]: Activities of Daily Living (functional independence) as measured by the Barthel Index. Improvement Target: 3% increase in Barthel Index scores over baseline (average improvement in patient Barthel Index scores from beginning to end of program participation) Data Source: ADL survey instrument. Outcome Improvement Target 1 Estimated Incentive Payment*:* $234,107	**Outcome Improvement Target 2** [IT-10.2]: Activities of Daily Living (functional independence) as measured by the Barthel Index. Improvement Target: 5% increase in Barthel Index scores over baseline (average improvement in patient Barthel Index scores from beginning to end of program participation) Data Source: ADL survey instrument. Outcome Improvement Target 2 Estimated Incentive Payment*:* $508,927
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $218,479	Year 4 Estimated Outcome Amount: $234,107	Year 5 Estimated Outcome Amount: $508,927
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $961,513			

Title of Outcome Measure (Improvement Target): IT-2.12- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions

Unique RHP outcome identification number(s): 138980111.3.40
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing all-cause hospital admission rates as measured by the PQI Composite Measure Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions among Medicaid-eligible elders 65 and above receiving services from the project "Community-Based Primary Care for the Elderly." The expected outcome by the end of the Waiver is to reduce hospital admission rates for Medicaid-eligible elders 65 and above receiving the intervention by 5% over baseline. The associated process milestones and improvement targets are:
Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include discussions with local health care providers and hospital administration regarding targeted conditions most strongly related to admissions. A review of the literature on this topic has already been conducted. The intervention will be planned targeting these risk factors.
- Establish baseline rates [P-2]. Prior work suggests that approximately 16% of Medicaid elders are hospitalized annually with the percentages increasing with age. Additional baseline data from our target population will be collected by survey at initial patient encounters regarding hospitalization rates in the prior 12 months.
- Develop and test data systems [P-3]. This will involve setting up methods to track and collect admission data from our target population and from area hospitals
- Potentially Preventable Admissions – Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions-[IT-2.12-]. All-cause hospital admissions will be measured by the PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions for patients provided services through the community-based medical model (mobile teams and community-based clinics). Additionally, we will establish a tracking system with the local hospitals to track these patients.

Rationale:
According to the CDC 2010 estimates, approximately 16% of those 65 and above will experience a hospital stay within a 12-month time frame and the percentage increases to 21% for

those ages 85 and over. Medicaid-eligible elders are more likely to experience hospital admission owing to chronic illnesses and comorbidities. Additionally, it has been proposed that upwards of 40% of hospital admissions are avoidable. Our project aims to reduce Potentially Preventable Admissions – Other Admissions Rate (All-cause hospital admission rates for Medicaid-eligible elders 65 and above receiving services from the project Community-Based Primary Care for the Elderly) by 5% over baseline. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage primary care physicians and other primary care providers, as well as local hospital administration, in evidence-based process models, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.
- Establish baseline rates [P-2]. While prior work provides an estimate of expected base rates, this process milestone is necessary as baseline rates have not been established for this particular population, which is at higher risk for hospital readmissions. Establishing baseline rates for our target population will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect all-cause hospital admission data from program records and area hospitals.
- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions-[IT-2.12-]. This outcome improvement target measures the number of non-maternal hospital admissions among patients of this program in RHP 10. Patients receiving care (including urgent care), care coordination and education from the program will demonstrate improved competence and performance related to clinical processes in effective patient management and education on self-management, resulting in fewer admissions.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions, UNT Health Science Center defined the population that will be directly impacted as approximately 3,071 patients receiving services from the project titled "Community-Based Primary Care for the Elderly." Based on various literature, it is anticipated that approximately 500 of those patients will be admitted to a hospital. The percentage of improvement expected by the project - is 5%, equating to 25 lives positively impacted by this outcome.

  Utilizing - the pricing matrix developed by Region-10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,100.

  The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

  Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.40	*3.IT-2.12*	*Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics -1.1.3: Community-Based Primary Care for the Elderly*		
Starting Point/Baseline:	**Baseline data:** Actual baseline data will be collected in DY2 and DY3 **Target Population**: Approximately 3,071 patients will receive - services from the project titled Community-Based Primary Care for the Elderly **Specific Number:** Based on various literature, it is anticipated that approximately 500 patients will be admitted to a hospital at baseline. Outcome 3 target is 5% reduction in hospital admissions (25 admissions prevented) for these hospitalized patients the target population. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program Records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $4,102 **Process Milestone 3** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 3 Estimated Incentive Payment: $4,102	**Outcome Improvement Target 1** [I-2.12-]: PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions hospital admission rates for Medicaid-eligible and near elders receiving services from the project titled Community-Based Primary Care for the Elderly. Improvement Target: 3% reduction (15 admissions prevented) in all-cause hospital admission rate over baseline Data Source: Program Records Outcome Improvement Target 1 Estimated Incentive Payment: $8,776	**Outcome Improvement Target 2** [IT 2.12-]: PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions hospital admission rates for Medicaid-eligible elders and near elders receiving services from the project titled Community-Based Primary Care for the Elderly. Improvement Target: 5% (25 hospitalizations prevented) reduction in all-cause hospital admission rate over baseline Data Source: Program Records Outcome Improvement Target 2 Estimated Incentive Payment: $19,078

138980111.3.40	*3.IT-2.12*	*Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.2 Expand Primary Care Capacity – Expand Mobile Clinics -1.1.3: Community-Based Primary Care for the Elderly*		
Starting Point/Baseline:	**Baseline data:** Actual baseline data will be collected in DY2 and DY3 **Target Population**: Approximately 3,071 patients will receive - services from the project titled Community-Based Primary Care for the Elderly **Specific Number:** Based on various literature, it is anticipated that approximately 500 patients will be admitted to a hospital at baseline. Outcome 3 target is 5% reduction in hospital admissions (25 admissions prevented) for these hospitalized patients the target population. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $8,204	Year 4 Estimated Outcome Amount: $8,776	Year 5 Estimated Outcome Amount: $19,078
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $36,057			

Title of Outcome Measure (Improvement Target): IT-2.12- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions

Unique RHP outcome identification number(s): 138980111.3.41
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing all-cause hospital admission rates for Medicaid-eligible elders 65 and above receiving services from the UNTHSC Department of Internal Medicine. The expected outcome by the end of the Waiver is to reduce all-cause hospital admission rates for Medicaid-eligible elders 65 and above receiving the intervention by 5% over baseline (anticipated 8 hospitalizations prevented). The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include discussions with local health care providers and hospital partners regarding targeted conditions most strongly related to admissions, which will be targeted in the intervention.
- Establish baseline rates [P-2]. Prior work suggests that approximately 16% of Medicaid elders are hospitalized annually with the percentages increasing with age. Additional baseline data from our target population will be collected at initial patient encounters.
- Develop and test data systems [P-3]. This will involve setting up methods to track and collect admission data from our target population and from partner hospitals
- Potentially Preventable Admissions (PPA) – IT-2.12- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions-: All-cause hospital admissions will be measured by tracking patients provided services and through partnering hospital records.

Rationale:
According to the CDC 2010 estimates, approximately 16% of those 65 and above will experience a hospital stay within a 12-month time frame. Medicaid-eligible elders are more likely to experience hospital admission owing to chronic illnesses and comorbidities. By enhancing access to geriatric primary care to those patients seen by the UNTHSC Department of Internal Medicine, we seek to reduce admission rate 5% over baseline (8 anticipated

hospitalizations prevented) among this population. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage primary care physicians and local hospital providers in discussion of evidence-based process models, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.
- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for the Medicaid-eligible elders receiving services from the UNTHSC Department of Internal Medicine. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect all-cause hospital admission data from program records and partnering hospitals.
- Potentially Preventable Admissions – IT-2.12- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions- This outcome improvement target measures the number of non-maternal all-cause admissions of the target population.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For Prevention Quality Indicators (PQI) composite measures potentially preventable hospitalizations for Ambulatory Care Sensitive Conditions -, the UNT Health Science Center defined the population that will be directly impacted by - the project - as Medicaid-eligible elders of Tarrant County ages 65 and above who receive services from the UNTHSC Department of Internal Medicine, - which would be approximately- 162 individuals. - The percentage of improvement - expected - by the project is 5%, equating to 8 lives positively impacted by this outcome

Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $7,100 due to the patient population mix -.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $4,260 for each positive outcome realized. Another additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $2,840 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.41	*3.IT-2.12*	*Potentially Preventable Admissions – IT-2.12- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.3 Expand Primary Care Capacity – Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elders*		
Starting Point/Baseline:	**Baseline data**: Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 and above who receive services from the UNTHSC Department of Internal Medicine **Specific Number:** In FY 11, approx. 750 Medicaid eligible elders received services from UNTHSC Department of Internal Medicine. This project will increase patient pool by 35% – 1,013 patients by DY5. It is anticipated that 16%, or **162**, of these patients will be admitted to the hospital. Our goal is reduction in hospitalization from 162 by 5%. **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 3** [P-2]: Establish baseline rates -Data Source: Program Records Process Milestone 3 Estimated Incentive Payment: $6,585	**Outcome Improvement Target 1** [IT 2.12-]: PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions - All-cause hospital admission rate for Medicaid-eligible elders 65 and above receiving services from the UNTHSC Department of Internal Medicine. Improvement Target: 3% reduction (5 hospitalizations prevented) in all-cause hospital admission rate over baseline Data Source: Program Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $7,044	**Outcome Improvement Target 2** [IT 2.12-]: PQI Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions - All-cause hospitalization admission rates for Medicaid-eligible elders 65 and above receiving services from the UNTHSC Department of Internal Medicine. Improvement Target: 5% reduction (8 hospitalizations prevented) in all-cause hospitalization rate over baseline Data Source: Program Records Outcome Improvement Target 2 Estimated Incentive Payment*:* $15,313

138980111.3.41	*3.IT-2.12*	*Potentially Preventable Admissions – IT-2.12- Prevention Quality Indicators (PQI) Composite Measures Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.1.3 Expand Primary Care Capacity – Expand existing primary care capacity – 1.1.2: Expanding Geriatric Primary Care and Consultative Services to Medicaid Eligible Elders*		
Starting Point/Baseline:	**Baseline data**: Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 and above who receive services from the UNTHSC Department of Internal Medicine **Specific Number:** In FY 11, approx. 750 Medicaid eligible elders received services from UNTHSC Department of Internal Medicine. This project will increase patient pool by 35% – 1,013 patients by DY5. It is anticipated that 16%, or **162**, of these patients will be admitted to the hospital. Our goal is reduction in hospitalization from 162 by 5%. **Description of Population:** Elderly patients who are eligible for coverage by Medicaid		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $6,585	Year 4 Estimated Outcome Amount: $7,044	Year 5 Estimated Outcome Amount: $15,313
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $28,942			

Title of Outcome Measure (Improvement Target): IT-11.3- Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. -(Percentage of people at high risk for infection receiving pneumococcal vaccination)

Unique RHP outcome identification number(s): 138980111.3.42
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in improving the percentage of people receiving the pneumococcal vaccination in minority populations. The expected outcome by the end of the Waiver is to improve pneumococcal vaccinations in minority populations receiving the intervention by 2% over baseline. The associated process milestones and improvement targets are:
Process Milestones & Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include identification and recruitment of content experts, content development, baseline data analysis and finalization of tracking and analysis methodology, educational plan development and target audience triangulation and assessment strategies.
- Establish baseline rates [P-2]. The baseline will The baseline will be obtained through the Texas Public Use Data File (Hospital Admissions) or data mart
- Improvement in Clinical Indicator in identified disparity group [IT-11.3-] Percentage of people at high risk for infection receiving pneumococcal vaccination will be measured by data aggregated by the North Texas Regional Extension Center and North Texas Accountable Healthcare Partnership and DY4 and DY5 will be compared to baseline.

Rationale:
Addressing Health Disparities in Minority Populations – IT-11. 3- Improve utilization rates of clnical preventive services (testing, preventive services, treatment) in target population with identified disparity. -(Percentage of people at high risk for infection receiving pneumococcal vaccination) was selected as an outcome measure because minority populations, especially African-Americans and Hispanics, are disproportionately underimmunized for invasive pneumococcal bacteria. This measure will assess the effectiveness of the project training materials which include modules in pneumonia prevention, including immunization, especially in minority populations. Medical home and chronic care models are also included in the training

and have been shown to improve immunization status. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage primary care physicians in updated training in emerging and evolving health care delivery models, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project. Determination of timelines and documentation of implementation are necessary components to assess the process and establish improvement metrics.
- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been confirmed for the patients of participating PCPs. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Addressing Health Disparities in Minority Populations – -Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Percentage of people at high risk for infection receiving pneumococcal vaccination) [IT-11.3-]. Primary care participants receiving education will demonstrate improvement resulting in increased pneumococcal immunization status of adults. Educational effectiveness will be measured by improvements in knowledge, competence and performance.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

- **Rationale/Justification:** For Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity, UNT Health Science Center defined the population that will be directly impacted by the project as patients in RHP 10 who are considered high risk for infection and receive services from PCPs receiving intervention, which would be approximately 38,185. The percentage of improvement in pneumonia vaccinations for this population is expected to be 2%, equating to 764 lives positively impacted by this outcome.

  Utilizing, - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive

outcome realized would be $417 (as cited in the article, "Pneumococcal Vaccination Reduces Mortality and Costs in Elderly" in the internet journal at www.respiratoryreviews.com), -which was based on the average savings per person vaccinated.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, the resulting additional valuation amount is $167 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, the resulting additional valuation amount is $167 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.42	*3.IT-11.3*	*Addressing Health Disparities in Minority Populations – IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity -(Percentage of people at high risk for infection receiving pneumococcal vaccination)*	
University of North Texas Health Science Center (UNTHSC)			138980111
Related Category 1 or 2 Projects::	*138980111.1.4 Increase Training of Primary Care Workforce- "Other" project option: Update primary care training programs to include training on the medical home and chronic care models, disease* registry use for population health management, patient panel management, oral health, and other identified training needs and/or quality/performance improvement (1.2.1: Training Primary Care Workforce in Evolving Health Care Delivery Models)		
Starting Point/Baseline:	**Baseline data:** Based on 2010 Census Data, 240,059 18-64 with chronic conditions have never received the pneumococcal vaccine and 141,667 ages 65 and older have never received the pneumococcal vaccine. Actual baseline data for providers and corresponding patients will be identified by performing a provider review and ID of impact metrics and baseline in DY2-3 to set baseline data. **Target Population:** Total number of people ages 18 and older who are: 1) considered high risk for infection, 2) have not ever received the pneumococcal vaccine and 3) are seen by the 12,788 PCPs in the Region. According to 2010 Census Data, n= 381,727. **Specific Number:** Estimated **38,185** are eligible based on 10% of PCPs receiving intervention; 3% improvement would impact 1,146 people **Description of Population:** Patients in RHP 10 who are considered high risk for infection and receive services from PCPs receiving intervention		
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 Develop and test data systems Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Develop and test data systems Data Source: Program Records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $49,191 **Process Milestone 3** [P-2]. Establish baseline rates Data Source: Program Records Process Milestone 3 Estimated Incentive Payment: $44,247	**Outcome Improvement Target 1 IT 11.1** Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider. Measure: Percentage of people at high risk for infection receiving pneumococcal vaccination Numerator: Number of people ages 18 and older at high risk for infection who have received a pneumococcal vaccination Denominator: Number of people ages 18 and older at high risk for pneumococcal infection Improvement Target: 1% improvement over baseline Data Source: North Texas Regional Extension Center and North Texas Accountable Healthcare Partnership Outcome Improvement Target 1 Estimated Incentive Payment*:* $52,623	**Outcome Improvement Target 2 IT 11.1** Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider. Measure: Percentage of people at high risk for infection receiving pneumococcal vaccination Numerator: Number of people ages 18 and older at high risk for infection who have received a pneumococcal vaccination Denominator: Number of people ages 18 and older at high risk for pneumococcal infection Improvement Target: 2% improvement over baseline Data Source: North Texas Regional Extension Center and North Texas Accountable Healthcare Partnership Outcome Improvement Target 2 Estimated Incentive Payment*:* $114,389

Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $49,191	Year 4 Estimated Outcome Amount: $52,623	Year 5 Estimated Outcome Amount: $114,398
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $216,213			

Title of Outcome Measure (Improvement Target): IT-1.8 – Depression Management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134).
Unique RHP outcome identification number(s): 138980111.3.43 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project at increasing access to care by directly capturing the total number of potential patients screened from the community. Screening will be conducted by the CHWs using the Geriatric Depression Scale (GDS). It is anticipated that 1,500 Medicaid eligible elders and near elders will be screened and receive a treatment plan per the IMPACT model from social workers and psychologists in conjunction with the patients primary care physician through project Community Based Behavioral Healthcare for Depressed Medicaid Elders and Near Elders. The associated process milestones and improvement targets are:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include meeting with local behavioral health care providers as well as patients to discuss health care barriers to quality of life. The GDS will be incorporated into the patient interviews to be developed in DYs 2 and 3 with beta testing completed in DY3.
- Establish baseline rates [P-2]. The baseline will be established by pre-mobile behavioral health care team encounters for each patient receiving services within the target population.
- Develop and test data systems [P-3]. The interview and data collection and analysis system will be developed over DY2-3 and beta tested in DY3. Full implementation of the system will be in DY4.
- Depression Management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) [IT-1.8]. The total number of patients receiving depression screens and treatment plans will be assessed from the program.

Rationale:
Depression is a major, but under-treated, problem among the elderly population, which is disproportionately experienced by poor elderly. Additionally, access to care for depressed Medicaid eligible elderly is a key issue given the limited numbers of health care providers that provide therapeutic treatment for depression. This project will substantially increase access to depression screening and management (1,500 patients) for elderly within community-based settings. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important, as it provides the opportunity to engage behavioral health care physicians as well as patients in evidence-based process models related to depression treatment, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project.
- Establish baseline rates [P-2]. This process milestone is necessary to establish baseline rates of depression within the eligible service population.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect depression measure.
- Depression Management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) [IT-1.8]. The total number of patients provided depression screening and treatment plans through this project will be measured. This outcome improvement target measures the community impact of this program by reaching and treating a substantial number of depressed elders of Tarrant County.

Outcome Measure Valuation:

For Depression Management: Screening and Treatment Plan for Clinical Depression, UNT Health Science Center defined the population that will be directly impacted by the project as 1,500 individuals who will receive services through this project. We are anticipating that we will provide depression screening and treatment plans for all patients.

Utilizing the pricing matrix developed by Region 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,759.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $704 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, which resulted in a valuation amount of $1,055 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the “halo effect”, due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center’s project’s values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may

receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.43	*3.IT-1.8*	*IT-1.8 Depression Management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) for Medicaid eligible elders and near elders receiving services from the mobile behavioral health care teams*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects:	*138980111.1.6 Enhance service availability of appropriate levels of behavioral health care – "Other" project option: Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above -– 1.12.4: Community-Based Behavioral Healthcare for Depressed Medicaid Elders and Near Elders*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY2 and DY3 **Target Population**: Approximately 18,000 elders and near elders residing in Tarrant. At least 5,000 experience symptoms of depression at any given time, all of which are eligible for services within this project **Specific Number:** Overall project target is 1,500 patients provided depression screening and treatment plans. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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 (Develop and test data systems) Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $**0**	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment: $46,595 **Process Milestone 3**[P-3]: Develop and test data systems for collection and program evaluation. Data Source: Program Records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $46,595	**Outcome Improvement Target 1** [IT-1.8]: Conduct depression screening and treatment planning protocols for 750 patients. Improvement Target: 750 depressed Medicaid elder and near elder patients Data Source: Program Records, GDS Outcome Improvement Target 1 Estimated Incentive Payment*:* $99,856	**Outcome Improvement Target 2** [IT-1.8]: Conduct depression screening and treatment planning protocols for 1500 patients. Improvement Target: 1500 depressed Medicaid elder and near elder patients Data Source: Program Records, GDS Outcome Improvement Target 2 Estimated Incentive Payment*:* $217,077
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount:** $93,190	**Year 4 Estimated Outcome Amount:** $99,856	**Year 5 Estimated Outcome Amount:** $217,077
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $410,123			

Title of Outcome Measure (Improvement Target): IT-1.9 – Depression Management: Depression Remission at Twelve Months (NQF #0710).
Unique RHP outcome identification number(s): 138980111.3.44 (Pass 2)
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC)/138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project at treating depression by demonstrating 12-month remission among patients receiving services. It is anticipated that a minimum of 10% (150 patients) will be depression-free 12-months after baseline assessment (as measured by the GDS). The associated process milestones and improvement targets are:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include meeting with local behavioral health care providers as well as patients to discuss health care barriers to quality of life. The GDS will be incorporated into the patient interviews to be developed in DYs 2 and 3 with beta testing completed in DY3.
- Establish baseline rates [P-2]. The baseline will be established by pre-mobile behavioral health care team encounters for each patient receiving services within the target population.
- Develop and test data systems [P-3]. The interview and data collection and analysis system will be developed over DY2-3 and beta tested in DY3. Full implementation of the system will be in DY4.
- Depression Management: Depression Remission at Twelve Months (NQF#0710). The total number of patients receiving depression services who are depression free after 12-months divided by the total number of patients receiving services.

Rationale:
Depression is a major, but under-treated, problem among the elderly population, which is disproportionately experienced by poor elderly. Additionally, access to care for depressed Medicaid eligible elderly is a key issue given the limited numbers of health care providers that provide therapeutic treatment for depression. This Category 3 measure will determine the efficicay of the current project by evaluating 12-month remission rates. It is anticipated that a minimum of 10% (150 patients) will score 10 or below on the GDS after 12 months from initial baseline evaluation. To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important, as it provides the opportunity to engage behavioral health care physicians as well as patients in evidence-based process models related to depression

treatment, to identify capacity, to plan and document needed resources, and to implement plans necessary for the project.

- Establish baseline rates [P-2]. This process milestone is necessary to establish baseline rates of depression within the eligible service population.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to collect depression measure.
- Depression Management: Depression Remission at Twelve Months (NQF#0710). The total number of patients provided depression treatment that are depression-free after 12 months as compared to the total number of patients receiving services. This outcome improvement target measures the community impact of this program by reaching and treating a substantial number of depressed elders of Tarrant County.

Outcome Measure Valuation:

Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

For Depression Management: Depression Remission at Twelve Months, UNT Health Science Center defined the population that will be directly impacted by the project as 1,500 individuals who will receive services through this project. We are expecting to decrease depression remission at twelve months for at least 10% of patients, equating to 150 lives positively impacted by this outcome.

Utilizing the pricing matrix developed by Region 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $1,759.

For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $704 for each positive outcome realized. Also, an additional multiplier was applied to determine the benefit it provided to the individual, which resulted in a valuation amount of $1,055 for each positive outcome realized.

The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the “halo effect”, due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

38980111.3.44	*3.IT-1.9*	*IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF#0710) for Medicaid eligible elders and near elders receiving services from the mobile behavioral health care teams*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects:	*138980111.1.6 Enhance service availability of appropriate levels of behavioral health care – "Other" project option: Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above -– 1.12.4: Community-Based Behavioral Healthcare for Depressed Medicaid Elders and Near Elders*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY2 and DY3 **Target Population**: Approximately 18,000 elders and near elders residing in Tarrant. At least 5,000 experience symptoms of depression at any given time, all of which are eligible for services within this project **Specific Number:** Overall project target is 1,500 patients provided depression screening and treatment plans and an minimum of 10% (150) will be depression-free after 12-months as measured by the GDS. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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 (Develop and test data systems) Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Program Records Process Milestone 2 Estimated Incentive Payment:$ 4,659 **Process Milestone 3**[P-3]: Develop and test data systems for collection and program evaluation. Data Source: Program Records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $4,660	**Outcome Improvement Target 1** [IT-1.9]: Establish remission rates at twelve months for patients receiving services. Improvement Target: 5% in remission at 12 months (75 patients). Data Source: Program Records, GDS Outcome Improvement Target 1 Estimated Incentive Payment*:* $9,986	**Outcome Improvement Target 2** [IT-1.9]: Establish remission rates at twelve months for patients receiving services. Improvement Target: 10% in remission at 12 months (150 patients). Data Source: Program Records, GDS Outcome Improvement Target 1 Estimated Incentive Payment*:* $21,708
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	**Year 3 Estimated Outcome Amount: $9,319**	**Year 4 Estimated Outcome Amount: $9,986**	**Year 5 Estimated Outcome Amount: $21,708**

38980111.3.44	*3.IT-1.9*	*IT-1.9 Depression Management: Depression Remission at Twelve Months (NQF#0710) for Medicaid eligible elders and near elders receiving services from the mobile behavioral health care teams*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects:	*138980111.1.6 Enhance service availability of appropriate levels of behavioral health care – "Other" project option: Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above -– 1.12.4: Community-Based Behavioral Healthcare for Depressed Medicaid Elders and Near Elders*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY2 and DY3 **Target Population**: Approximately 18,000 elders and near elders residing in Tarrant. At least 5,000 experience symptoms of depression at any given time, all of which are eligible for services within this project **Specific Number:** Overall project target is 1,500 patients provided depression screening and treatment plans and an minimum of 10% (150) will be depression-free after 12-months as measured by the GDS. **Description of Population:** Elderly and near elderly patients who are eligible for coverage by Medicaid		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$41,013			

Title of Outcome Measure (Improvement Target): IT-4.5 Patient Fall Rate – NQF 0141

Unique RHP outcome identification number(s): 138980111.3.45
Performing Provider Name/TPI: University of North Texas Health Science Center (UNTHSC) / 138980111

Outcome Measure Description:
This outcome measure will assess the effectiveness of the project in reducing the number of falls for Medicaid-eligible elders 65 receiving the intervention. The expected outcome by the end of the Waiver is a reduction in falls of patients receiving the intervention by 10% over baseline (23 falls prevented). The associated process milestones and improvement targets are:

Process Milestones and Outcome Improvement Targets for each year:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. Project planning will include meeting with local hospital partners and health care providers to discuss best practices for fall risk reduction and risk factors for falls among the target population (within hospitals and at home).
- Establish baseline rates [P-2]. The baseline will be established during initial encounters by medical teams and review of hospital records.
- Develop and test data systems [P-3]. The data collection system will be developed over DY2-3 and beta tested in DY3.
- Patient Fall Rate – NQF 0141 [IT-4.5] - will be measured by self-report and informant report by medical teams during home visits and follow-up encounters. Comparison of falls prior to and postintervention will be conducted to test the efficacy of the project.

Rationale:
Falls among the elderly is a significant health care issue among the elderly. Every 18 seconds an older adult is treated in an ED for falls, which is the leading cause of hospital admissions for trauma among the elderly. Approximately one third of older adults fall each year in the U.S. The current discharge planning and care coordination program will have targeted fall prevention education provided to patients. Preventing future falls will have a significant impact in reducing hospital admissions and 30-day readmissions among this targeted population. Through implementation of this discharge planning and care coordination model, we will reduce the number of falls in patients receiving the intervention by 10% over baseline (23 falls prevented). To support the achievement of this outcome, specific process milestones and metrics were selected:

- Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans [P-1]. This milestone is important as it provides the opportunity to engage local hospital partners, primary care physicians, as well as patients in evidence-based process models, to

identify capacity, to plan and document needed resources, and to implement plans necessary for the project.

- Establish baseline rates [P-2]. This process milestone is necessary as baseline rates have not been established for target population. Establishing baseline rates will provide the ability to assess the effectiveness of the project.
- Develop and test data systems [P-3]. This process milestone is necessary to ensure that appropriate methods are established to appropriate measures.
- Patient Fall Rate – NQF 0141 [IT-4.5]. - This outcome improvement target measures the number of falls experienced by the target population before and after intervention. Participants in this intervention will demonstrate a reduction in number of falls, resulting in a decrease in hospital admission rates as well as improvement in quality of life.

Outcome Measure Valuation:

- **Approach/Methodology:** Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. UNT Health Science Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. A full explanation of the model is contained in the RHP plan, Section V.B

- **Rationale/Justification:** For Patient Fall Rate -, UNT Health Science Center defined the population that will be directly impacted by the project as elderly patients who are eligible for coverage by Medicaid, which we have estimated to be approximately 750. It is anticipated 30% of these patients (225) will - experience a fall. The percentage of improvement is expected to be 10% (23 falls prevented) -.

  Utilizing - the pricing matrix developed by Region- 10 providers to determine the value to the health care system, it was determined that the valuation amount for each positive outcome realized would be $17,500 (as cited in the article "Cost of Falls Among Older Adults" by the CDC) -.
  For the selected outcome, an additional multiplier was applied to determine the benefit it provided to the community, which resulted in a valuation amount of $14,000 for each positive outcome realized

  The aggregate annual benefit for the selected outcome was then multiplied by five, which is the number of valuation years, to determine the total direct outcome value. Finally, an additional 30% multiplier was applied, also known as the "halo effect", due to the positive impact the project would have on the population beyond those directly involved by the project.

Because the Region 10 model assigns prices to each project by computing the total value of the Category 3 outcomes specific to each project, the UNT Health Science Center's project's values, in some cases, exceeded the maximum DSRIP payment amount that an individual project may receive. Furthermore, when all UNT Health Science Center's project's values were computed, the cumulative valuations for all projects exceeded the UNT Health Science Center's total DSRIP allocation. As a result, the UNT Health Science Center discounted all projects to a reduced price in order stay within the maximum limit on an individual project's payment amount and the cumulative DSRIP allocation to the UNT Health Science Center.

138980111.3.45	*3.IT-4.5*	*IT-4.5 Patient Fall Rate – NQF 0141*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.5 – Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid Eligible elders)*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 who are discharged from UNTHSC Division of Geriatrics hospital partners (n=750 annually). The goal is 10% reduction in falls (23 falls prevented). **-Specific Number:** 750 Medicaid eligible elders age 65 and above who receive services from UNTHSC Division of Geriatrics partner hospitals **Description of Population:** Elderly patients who are eligible for coverage by both Medicaid		
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 (Develop and test data systems) Data Source: Program Records Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Program records Process Milestone 2 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 3** [P-2]: Establish baseline rates Data Source: Program records Process Milestone 3 Estimated Incentive Payment *(maximum amount):* $40,574	**Outcome Improvement Target 1** [IT 4.5-]: Patient fall rate -Reduce Number of Falls Over Baseline Improvement Target: 5% reduction (13 falls prevented) in number of falls over baseline for target population receiving intervention Data Source: Program records Outcome Improvement Target 1 Estimated Incentive Payment*:* $43,405	**Outcome Improvement Target 2** [IT 4.5-]: Patient fall rate -Reduce Number of Falls Over Baseline Improvement Target: 10% reduction (23 falls prevented) in number of falls over baseline for target population receiving intervention Data Source: Program records Outcome Improvement Target 2 Estimated Incentive Payment*:* $94,359

138980111.3.45	*3.IT-4.5*	*IT-4.5 Patient Fall Rate – NQF 0141*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.5 – Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid Eligible elders)*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 who are discharged from UNTHSC Division of Geriatrics hospital partners (n=750 annually). The goal is 10% reduction in falls (23 falls prevented). **-Specific Number:** 750 Medicaid eligible elders age 65 and above who receive services from UNTHSC Division of Geriatrics partner hospitals **Description of Population:** Elderly patients who are eligible for coverage by both Medicaid		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $40,574	Year 4 Estimated Outcome Amount: $43,405	Year 5 Estimated Outcome Amount: $94,359

138980111.3.45	*3.IT-4.5*	*IT-4.5 Patient Fall Rate – NQF 0141*	
University of North Texas Health Science Center (UNTHSC)			*138980111*
Related Category 1 or 2 Projects::	*138980111.2.5 – Implement/Expand Care Transitions Programs – Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population – 2.12.2: Discharge Planning and Care Coordination for Medicaid Eligible elders)*		
Starting Point/Baseline:	**Baseline data:** Baseline data will be collected in DY3. **Target Population:** Medicaid-eligible elders of Tarrant County age 65 who are discharged from UNTHSC Division of Geriatrics hospital partners (n=750 annually). The goal is 10% reduction in falls (23 falls prevented). **-Specific Number:** 750 Medicaid eligible elders age 65 and above who receive services from UNTHSC Division of Geriatrics partner hospitals **Description of Population:** Elderly patients who are eligible for coverage by both Medicaid		
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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $178,338			

Title of Outcome Measure (Improvement Target): IT 2.13 Potentially Preventable Admissions – Other Admissions Rate

Unique RHP outcome identification number(s): 162334001.3.1 (Pass 2)
Provider name/TPI: JPS Physician Group/162334001

Outcome Measure Description:
By the end of the Waiver, our goal is to reduce inpatient admissions with a primary diagnosis code of pain.

Process Milestones:
In DY2 and DY3, we will validate our data on inpatient admits of pain diagnosis while the pain center redesign is being established, which will include the increase in specialist providers, available appointment time and procedure hours and availability. An initial review based on diagnosis indicates that 15% of admits could have been prevented if under the care of a pain specialist. This is from the population of Self Pay and Connections patients which is 59.3% of total inpatient admits with a primary diagnosis of pain. Although our target is Self-Pay and Connections, the depth of which we will be able to touch all those associated with pain in the Tarrant County area is substantial. Currently, Tarrant County does not have a pain center that offers the scope of services, both medical and interventional, that the pain center will be able to execute.

Outcome Improvement Targets:
DY4: Reduce admissions by 7% over baseline of 3.9 LOS from the population of Self Pay and Connections patients of 89 admits per year on average which would lower to 3.6 LOS.
DY5: Reduce admission by 15% over baseline of 3.9 LOS from the population of Self Pay and Connections patients of 89 admits per year on average which would lower to 3.3 LOS.

Rationale:
Specialty care clinics improve access for targeted populations in areas where there are gaps in specialty care. These types of clinics allow for enhanced care coordination for those patients requiring intensive specialty services. Redesigning the pain management clinic will shorten appointment cycle time and maximize provider productivity, allowing the most efficient utilization of pain provider resources and increasing patient access to specialty care in order to prevent avoidable admissions. Category 3 Outcome 2.13 was selected over Outcome 13.1 since the population included all inpatient admits, not directed to hospice or palliative care patients.

Outcome Measure Valuation:
Our milestones measure an increased population receiving pain management by increasing the number of specialists to meet the demand for in-person visits and procedures, which allow

patients to receive more timely services by specially trained providers. By implementing a single-site pain management facility with medical management and procedural capability, we will significantly increase efficiency. We are projecting to have two board certified pain physicians and two mid-levels dedicated to this center. This will be in concert with four additional highly trained physicians operating in PCMH clinics in strategic locations to service chronic pain patients across Tarrant County. For our inpatient consults, we will have one dedicated board certified pain physician along with one mid-level dedicated to service the inpatient population.

The project will increase access for the pain management population, resulting in decreased wait times by providing pain services for >45 patients per day at a central location and - >50 others at satellite PCMH clinics and >30 inpatient consults. This will also expand scope of pain services available to both medical and interventional complex pain patients, including inpatient and ambulatory oncology patients.

This redesign will be the most efficient for the staff providing care, the patients receiving care and enhance procedure cost controls. Most of the procedures currently performed in a JPS Health Network operating room can be done in a procedure room setting if sedation and monitoring are available. This will lead to significant cost savings, and we will be able to provide care to a greater number of patients. The clinic staff will utilize the pain clinic procedure room for most procedures, with the main operating room utilized only when required.

With the implementation of these collective measures, we anticipate decreasing admissions for this population (Self-Pay and Connections) of 15% by the end of the Waiver.

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

162334001.3.1	*IT-2.13*	*Other Admissions Rate*	
JPS Health Network Physician Group			*162334001*
Related Category 1 or 2 Projects:	*162334001.1.1*		
Starting Point/Baseline:	*JPS Connection and Self-pay Inpatient admits with primary diagnosis of pain*		
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 [P-1]**:** Validate baseline data. Data Source: EHR Process Milestone 1: Estimated Incentive Payment*:* $0 **Process Milestone** [P-2]: Review data and determine improvement implementation guidelines and resources needed. Data Source: Documented redesign plan The redesign will include: • Clinic & procedure suite layout and design • Clinic mgt & staffing • Physician/provider staffing • Referral guidelines and requirements • Overall protocol guidelines for full pain clinic operations • Patient termination policy, procedure, and protocol for violators • Drug testing policy and procedures	**Process Milestone** [P-3]**:** Implement redesign plan Data Source: Redesign plan The redesign will include: • Clinic & procedure suite layout and design • Clinic mgt & staffing • Physician/provider staffing • Referral guidelines and requirements • Overall protocol guidelines for full pain clinic operations • Patient termination policy, procedure, and protocol for violators • Drug testing policy and procedures • Spine surgical backup and surgery services • Pharmacy services support • Clinic security • Establish 4 primary care PCMH's specializing in care for chronic pain patients which will increase outpatient visits • Develop a pain management consult service for complex inpatient pain management	**Outcome Improvement Target 1** [IT-2.13]: Improvement Target: Reduce admits with pain as primary diagnosis 7% improvement over baseline. Baseline is 89 which are the Self Pay and Connections patients, average LOS is currently 3.9 days. In DY4, our plan is to lower that LOS by 7% which would drop to 3.6 days. Data Source: EHR Outcome Improvement Target 1: Estimated Incentive Payment*:* $55,216	**Outcome Improvement Target 2** [IT-2.13]: Improvement Target: Reduce admits with pain as primary diagnosis 15% improvement over baseline. Baseline is 89 which are the Self Pay and Connections patients, average LOS is currently 3.9 days. In DY5, our plan is to lower that LOS by 15% which would drop to 3.3 days. Data Source: EHR Outcome Improvement Target 2: Estimated Incentive Payment*:* $120,034

162334001.3.1	*IT-2.13*	*Other Admissions Rate*	
JPS Health Network Physician Group			*162334001*
Related Category 1 or 2 Projects:	*162334001.1.1*		
Starting Point/Baseline:	*JPS Connection and Self-pay Inpatient admits with primary diagnosis of pain*		
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)**
• Spine surgical backup and surgery services • Pharmacy services support • Clinic security • Establish 4 primary care PCMH's specializing in care for chronic pain patients which will increase outpatient visits • Develop a pain management consult service for complex inpatient pain management Process Milestone 2: Estimated Incentive Payment*:* $0	Process Milestone 3: Estimated Incentive Payment*:* $51,530		
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $51,530**	**Year 4 Estimated Outcome Amount: $55,216**	**Year 5 Estimated Outcome Amount: $120,034**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $226,780			

Title of Outcome Measure (Improvement Target): IT- 4.10 Other Outcome Improvement Target – Reduce ALOS for Oncology Inpatient

Unique RHP outcome identification number(s): 162334001.3.2 (Pass 2)
Provider name/TPI: JPS Physician Group/162334001

Outcome Measure Description:
By the end of the Waiver, our goal will be to decrease average length of stay (ALOS) for oncology patients who have been admitted with a primary diagnosis of pain.

Process Milestones:
In DY2 and DY3, we will establish the baseline and validate our data on oncology patients admitted with pain. An initial review indicates that the ALOS is six days; however, with an inpatient pain consult, we could reduce the ALOS by one day.

Outcome Improvement Targets:
DY4: Reduce ALOS by (16.6%) one day over baseline of 6.0 ALOS from the population of Self Pay and Connections patients of 71 admits per year on average amounting to 510 days which would lower to 5.0 ALOS or 425 days (decreased by 85). At an average cost per day of $2,235.10, this would amount to $189,984 in savings in one year alone.
DY5: Reduce ALOS by (40%) 2.4 days over baseline of 6.0 ALOS from the population of Self Pay and Connections patients of 71 admits per year on average amounting to 510 days which would lower to 3.6 ALOS or 306 days (decreased by 204). At an average cost per day of $2,235.10, this would amount to $455,960 in savings by the end of the waiver. These costs are all estimated and have the ability to be much greater in savings than presented as the access to monitor the oncology patient's pain by a certified board pain physician will be able to reduce actual admits to inpatient (not just reduce LOS) over time if being cared for by this specialist in an on-going fashion.

Rationale:
Providing an inpatient pain consult to oncology admissions who are admitted for a primary diagnosis of pain can substantially reduce their length of stay if a specialist was available. With the pain clinic redesign, the increased number of specialists available to meet the demand for in-person visits, consults and procedures will allow the patient to be treated and relieved of pain in a timelier manner.

Oncology patients have increased on average year-over-year by 6% since 2006, according to the American College of Surgeons and 5% per year as reported by the Texas Cancer Registry. We

predict an influx of inpatient days linked with oncology patients and their simultaneous pain needs.

Category 3 Outcome 4.10 was selected over Outcome 4.9 since our target was not based on "total number of inpatient days for patients diagnosed with sever sepsis, septic shock, and/or lactate>4mmol/L (36mg/dl)" as referenced in Outcome 4.9. Therefore since there was not a Category 3 specifically referencing oncology admits, we used Outcome 4.10 which is for "other".

Outcome Measure Valuation:

Our milestones measure an increased population receiving pain management in the oncology population. Not just for Self-Pay and Connections patients, which is what our outcomes are based on, but for all oncology patients in Tarrant County. Once the population is aware of the pain treatments that our Oncology services provide, the Commercial/Medicare/Medicaid patients will veer to the JPS Health Network for their Oncology services. The ability to provide inpatient pain consults will decrease the length of stay. In DY4, our goal is to decrease LOS by 16.6% (or one day) and by DY5, decrease by 40% (or 2.5 days) down from the current ALOS of 6 days. At an average cost per day of $2,235.10, this would amount to $455,960 in savings by the end of the waiver. These costs are all estimated and have the ability to be much greater in savings than presented as the access to monitor the oncology patient's pain by a certified board pain physician will be able to reduce actual admits to inpatient (not just reduce LOS) over time if being cared for by this specialist in an on-going fashion.

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

162334001.3.2	*IT-4.10*	*Other Outcome Improvement Target*	
JPS Health Network Physician Group			*162334001*
Related Category 1 or 2 Projects:	*-1 162334001.1.1*		
Starting Point/Baseline:	*Early indicators suggest ALOS for Oncology Patients admitted for Pain is 6 days*		
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]**:** Validate baseline data. Data Source: EHR Process Milestone 1 Estimated Incentive Payment*:* $0 **Process Milestone 2** [P-2]: Review data and determine improvement implementation guidelines and resources needed. Data Source: Documented redesign plan The redesign will include: • Clinic & procedure suite layout and design • Clinic mgt & staffing • Physician/provider staffing • Referral guidelines and requirements • Overall protocol guidelines for full pain clinic operations • Patient termination policy, procedure, and protocol for violators • Drug testing policy and procedures	**Process Milestone** [P-3]**:** Implement redesign plan Data Source: Redesign plan The redesign will include: • Clinic & procedure suite layout and design • Clinic mgt & staffing • Physician/provider staffing • Referral guidelines and requirements • Overall protocol guidelines for full pain clinic operations • Patient termination policy, procedure, and protocol for violators • Drug testing policy and procedures • Spine surgical backup and surgery services • Pharmacy services support • Clinic security • Establish 4 primary care PCMH's specializing in care for chronic pain patients which will increase outpatient visits • Develop a pain management consult service for complex inpatient pain management	**Outcome Improvement Target 1** [IT-4.10]: Improvement Target: Decrease ALOS to our Oncology population being admitted with pain diagnosis by 1.0 days (16.6%) improvement over baseline of 71 admits per year on average amounting to 510 days which would lower to 5.0 ALOS or 425 days (decreased by 85). Data Source: EHR **Outcome Improvement Target 1** Estimated Incentive Payment*:* $180,329	**Outcome Improvement Target 2** [IT-4.10]: Improvement Target: Decrease ALOS to our Oncology population being admitted with pain diagnosis by 2.4 days (40%) improvement over baseline of 71 admits per year on average amounting to 510 days which would lower to 3.6 ALOS or 306 days (decreased by 204). Data Source: EHR **Outcome Improvement Target 2** Estimated Incentive Payment*:* $392,019

162334001.3.2	*IT-4.10*	*Other Outcome Improvement Target*	
JPS Health Network Physician Group			*162334001*
Related Category 1 or 2 Projects:	*-1 162334001.1.1*		
Starting Point/Baseline:	*Early indicators suggest ALOS for Oncology Patients admitted for Pain is 6 days*		
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)**
• Spine surgical backup and surgery services • Pharmacy services support • Clinic security • Establish 4 primary care PCMH's specializing in care for chronic pain patients which will increase outpatient visits • Develop a pain management consult service for complex inpatient pain management Process Milestone 2 Estimated Incentive Payment*:* $0	**Process Milestone 3** Estimated Incentive Payment*:* $168,291		
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $168,291**	**Year 4 Estimated Outcome Amount: $180,329**	**Year 5 Estimated Outcome Amount: $392,019**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $740,639			

Title of Outcome Measure (Improvement Target): IT 9-2 Right Care, Right Setting – ED Appropriate Utilization

Unique RHP outcome identification number(s): 162334001.3.3 (Pass 2)
Provider name/TPI: JPS Physician Group/162334001

Outcome Measure Description:
By the end of the Waiver, our goal is to reduce Emergency Department (ED) visits with primary diagnosis of pain.

Process Milestones:
In DY2 and DY3, we will establish the baseline and validate our data on ED visits of pain diagnosis while pain center redesign is being established, which will include the increase in specialist providers, available appointment time and procedure hours.

Outcome Improvement Targets:
DY4: Reduce ED visits of pain diagnosis by 10% over baseline of 4,386 from the population of Self Pay and Connections patients of which would reduce ED visits by a count of 439. At an average cost per visit of $515.98, this would amount to $226,515 in savings in one year alone.

DY5: Reduce ED visits of pain diagnosis by 20% over baseline of 4,386 from the population of Self Pay and Connections patients of which would reduce ED visits by a count of 877. At an average cost per visit of $515.98, this would amount to $452,515 in savings by the end of the waiver.

Rationale:
Specialty care clinics improve access for targeted populations in areas where there are gaps in specialty care. These types of clinics allow for enhanced care coordination for those patients requiring intensive specialty services. Redesigning the pain management clinic will shorten appointment cycle time and maximize provider productivity, allowing the most efficient utilization of pain provider resources, which will provide for appropriate utilization in the ED.

Outcome Measure Valuation:
To provide a complete spectrum of pain management services at a single site for the JPS Health Network and pain-focused PCMH clinics in four strategic locations. The goal is to provide care for >45 patients per day at a primary site, - >50 at satellite PCMH clinics and >30 inpatient consults. Increased numbers of specialist and extenders to meet procedural demand and referral demand for in-person visits, consults and procedures will allow patients to receive more timely services.

This redesign will be the most efficient for the staff providing care, the patients receiving care and enhance procedure cost controls. Most of the procedures currently performed in a JPS Health Network operating room can be done in a procedure room setting if sedation and monitoring are available. This will be a significant cost savings and we will be able to provide care to a greater number of patients. The clinic staff will utilize the pain clinic procedure room for most procedures, with the main operating room serving the rest. We are projecting to have two board certified pain physicians and two mid-levels dedicated to this center. This will be in concert with four additional highly trained physicians operating in PCMH clinics in strategic locations to service chronic pain patients across Tarrant County. For our inpatient consults, we will have one dedicated board certified pain physician along with one mid-level dedicated to service the inpatient population.

Our milestones measure an increased population receiving pain management by increasing the number of specialists to meet the demand for in-person visits and procedures, which allow patients to receive more timely services. This is from the population of Self Pay and Connections patients which is 70.4% of ED visits with a primary diagnosis of pain. Although our target is Self-Pay and Connections, the depth of which we will be able to touch all those associated with pain in the Tarrant County area is substantial. Currently, Tarrant County does not have a pain center that offers the scope of services, both medical and interventional, that the pain center will be able to execute.

As a Region, providers collaborated on determining specific values for each Category 3 outcome. This was completed by using literature, historical provider-level data or other evidence-based resources to determine specific values for each outcome. Then, based on the number of milestones for both process and improvement, a dollar allocation was made based on the total potential value of each outcome. Improvement milestones were weighted more heavily and thus received more of the funding allocation than process milestones. Additionally, we took into account if an improvement milestone was more complex and involved more effort (resources, time, etc.) to achieve a particular targeted outcome. We then allocated more funding to these metrics. For example, we gave a greater weight to a hypertension- or diabetes-related outcome over a metric such as patient satisfaction because of the quality impact and downstream cost savings/clinical implications. Hypertension or diabetes control will have greater impact than patient satisfaction.

162334001.3.3	*IT-9.2*	*ED Appropriate Utilization*	
JPS Health Network Physician Group			*162334001*
Related Category 1 or 2 Projects:	*162334001.1.1*		
Starting Point/Baseline:	*ED visits with primary diagnosis code of pain*		
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 [P-1]**:** Validate baseline data. Data Source: EHR Process Milestone 1 Estimated Incentive Payment*:* $0 **Process Milestone** [P-2]: Review data and determine improvement implementation guidelines and resources needed. Data Source: Documented redesign plan The redesign will include: • Clinic & procedure suite layout and design • Clinic mgt & staffing • Physician/provider staffing • Referral guidelines and requirements • Overall protocol guidelines for full pain clinic operations • Patient termination policy, procedure, and protocol for violators • Drug testing policy and procedures	**Process Milestone** [P-3]**:** Implement redesign plan Data Source: Redesign plan The redesign will include: • Clinic & procedure suite layout and design • Clinic mgt & staffing • Physician/provider staffing • Referral guidelines and requirements • Overall protocol guidelines for full pain clinic operations • Patient termination policy, procedure, and protocol for violators • Drug testing policy and procedures • Spine surgical backup and surgery services • Pharmacy services support • Clinic security • Establish 4 primary care PCMH's specializing in care for chronic pain patients which will increase outpatient visits • Develop a pain management consult service for complex inpatient pain management	**Outcome Improvement Target 1** [IT-9.2]: Improvement Target: Decrease visits in ED with diagnosis of pain by 10% improvement over baseline of 4,386 from the population of Self Pay and Connections patients which would reduce ED visits by a count of 439 in DY4. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $193,933	**Outcome Improvement Target 2** [IT-9.2]: Improvement Target: Decrease visits in ED with diagnosis of pain by 20% improvement over baseline of 4,386 from the population of Self Pay and Connections patients which would reduce ED visits by a count of 877 by DY5. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $421,594

162334001.3.3	*IT-9.2*	*ED Appropriate Utilization*	
JPS Health Network Physician Group			*162334001*
Related Category 1 or 2 Projects:	*162334001.1.1*		
Starting Point/Baseline:	*ED visits with primary diagnosis code of pain*		
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)**
• Spine surgical backup and surgery services • Pharmacy services support • Clinic security • Establish 4 primary care PCMH's specializing in care for chronic pain patients which will increase outpatient visits • Develop a pain management consult service for complex inpatient pain management Process Milestone 2 Estimated Incentive Payment*:* $0	Process Milestone 3 Estimated Incentive Payment*:* $180,987		
Year 2 Estimated Outcome Amount: $0	**Year 3 Estimated Outcome Amount: $180,987**	**Year 4 Estimated Outcome Amount: $193,933**	**Year 5 Estimated Outcome Amount: $421,594**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $796,514			

Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization

Unique RHP outcome identification number(s): 186221101.3.1
Performing Provider Name/TPI: Methodist Mansfield Medical Center/ 186221101

Outcome Measure Description:
The outcome measure of ED appropriate utilization will result in a 5% decrease in ED utilization of frequent ED users by DY5-.

Process Milestones and Outcome Improvement Targets for each year:
By mid-DY2, a project plan will be conducted to identify the patient populations to be targeted with the Patient Navigation program, determine our current capacities, identify needed resources, determine timelines and document implementation plans. Developing and testing data will be completed in DY2 by beginning to provide navigation services. In DY3, we will conduct a Plan Do Study Act (PDSA) improvement cycle based on the initial process results of providing the navigation service. In DY3 we will establish a baseline of - how many patients who are most at risk of receiving disconnected and fragmented care can be impacted which is expected to be 1,853. In DY4 and DY5 we will achieve a reduction in ED utilization by frequent ED users by 2.5% - in DY4 from DY3 and an additional 2.5% in DY5 from and DY4 all measured against the DY-3 baseline which is expected to be 1,853. Also in DY4 and DY5 we will achieve a reduction in all-cause readmissions with a 2.5% reduction in DY4 from DY3 and an additional 2.5% in DY5 from and DY4 all measured against the DY-3 baseline which is expected to be 252 readmissions.

Rationale:
Our process milestones measure the project planning, plan testing, cycles of improvement and baseline impact rate for which we can - reduce in the number of patients who frequently use the ED or are readmitted due to a lack of care in the appropriate location. As a result of these efforts, there will be a reduction in the number of ED visits by frequent ED users of 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decreased inappropriate ED utilization.

Outcome Measure Valuation:

Approach/Methodology
The process milestones during DY2 and DY3 represent the planning and development of the patient navigation program. Each process milestone is required in order to provide the navigation program. The Improvement Targets in DY4 and DY5 represent the effectiveness of the navigation program. The weighting and valuation methodology considers a slightly higher weight and value to the Improvement Targets in DY4 and DY5, which represents the effectiveness of the program and impact to the frequent users of the ED.

Rationale/Justification:
The process milestones during DY2 and DY3 will impact over 30,000 of the ED patients as they are screened and analyzed for potential frequent use and possible patient navigation intervention. The DY4 and DY5 improvement targets each represent a significant improvement to the community and lower costs for frequent users of the ED.

186221101.3.1	*IT-9.2*	*ED Appropriate Utilization*	
Methodist Mansfield Medical Center			*186221101*
Related Category 1 or 2 Projects:	*186221101.2.1*		
Starting Point/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: Provider documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $18,212 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Provider documents Milestone 2 Estimated Incentive Payment *(maximum amount):* $18,212	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Provider documents Milestone 3 Estimated Incentive Payment *(maximum amount):* $31,665 **Process Milestone 4** [P-2]: Establish baseline rates / Expected to be 1,853 targeted population Data Source: Provider documents Milestone 4 Estimated Incentive Payment *(maximum amount):* $31,665	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate utilization Improvement Target: decrease utilization of ED visits from targeted population by 2.5% Data Source: Provider Documents Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount):* $67,747	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate utilization Improvement Target: decrease utilization of ED visits from prior year DY4 by 2.5% Data Source: Provider Documents Outcome Improvement Target 2 Estimated Incentive Payment *(maximum amount):* $162,005
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,423	Year 3 Estimated Outcome Amount: $63,329	Year 4 Estimated Outcome Amount: $67,747	Year 5 Estimated Outcome Amount: $162,005
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$329,504			

Title of Outcome Measure (Improvement Target): IT-3.1 All-cause Readmission Rate

Unique RHP outcome identification number(s): 186221101.3.2
Performing Provider Name/TPI: Methodist Mansfield Medical Center/ 186221101

Outcome Measure Description:
The outcome measure of All-cause readmission rate will result in a 5% decrease in all-cause readmissions from the targeted population by DY5 by providing better care sites for frequent users of ED services.

Process Milestones and Outcome Improvement Targets for each year:
By mid-DY2, a needs assessment to identify the patient populations to be targeted with the Patient Navigation program will be conducted. Establishment of 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 navigation education will be completed by the end of DY2. We will begin to provide care management/navigation services to targeted patients by the end of DY2 by providing one new navigator providing service to the first qualified patient. By the end of DY3 we will provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. Reduction in all-cause readmissions will be achieved with 2.5% reduction in DY4 from DY3 baseline of 252 readmissions and an additional 2.5% in DY5 from DY4 all measured against the DY-3 baseline which is expected to be 252 readmissions.

Rationale:
Our milestones measure the reduction in the number of patients who frequently use the ED; 1) we are increasing the number of patients identified as frequent users of the ED, 2) increasing the number of patient navigators available to provide services to those patients, and 3) increasing the number of patients referred to more appropriate care settings. As a result of these efforts, there will be a reduction in the number of readmissions from the targeted population by 5% by DY5. These milestones will measure whether we have increased the number of frequent ED users that are provided navigation services, increased the number of patient navigation resources, and as a result, decrease inappropriate ED utilization.

Outcome Measure Valuation:

Approach/Methodology:
The process milestones during DY2 and DY3 represent the planning and development of the patient navigation program. Each process milestone is required in order to provide the navigation program. The Improvement Targets in DY4 and DY5 represent the effectiveness of the navigation program. The weighting and valuation methodology considers a slightly higher weight and value to the Improvement Targets in DY4 and DY5, which represents the effectiveness of the program and impact to the frequent users of the ED.
Rationale/Justification:

Please describe your rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), including, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, estimated local funding, etc.

The process milestones during DY2 and DY3 will impact over 30,000 of the ED patients as they are screened and analyzed for potential frequent use and possible patient navigation intervention. The DY4 and DY5 improvement targets each represent a significant improvement to the community and lower costs for frequent users of the ED.

186221101.3.2	*IT-3.1*	*All-cause 30-Day Readmission Rate*	
Methodist Mansfield Medical Center			*186221101*
Related Category 1 or 2 Projects:	*186221101.2.1*		
Starting Point/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: Provider documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,032 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Provider documents Milestone 2 Estimated Incentive Payment *(maximum amount):* $8,033	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Provider documents Milestone 3 Estimated Incentive Payment *(maximum amount):* $13,966 **Process Milestone 4** [P-2]: Establish baseline rates / Expected to be 252 readmissions from targeted population. Data Source: Provider documents Milestone 4 Estimated Incentive Payment *(maximum amount):* $13,966	**Outcome Improvement Target 1** [IT-3.1]: All-cause 30-day readmission rate Improvement Target: decrease readmissions to the hospital from target population by 2.5% Data Source: Provider Documents Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount):$* 29,880	**Outcome Improvement Target 1** [IT-3.1]: All-cause 30-day readmission rate Improvement Target: decrease readmissions to the hospital from targeted population by 2.5% from prior year DY4 Data Source: Provider Documents Outcome Improvement Target 2 Estimated Incentive Payment *(maximum amount):* $71,453
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $16,065	Year 3 Estimated Outcome Amount: $27,932	Year 4 Estimated Outcome Amount: $29,880	Year 5 Estimated Outcome Amount: $71,453
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** 145,330			

Title of Outcome Measure (Improvement Target): IT-1.11 Diabetes Care: Blood Pressure Poor Control

Unique RHP outcome identification number(s): 186221101.3.3
Performing Provider Name/TPI: Methodist Mansfield Medical Center / 186221101

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
The outcome measure of Diabetes Care: Blood Pressure Control rate will result in a 3% improvement by DY5 of patients in the program with controlled blood pressure. Out of the 1000 patients expected to be in the program, 25% or 250 are expected to have controlled blood pressure levels. The project seeks to improve this number by 1.5% in DY4 and an additional 1.5% in DY5 of targeted patients in the program with controlled blood pressure. This project will identify patients in the ED who are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes. By mid-DY2, project planning will be conducted by engaging multidisciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients who meet the criteria to receive care under the chronic care model. During DY3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

Rationale:
Diabetes is one of the most costly and highly prevalent chronic diseases in the U.S. Approximately 20.8 million Americans have diabetes and half of these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20% of all deaths in people over 25 years of age. Many complications, such as amputation, blindness and kidney failure can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Outcome Measure Valuation:

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Health care cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Health care value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

186221101.3.3	***IT-1.11***	**Blood pressure control (<140/80mm Hg)**	
Methodist Mansfield Medical Center			186221101
Related Category 1 or 2 Projects:	186221101.2.2		
Starting Point/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: Provider documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $950 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider documents Milestone 2 Estimated Incentive Payment *(maximum amount):* $951	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Provider documents Milestone 3 Estimated Incentive Payment *(maximum amount):* $3,305	**Outcome Improvement Target 1** [IT-1.11]: Diabetes care: Blood pressure control (<140/80mm Hg) Improvement Target: increase diabetic ED patients targeted in the chronic care program with controlled blood pressure by 1.5% or 4 patients. Baseline: 250/Goal: increase of 1.5% or 4 patients. Data Source: Provider Documents Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount):* $3,535	**Outcome Improvement Target 2** [IT-1.11]: Diabetes care: Blood pressure control (<140/80mm Hg) Improvement Target: increase diabetic ED patients targeted in the chronic care program with controlled blood pressure by 1.5% over DY4 or 4 patients. Baseline: 254/Goal: increase of 1.5% or 4 patients. Data Source: Provider Documents Outcome Improvement Target 2 Estimated Incentive Payment *(maximum amount):* $8,454
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $1,901	Year 3 Estimated Outcome Amount: $3,305	Year 4 Estimated Outcome Amount: $3,535	Year 5 Estimated Outcome Amount: $8,454
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $17,195			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c Poor Control

Unique RHP outcome identification number(s): 186221101.3.4
Performing Provider Name/TPI: Methodist Mansfield Medical Center / 186221101

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
The outcome measure of Diabetes Care: HbA1c Poor Control rate will result in a 3% decrease by DY5 of patients in the program with uncontrolled A1c levels. Out of the 1000 patients expected to be in the program, 65% or 650 are expected to have uncontrolled A1c levels. The project seeks to decrease this number by 1.5% in DY4 and an additional 1.5% in DY5 of targeted patients in the program with uncontrolled A1c levels. This project will identify patients in the ED who are identified as having poor diabetes control. Based on the project's efforts to develop clinical care management criteria, standing orders and education services, these patients will be better prepared to self-manage and control their diabetes conditions. The clinical care management criteria, standing orders and availability of education services will be distributed, communicated and shared with the network of primary care providers and charitable clinics in the service area providing consistent methodology for diabetes care in the market ultimately leading to better diabetes control outcomes. By mid-DY2, project planning will be conducted by engaging multidisciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients who meet the criteria to receive care under the chronic care model. During DY3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

Rationale:
Diabetes is one of the most costly and highly prevalent chronic diseases in the U.S. Approximately 20.8 million Americans have diabetes and half of these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20% of all deaths in people over 25 years of age. Many complications, such as amputation, blindness and kidney failure can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Outcome Measure Valuation:

The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Health care cost/benefit. An Individual impact valuation is determined by applying an "impact" rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Health care value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A "reasonableness" assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

186221101.3.4	***IT-1.10***	***Diabetes care: HbA1c poor control (>9.0%)***	
Methodist Mansfield Medical Center			*186221101*
Related Category 1 or 2 Projects:	*186221101.2.2*		
Starting Point/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: Provider documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,589 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider documents Milestone 2 Estimated Incentive Payment *(maximum amount):* $3,588	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Provider documents Milestone 3 Estimated Incentive Payment *(maximum amount):* $12,479	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: decrease diabetic ED patients targeted in the chronic care program with uncontrolled A1c levels by 1.5% or 10 patients. Baseline: 650/Goal: decrease of 1.5% or 10 patients. Data Source: Provider Documents Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount):* $13,350	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: decrease diabetic ED patients targeted in the chronic care program with uncontrolled A1c levels by 1.5% over DY4 or 10 patients. Baseline: 640/Goal: decrease of 1.5% or 10 patients. Data Source: Provider Documents Outcome Improvement Target 2 Estimated Incentive Payment *(maximum amount):* $31,923
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $7,177	Year 3 Estimated Outcome Amount: $12,479	Year 4 Estimated Outcome Amount: $13,350	Year 5 Estimated Outcome Amount: $31,923
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $64,929			

Title of Outcome Measure (Improvement Target): IT-3.3 Diabetes 30-Day Readmission Rate

Unique RHP outcome identification number(s): 186221101.3.5
Performing Provider Name/TPI: Methodist Mansfield Medical Center / 186221101

Outcome Measure Description:

Process Milestones and Outcome Improvement Targets for each year:
The outcome measure of diabetic 30-day readmission rate will result in a 10% reduction of the diabetes 30-day readmission rate from the targeted population in DY4 and an additional 10% reduction in DY5 by providing better care sites for frequent users of ED services. The target population in DY4 for the chronic care program is expected to be 1000 patients. Historically the diabetes readmission rate at the hospital is 6.8%. Therefore, we expect the diabetes 30-day readmission rate among this target population to be 6.8% or 68 patients. In DY4, the goal is to decrease diabetes 30-day readmissions to the hospital from this target population by 10% with an addional 10% reduction over DY4 in DY5. By mid-DY2, project planning will be conducted by engaging multidisciplinary stakeholders, identifying current capacity and needed resources. Establishment of baseline rates will provide an opportunity to adjust targets on the number of patients who meet the criteria to receive care under the chronic care model. During DY3, an effort to disseminate findings and summary of the chronic disease care model and project plan will result in stakeholders having a better knowledge base of the program.

Rationale:
This measure estimates the hospital-level, risk-standardized rate of unplanned, diabetes-related readmissions within 30 days of hospital discharge (RSRR) for patients ages 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one for each of the following specialty cohorts: surgery, general medicine, cardio-respiratory, cardiovascular and neurology. This measure will indicate the effectiveness of education patients on self-management, providing standing orders, education on chronic disease management and methods for the patient to follow up on the management of their chronic diabetes condition.

Outcome Measure Valuation:
The valuation methodology for this project is based on a standardized RHP approach. We determine the total population expected to be enrolled in the program. We apply the expected improvement/reduction percentage or number of patients to the population enrolled in the program. That results in the number of individuals impacted by this project. The value for each patient with a positive outcome is based on empirical studies and data collected from various research projects and sources. This number is multiplied by the number of impacted individuals to determine a Health care cost/benefit. An Individual impact valuation is determined by

applying an “impact” rating (from 1-5) based on potential impact to an individual with a positive outcome, whether it is related to health status, lifestyle, income ability or impact to length of life. This rating multiplied by the Health care value determines the Individual Impact value. The same method is used for the Community Impact Valuation. The sum of all three indicates an annual impact value. This is multiplied by the five year term of the project and increased due to inflation. This total five year total is then spread based on the number of milestones associated with the project.

Our rationale for valuing each outcome measure (and its associated process milestones and outcome improvement targets), is based on the following, but not limited to, various factors such as size, project scope, population served, community benefit, cost avoidance, addressing priority community need, and estimated local funding. The process and improvement milestones are attributed a value based on the above methodology. A “reasonableness” assessment is conducted to compare value based on community/health/individual impact to the potential program costs projected for the project. Any adjustments are made accordingly.

186221101.3.5	***IT-3.3***	***Diabetes 30-Day Readmission Rate***	
Methodist Mansfield Medical Center			*186221101*
Related Category 1 or 2 Projects:	*186221101.2.2*		
Starting Point/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: Provider documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $6,140 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider documents Milestone 2 Estimated Incentive Payment *(maximum amount):* $6,140	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Provider documents Milestone 3 Estimated Incentive Payment *(maximum amount):* $21,350	**Outcome Improvement Target 1** [IT-3.3]: Diabetes 30-day readmission rate Improvement Target: decrease readmissions to the hospital from the targeted population by 10% Baseline: 6.8% of the 1000 eligible program participants (68) / Goal: Reduce by 10% or 7 patients Data Source: Provider Documents Outcome Improvement Target 1 Estimated Incentive Payment *(maximum amount):* $22,840	**Outcome Improvement Target 2** [IT-3.3]: Diabetes 30-day readmission rate Improvement Target: decrease readmissions to the hospital from the targeted population by 10% Baseline: 61/Goal: Reduce by additional 10% or 6 patients. Data Source: Provider Documents Outcome Improvement Target 2 Estimated Incentive Payment *(maximum amount):* $54,617
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $12,280	Year 3 Estimated Outcome Amount: $21,350	Year 4 Estimated Outcome Amount: $22,840	Year 5 Estimated Outcome Amount: $54,617
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $111,087			

Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (**Standalone measure**)

Unique RHP outcome identification number(s): 206106101.3.1 (Pass 2)
Performing Provider Name/TPI: Wise Clinical Care Associates/206106101

Outcome Measure Description:
By the end of the waiver our goal is to reduce the HbA1c >9% to less than 20% of the patient population. We will establish the baseline in DY2. Our data pulled from eClinical Works shows the rate of HbA1c >9% to be 35.94% of the population in DY1. In DY3 we propose to lower the HbA1c >9% to below 30%, below 25% in DY4 and lower than 20% by the end of DY5.

Rationale:
According to Texas Department of State Health Services, 9.7% of adults 18 years and older have been diagnosed with diabetes. This disease is not only costly to the health care system, but interventions have also shown promise in decreasing hospitalizations and improving quality of life for diabetics. The importance of glycemic control is particularly well documented, and hemoglobin HbA1c testing is a well-established strategy to monitor glycemic control in patients with diabetes (NCQA, NQF, PQRI, PCPI). Measuring HbA1c values >9.0% among patients aged 18 to 75 years identifies those patients who are in poor control and at highest risk for major health complications. We can measure whether care improvements designed to reduce this rate are working, as well as identify the high-risk patients we should target for focused care improvement. In order to get high-risk patients' blood sugar levels under control, we will be implementing best practices in our care coordination through Category 2.1.1-Patient Centered Medical Homes. We chose this improvement measurement in DY3 so we can include this area of focus while implementing this care model in our clinics. We will use the disease registry capabilities and increase our registered patients so we can better track our progress. We will also increase diabetic testing and provide proven standards of care for our population of patients.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Wise Clinical Care Associates has computed the value of this project using the model developed at the Regional level. A full explanation of the model is contained in the RHP plan, Section V.B.

Instead of valuing each outcome for our PCMH individually, we used our RHP method of providing a value per empaneled patient at the end of the waiver and multiplying that times 5 years to reflect the value of the project as a whole. We also chose to use a net savings rate of $2,366 per new patient and $1,186 for each existing patient. This value was calculated by the Baylor Health Care system for our region.

We assumed a 20% attrition rate. We also added 935 patients per year based on historical numbers. Using this valuation model we counted 4606 new empaneled patients in the first year for a savings of $10,897,796. The second year had 3,685 existing patients and 935 new patients for a second year value of $6,582,382. Third year used 3,696 existing patients and 935 new patients for a value of $6,595,476. Fourth year has 3,705 existing patients and 935 new patients for a value of $6,605,951. The fifth year assumes 3,712 existing patients and 935 new patients for a value of $6,614,331. The total value of this project based on this valuation model is $37,295,937.

We took our overall value for project 2.1.1 and applied it proportionately across all categories with weighting per year reflecting the weighting change for each category. We then allocated the amount for Category 1 for each DY equally on attainment of metrics.
We weighted outcome, IT-1.10, with 75% of the Category 3 allocation and 25% going to IT-6.1 Percent improvement over baseline of patient satisfaction scores - (2) how well their doctors communicate.

206106101.3.1	*IT-1.10*	Diabetes care: HbA1c poor control (>9.0%) - NQF 0059 (**Standalone measure**)	
Wise Clinical Care Associates			*206106101*
Related Category 1 or 2 Projects:	*206106101.2.1*		
Starting Point/Baseline:	*Using data from the target population in DY1 shows HbA1c control >9% at 35.94%.*		
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 HbA1c poor control [>9.0%]) Data Source: EMR Process Milestone 1 Estimated Incentive Payment*:* $0	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: ≤30% of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c control > 9.0% as of September 30 of 2014 with diabetes (type 1 and type 2) Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $371,915	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: ≤25% of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c control > 9.0% as of September 30 of 2015 with diabetes (type 1 and type 2) Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $398,517	**Outcome Improvement Target 3** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: ≤20% of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c control > 9.0% as of September 30 of 2016 with diabetes (type 1 and type 2) Data Source: EMR Outcome Improvement Target 3 Estimated Incentive Payment*:* $866,342
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $371,915	Year 4 Estimated Outcome Amount: $398,517	Year 5 Estimated Outcome Amount: $866,342
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,636,774			

Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate

Unique RHP outcome identification number(s): 206106101.3.2 (Pass 2)
Performing Provider Name/TPI: Wise Clinical Care Associates/206106101

Outcome Measure Description:
By the end of the waiver our goal is to improve patient satisfaction 8% over baseline or at least 5% higher than the national average for patient satisfaction scores for the providers, specifically physician communication. Our first year will still include understanding the requirements of a PCMH and specifically NCQA standards.

Rationale:
The same survey will be used to measure this outcome during all reporting periods, so we will spend DY2 making sure we have the appropriate survey in place. In DY3 we will establish baseline using the same survey we plan to use in DY4 and DY5. In looking at our current survey both of our physicians are scoring higher than the national average. We wish to maintain a high score with patients throughout PCMH implementation, so this measure will improve slightly in DY4 and DY5

Outcome Measure Valuation:
Instead of valuing each outcome for our PCMH individually, we used our RHP method of providing a value per empaneled patient at the end of the waiver and multiplying that times 5 years to reflect the value of the project as a whole. Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Wise Clinical Care Associates has computed the value of this project using the model developed at the Regional level. A full explanation of the model is contained in the RHP plan, Section V.B.

Instead of valuing each outcome for our PCMH individually, we used our RHP method of providing a value per empaneled patient at the end of the waiver and multiplying that times 5 years to reflect the value of the project as a whole. We used values determined by Baylor Health System of $2,366 in savings for empaneled patients in their first year and $1,186 per patient in subsequent years. We assumed a 20% attrition rate. We also added 935 patients per year based on historical numbers. Using this valuation model we counted 4606 new empaneled patients in the first year for a savings of $10,897,796. The second year had 3,685 existing patients and 935 new patients for a second year value of $6,582,382. Third year used 3,696 existing patients and 935 new patients for a value of $6,595,476. Fourth year has 3,705 existing patients and 935 new patients for a value of $6,605,951. The fifth year assumes 3,712 existing patients and 935 new

patients for a value of $6,614,331. The total value of this project based on this valuation model is $37,295,937.

We took our overall value for project 2.1.1 and applied it proportionately across all categories with weighting per year reflecting the weighting change each category. We then allocated the amount for Category 1 for each DY equally on attainment of metrics.

We weighted outcome, IT-1.10, with 75% of the Category 3 allocation and 25% going to IT-6.1 Percent improvement over baseline of patient satisfaction scores - (2) how well their doctors communicate.

206106101.3.2	*IT-6.1*	Percent improvement over baseline of patient satisfaction scores (2) how well their doctors communicate	
Wise Clinical Care Associates			*206106101*
Related Category 1 or 2 Projects:	*206106101.2.1*		
Starting Point/Baseline:	*Using current survey, both physicians are above national average in patient satisfaction scores on communication. Baseline will be established in DY3 using approved survey*		
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: Documentation of plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Process Milestone 2** [P- 2]: Establish baseline rates Data Source: Survey Reports Process Milestone 2 Estimated Incentive Payment: $123,972	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores Improvement Target: Lower of 5% over baseline or 2% higher than national average Data Source: Survey Reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $132,839	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores Improvement Target: Lower of 8% over baseline or 5% higher than national average Data Source: Survey Reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $288,780
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $123,972	Year 4 Estimated Outcome Amount: $132,839	Year 5 Estimated Outcome Amount: $288,780
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $545,591			

Title of Outcome Measure (Improvement Target): Potentially Preventable All-cause Readmissions – 30-day Readmission rates

Unique RHP outcome identification number(s): 216719901.3.1
Performing Provider/TPI: Glen Rose Medical Center/216719901

Outcome Measure Description:

By the end of the five-year project we intend to have a total of 10% reduction in GRMC's overall readmission rate. We will achieve this through Category 1 project of increasing patients access to their primary care physicians, ensuring follow up appointment availability to eliminate delay in care. Oct 11-Aug 2012 we had 934 inpatient and observation patients and of those 216 were readmits.

In DY 2 we will establish our baseline rates and in DY 3 we will conduct Plan Do Study Act cycles to discover the whys of the readmissions and to create a comprehensive plan on how to change the trend of readmissions. We will then disseminate those findings and future plans to our stakeholders and hospital employees so that we can start decreasing the number of readmissions. By DY 4 and 5 we should start to see an improvement and have targeted a 10% improvement over our base for DY 4 and then a total improvement of 15% over DY 5

Rationale:
The national prevention council has created the national prevention strategy which places emphasis on moving us from being a system of the sick to one based on wellness and prevention. When a patient is seen in a clinic setting post discharge earlier intervention can be obtained thus decreasing the number of readmissions as well as the associated costs that go hand in hand with readmissions.

Outcome Measure Valuation:
Performing providers in Region 10 recognize that Category 3 outcomes represent the value that CMS hopes to achieve through the Waiver. Accordingly, Region 10 has priced its projects and outcomes by computing the total value of the Category 3 outcomes connected to each project. Glen Rose Medical Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*
So that the patients in our community have timely access to their primary care providers and with the decrease in readmissions, a reduction in the cost to patients. Our milestones will measure the additional clinic hours and visits provided as well as documenting the correlation in category 3 of decreased readmissions.

216719901.3.1	*3.IT-3.1*	*Potentially Preventable Readmissions for All-cause 30- day readmission rate*	
Glen Rose Medical Center			*216719901*
Related Category 1 or 2 Projects:	*216719901.1.1*		
Starting Point/Baseline:	*216 Readmits for all cause out of 934 admits*		
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: Implementation plans and timelines Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,234.5 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Census and Readmission report Process Milestone 2 Estimated Incentive Payment: $5,234.5	**Process Milestone 3** [P-4] Conduct Plan Do Study Act cycles to improve data collection and intervention activities Data Source: Studies performed during PDSA cycles Process Milestone 3 Estimated Incentive Payment: $6,067 **Process Milestone 4** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Process Milestone 4 Estimated Incentive Payment:$6,067 **Outcome Improvement Target 1** [IT-3.1]: All-cause 30-day readmission rate Improvement Target: 5% over baseline Data Source: Census and Readmission report Outcome Improvement Target 1 Estimated Incentive Payment*:* $6,068	**Outcome Improvement Target 2** [IT-3.1]: All-cause 30-day readmission rate Improvement Target:10% over baseline Data Source: Census and Readmission report Outcome Improvement Target 2 Estimated Incentive Payment*:* $19,472	**Outcome Improvement Target 3** [IT-3.1]: All-cause 30-day readmission rate Improvement Target:15% over baseline Data Source: Census and Readmission report Outcome Improvement Target 3 Estimated Incentive Payment*:* $46,563

216719901.3.1	*3.IT-3.1*	*Potentially Preventable Readmissions for All-cause 30- day readmission rate*	
Glen Rose Medical Center			*216719901*
Related Category 1 or 2 Projects:	*216719901.1.1*		
Starting Point/Baseline:	*216 Readmits for all cause out of 934 admits*		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $10,469	Year 3 Estimated Outcome Amount: $18,202	Year 4 Estimated Outcome Amount: $19,472	Year 5 Estimated Outcome Amount: $46,563
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $94,706			

Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction – Percent improvement over baseline of patient satisfaction scores

Performing Provider Name: Glen Rose Medical Center/216719901
Unique RHP outcome identification number(s): 216719901.3.2 (Pass 2)

Outcome Measure Description:

DY2 – Eestablish baseline rates and begin the education process for all stakeholders.

DY3 – Analyze our baseline and develop our plan of correction to show a 5% increase in HCAHPS.

DY5 – Increase patient satisfaction scores by 25%.

Rationale:
"Analyzing patient safety measures can alert hospitals to communication breakdowns that lead to lapses in care. Increasing patient satisfaction can thus significantly impact the quality of care and patient safety."[455] The New England Journal of Medicine article on patients' perception of hospital care in the United States found that patients' satisfaction with care was associated with the quality of clinical care in the hospitals. Glen Rose Medical Center has targeted an increase in patient satisfaction scores by 25% by the end of the five-year Waiver period.

Outcome Measure Valuation:
Glen Rose Medical Center has computed the value of this project using the model developed at the Regional level. That model computes separate values for impacts on the health care system, the individual and the community. *(See Section V.B. for a full explanation of the model.)*

Glen Rose Medical Center defined the population that will be directly impacted by the project as patients with Medicare who are the target of HCAHPS survey. The percentage of the population expected to be positively impacted by the project is all patients, which was determined based on studies of similar projects implemented elsewhere. We used the pricing matrix developed by Regional providers to determine the value to the health care system for each positive outcome realized as the result of our project.

To determine the value to each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, patient experience improves, which results from improved safety and quality of care that better health outcomes and reduce costs. To determine the value to the

[455] Rodak S. Using patient satisfaction measures to reduce hospital readmissions. *Becker Hospital Review*. March 13, 2012.

community of each individual positively impacted, we concluded that, on a scale of 1 to 5, the value of this project is a 2. We believe this to be the correct number because when a person is positively impacted, his or her quality of life improve, productivity increases, and the burden on

216719901.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Glen Rose Medical Center			*216719901*
Related Category 1 or 2 Projects:	*216719901.2.1*		
Starting Point/Baseline:	**Target Population:** All patients that receive care at GRMC (934) **Baseline:** will be determined in DY2 from HCAHPS 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)**
Process Milestone 1 [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Implementation plans and timelines Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,753 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: Census and Readmission report Process Milestone 2 Estimated Incentive Payment: $1,753	**Process Milestone 3** [P-3] Conduct Plan Do Study Act cycles to improve data collection and intervention activities Data Source: Studies performed Process Milestone 3 Estimated Incentive Payment: $2,032 **Process Milestone 4** [P-4] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Stakeholders reports Process Milestone 3 Estimated Incentive Payment:$2,032 **Outcome Improvement Target 1** [IT-6.1]:Percent improvement over baseline of patient satisfaction scores Improvement Target: 5% over baseline Data Source: HCAHPS report Outcome Improvement Target 1 Estimated Incentive Payment*:* $2,033	**Outcome Improvement Target 2** [IT-6.1]:Percent improvement over baseline of patient satisfaction scores Improvement Target: 15% over baseline Data Source: HCAHPS report Outcome Improvement Target 2 Estimated Incentive Payment*:* $6,533	**Outcome Improvement Target 3** [IT-6.1]:Percent improvement over baseline of patient satisfaction scores Improvement Target: 25% over baseline Data Source: HCAHPS report Outcome Improvement Target 3 Estimated Incentive Payment*:* $15,624

216719901.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Glen Rose Medical Center			*216719901*
Related Category 1 or 2 Projects:	*216719901.2.1*		
Starting Point/Baseline:	**Target Population:** All patients that receive care at GRMC (934) **Baseline:** will be determined in DY2 from HCAHPS 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $3,506	**Year 3 Estimated Outcome Amount: $6,097**	**Year 4 Estimated Outcome Amount: $6,533**	**Year 5 Estimated Outcome Amount: $15,624**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $31,760			

Category 4: Population-Focused Improvements

Medical center of Arlington
020940501

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Medical Center of Arlington/020950401
Unique RHP identification number: 020950401.4.2

Domain Descriptions:
Medical Center of Arlington will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Medical Center of Arlington healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Medical Center of Arlington currently tracks and reports 2 of the 8 measurements for public reporting. Measurements that have not yet been addressed are:

- Congestive heart Failure Admission Rate
- Diabetes Admission Rates
- Behavioral Health and Substance Abuse Admission Rate
- Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate
- Hypertension Admission rate
- Pediatric Asthma

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Medical Center of Arlington will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Medical Center of Arlington patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. The proposed project to establish a Care Transition Program is targeted for interventions for patients at high risk for readmission. Preventable admissions will be impacted by interventions deployed for patients to ensure appropriate services are carried out to avoid discontinuity of care. Specifically, this project will track the outcome for reduced readmissions for Congestive Heart Failure patients.

We expect to improve the readmission rate for CHF patients by end of the waiver by15%.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions
Performing Provider Name/TPI: Medical Center of Arlington/020950401
Unique RHP identification number: 020950401.4.3

Domain Descriptions:
Medical Center of Arlington will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Medical Center of Arlington healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Medical Center of Arlington currently tracks and reports 2 of the 7 measurements for public reporting. Measurements that have not yet been addressed are:

- Diabetes: 30-Day Readmissions
- Behavioral Health & Substance Abuse: 30-Day Readmissions
- Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions
- Stroke: 30- Day Readmissions
- Pediatric Asthma: 30-Day Readmissions

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Medical Center of Arlington will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Medical Center of Arlington patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience is intended to implement process improvements to change the patient satisfaction and experience of hospitalization. Key areas of experience can influence the risk of readmission, including communication, care from nurses and doctors and medication management and discharge process. In particular, how well the staff communicates with patients about medications, and whether key information is provided at discharge can directly impact the risk of readmission for patients.

Another proposed project to establish a Care Transition Program will implement targeted interventions for patients at high risk for readmission to reduce readmissions. Specifically, this project will also track the outcome for reduced readmissions for Congestive Heart Failure patients.

In addition, the proposed project for Sepsis improvement involves the timely identification/diagnosis of sepsis and evidence-based treatment for patients. It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence-based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management is vital for continued care of sepsis and reduced risk for readmissions.

We expect to improve the readmission rate for CHF patients by end of the waiver by15%. We also expect to see a reduction in readmissions for patients with an initial index admission of Sepsis and those readmitted for Sepsis with initial diagnosis other than Sepsis. Readmissions due to medication management will also be reduced.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications
Performing Provider Name/TPI: Medical Center of Arlington/020950401
Unique RHP identification number: 020950401.4.4

Domain Descriptions:
Medical Center of Arlington will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Medical Center of Arlington healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Currently, 15 of the sixty four measurements are being tracked and reported in a form of public healthcare statistics. All other measures are tracked and reported internally

Currently, HHSC will make potentially preventable event data to providers. In addition, Medical Center of Arlington will expand existing data collecting system and optimize old system for new reporting processes.

In addition, many DSRIP projects will provide interventions to Medical Center of Arlington patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain.

The proposed project to implement an innovative program for Sepsis improvement aims to identify /diagnosis Sepsis sooner and begin evidence-based treatment to reduce mortality and complications for septic shock and severe sepsis.

Improved sepsis care reduces complications particularly those common in septic patients such as pulmonary embolism, acute myocardial infarction, venous thrombosis, major liver complications, renal failure with and without Dialysis and encephalopathy. Also, the project will focus on reducing the average length of stay for sepsis patients. Reducing the length of stay of patients diagnosed with sepsis will also impact a reduction in complications. Evidence shows with increased length of stay there is increased risk of preventable complications.

The proposed project to Redesign the Patient Experience will focus on patients satisfaction and experience. Improved patient communication and satisfaction with caregivers has been shown to improve quality and safety of care. Studies have linked patient satisfaction with communication with doctor nurses, responsive to patients' needs and cleanliness to patient perceptions of hospital practices and facility infection rates.

Preventable complications rates are expected to be reduced 5% a year with appropriate Sepsis care for hospitalized patients and improved patient experience.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare
Performing Provider Name/TPI: Medical Center of Arlington/020950401
Unique RHP identification number: 020950401.4.5

Domain Descriptions:
Medical Center of Arlington will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Medical Center of Arlington healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Currently, 2 of the two measurements are being tracked and reported.

Patient Satisfaction is surveyed by Gallup for HCAHPS requirements. It is reported internally each week for preliminary results. As required, final results are report to CMS and posted publically. Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys. CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. Additional HCAHPS results can be found on HCAHPS On-Line, (www.hcahpsonline.org).

Medication management is only reported publically as a required element of certain CORE MEASURES reporting. However, it is tracked and reported internally for all inpatients by the quality department as a patient safety and quality of care measurement.

Medical Center of Arlington will expand existing data collecting system and optimize old system for new reporting processes as necessary.

In addition, Medical Center of Arlington has proposed several quality-based projects that will provide improvement of care to all Medical Center of Arlington patients in multiple areas, resulting in improvement patient satisfaction throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience is aimed at improving the patient satisfaction of the care received (RD-4 1. Patient Satisfaction).The goal to improve patient satisfaction and experience is also important for improved quality and safety of care provided. Studies have linked patient satisfaction with communication with doctor nurses, responsive to patients' needs and cleanliness to patient perceptions of hospital practices and facility infection rates.

Another focus for Redesign Patient Experience is medication management (RD-4 2. Medication management). How well the staff communicates with patients about medicines, and whether key information is provided at discharge is critical to successful medication management and patient safety.

The proposed project for process improvement for Sepsis care involves the timely identification/diagnosis of sepsis and evidence-based treatment for patients. Improving processes in this program includes effective communication. The communication between the emergency room, doctors, nurses/ care givers and families for these critically ill patients is vital to the plan of care. Teaching patients and families the cause and symptoms of sepsis is also important for care management . Patient satisfaction is improved with effective communication.

It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence-based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management if vital for continued care of sepsis.

Another proposed project to establish a Care Transition Program is targeted for interventions for patients at high risk for readmission. Part of Care transitions is the coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. Medication management is an important part of transition to another care setting including home in order to promote safe and effective care.

Patients enrolled in the Care Transition program will have a greater patient experience and satisfaction when leaving the hospital. It is important in the program that patients are assessed for discharge needs and proper discharge planning and placement is conducted. Specifically, this project will track the outcome for reduced readmissions for Congestive Heart Failure patients.

We expected to improve Patient satisfaction HCAHPS Grand Composite scores to be > 75th percentile by the end of the waiver. Although we are over 95% compliant with Medication Management documentation, we have only earned a 50% on the composite scores on Communication on medications in HCAHPS. We expect effective communication improvement will increase HCAHPS medication scores by 50% by the end of the waiver.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department
Performing Provider Name/TPI: Medical Center of Arlington/020950401
Unique RHP identification number: 020950401.4.6

Domain Descriptions:
Medical Center of Arlington will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Medical Center of Arlington healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Medical Center of Arlington currently tracks and reports Admit decision time to ED departure for admitted patients for THE JOINT COMMISSION and internal quality requirements. The current tracking system is already in place and will be modified or improved as necessary to satisfy the requirement of new reporting domain

In addition, the proposed project for Sepsis improvement involves the timely identification and evidence-based treatment of patients. A key component of a Sepsis protocol is the timely identification/diagnosis of septic shock/severe sepsis to admit and begin evidence-based treatment. Process improvements implemented for sepsis protocols in the ED support the goal of less than 1 hour for ED admit/ departure (decision time) for critical patients.

We expect the ED Admit time will be reduced by 25% by the end of the waiver.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY

Category 4: Population-Focused Measures *Medical Center of Arlington/020950401*				
	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	$92,723	$42,991		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$42,992	$45,990	$49,990
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$42,991	$45,991	$49,990
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			$45,990	$49,990
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Calendar Year Jan 2013 –Dec 2013	Calendar Year Jan 2014-Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Calendar Year Jan 2013 –Dec 2013	Calendar Year Jan 2014-Dec 2014	Calendar Year Jan 2015 –Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$42,991	$45,991	$49,990
Domain 5: Emergency Department				
Measurement period for report		Calendar Year Jan 2013 –Dec 2013	Calendar Year Jan 2014-Dec 2014	Calendar Year Jan 2015- Dec 2015

Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$42,991	$45,991	$49,990
Grand Total Payments Across Category 4	$92,723	$214,956	$229,953	$249,950

Cook Children's Medical Center
021184901

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Cook Children's Medical Center/021184901
Unique RHP identification number: 021184901.4.2

Domain Descriptions:
There are no system capability changes required for reporting the two potentially affected measures 1) Bacterial pneumonia immunization and 2) Influenza immunization since these values are already reported to CMS and to Joint Commission. The immunization rates would be measured and reported annually.

Primary care is the customary site for pediatric immunizations so to the extent that more children access a pediatric primary care medical home there should be a concomitant increase in immunization and subsequent reduction in bacterial pneumonia or influenza hospital admissions.

Due to the extremely small number of inpatient admissions for pediatric bacterial pneumonia or influenza, the comparatively small number of patients in a primary care setting and the lack of chronicity between immunization and disease expression it is improbable that a clear population improvement can be demonstrated.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Cook Children's Medical Center/021184901
Unique RHP identification number: 021184901.4.3

Domain Descriptions:
No measureable impact is expected for this domain related to the interventions.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Cook Children's Medical Center/021184901
Unique RHP identification number: 021184901.4.4

Domain Descriptions:
No measureable impact is expected for this domain related to the interventions.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Cook Children's Medical Center/021184901
Unique RHP identification number: 021184901.4.5

Domain Descriptions:
No measureable impact is expected for this domain related to the interventions.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Cook Children's Medical Center/021184901
Unique RHP identification number: 021184901.4.6

Domain Descriptions:
No measureable impact is expected for this domain related to the interventions.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the

Category 4: Population-Focused Measures Cook Children's Medical Center/021184901				
	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	$ 358,850	$ 166,382		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$ 166,382	$ 177,990	$ 193,468
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$ 166,382	$ 177,990	$ 193,468
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			$ 177,990	$ 193,468
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-	10/1/2014-

			9/30/2014	9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$ 166,382	$ 177,990	$ 193,468
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$ 166,382	$ 177,990	$ 193,466
Grand Total Payments Across Category 4	$ 358,850	$ 831,910	$ 889,950	$ 967,338

North Hills Hospital
094105602

Reporting Domain 1: Potentially Preventable Admissions:
Performing Provider Name/TPI: North Hills Hospital/094105602
Unique RHP identification number: 094105602.4.2

Domain Descriptions:
North Hills Hospital will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current North Hills Hospital healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

North Hills Hospital currently tracks and reports 2 of the 8 measurements for public reporting. Measurements that have not yet been addressed are:

- Congestive heart Failure Admission Rate
- Diabetes Admission Rates
- Behavioral Health and Substance Abuse Admission Rate
- Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate
- Hypertension Admission rate
- Pediatric Asthma

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, North Hills Hospital will expand existing data collecting system and optimize old system for new reporting processes.

North Hills Hospital does not expect any impact in this Reporting Domain from proposed Category 1, and 2 projects and Category 3 outcomes.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: North Hills Hospital/094105602
Unique RHP identification number: 094105602.4.3

Domain Descriptions:
North Hills Hospital will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current North Hills Hospital healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

North Hills Hospital currently tracks and reports 2 of the 7 measurements for public reporting. Measurements that have not yet been addressed are:

- Diabetes: 30-Day Readmissions
- Behavioral Health & Substance Abuse: 30-Day Readmissions
- Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions
- Stroke: 30- Day Readmissions
- Pediatric Asthma: 30-Day Readmissions

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, North Hills Hospital will expand existing data collecting system and optimize old system for new reporting processes.

In addition, a proposed DSRIP project will provide interventions to North Hills Hospital patients, resulting in improvement of Preventable Readmissions.

The proposed project for Sepsis improvement involves the timely identification/diagnosis of sepsis and evidence-based treatment for patients. It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence-based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management is vital for continued care of sepsis and reduced risk for readmissions.

We expect to see a reduction in readmissions for patients with an initial index admission of Sepsis and those readmitted for Sepsis with initial diagnosis other than Sepsis.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications
Performing Provider Name/TPI: North Hills Hospital/094105602
Unique RHP identification number: 094105602.4.4

Domain Descriptions:
North Hills Hospital will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current North Hills Hospital healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Currently, 15 of the sixty four measurements are being tracked and reported in a form of public healthcare statistics. All other measures are tracked and reported internally.

Currently, HHSC will make potentially preventable event data to providers. In addition, North Hills Hospital will expand existing data collecting system and optimize old system for new reporting processes.

In addition, a proposed DSRIP project will provide interventions to North Hills Hospital resulting in improvement of PPCs throughout all measurements in the Reporting Domain.

The proposed project to implement an innovative program for Sepsis improvement aims to identify /diagnosis Sepsis sooner and begin evidence-based treatment to reduce mortality and complications for septic shock and severe sepsis.

Improved sepsis care reduces complications particularly those common in septic patients such as pulmonary embolism, acute myocardial infarction, venous thrombosis, major liver complications, renal failure with and without Dialysis and encephalopathy. Also, the project will focus on reducing the average length of stay for sepsis patients. Reducing the length of stay of patients diagnosed with sepsis will also impact a reduction in complications. Evidence shows with increased length of stay there is increased risk of preventable complications.

Preventable complications rates are expected to be reduced 5% year with appropriate Sepsis care for hospitalized patients and improved patient experience.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: North Hills Hospital/094105602
Unique RHP identification number: 094105602.4.5

Domain Descriptions:
North Hills Hospital will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current North Hills Hospital healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Currently, 2 of the two measurements are being tracked and reported.

Patient Satisfaction is surveyed by Gallup for HCAHPS requirements. It is reported internally each week for preliminary results. As required, final results are report to CMS and posted publically. Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys. CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. Additional HCAHPS results can be found on HCAHPS On-Line, (www.hcahpsonline.org).

Medication management is only reported publically as a required element of certain CORE MEASURES reporting. However, it is tracked and reported internally for all inpatients by the quality department as a patient safety and quality of care measurement.

North Hills Hospital will expand existing data collecting system and optimize old system for new reporting processes as necessary.

In addition, North Hills Hospital has proposed a quality-based project that will provide improvement of care to all North Hills Hospital patients resulting in improvement patient satisfaction throughout all measurements in the Reporting Domain.

The proposed project for process improvement for Sepsis care involves the timely identification/diagnosis of sepsis and evidence-based treatment for patients. Improving processes in this program includes effective communication. The communication between the emergency room, doctors, nurses/ care givers and families for these critically ill patients is vital to the plan of care. Teaching patients and families the cause and symptoms of sepsis is also important for care management. Patient satisfaction is improved with effective communication.

It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence-based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management if vital for continued care of sepsis.

Although we are over 95% compliant with Medication Management documentation, we have only earned a 54% on the composite scores on Communication on medications in HCAHPS. We expect effective communication improvement will increase HCAHPS medication scores by 50% by the end of the waiver. In addition, scores for Communication with doctors and nurses as well as discharge process is expected to improve with overall HCAHPS Grand Composite scores to be > 75 percentile of CMS scores.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: North Hills Hospital/094105602
Unique RHP identification number: 094105602.4.6

Domain Descriptions:
North Hills Hospital will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current North Hills Hospital healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

North Hills Hospital currently tracks and reports Admit decision time to ED departure for admitted patients for THE JOINT COMMISSION and internal quality requirements. The current tracking system is already in place and will be modified or improved as necessary to satisfy the requirement of new reporting domain

In addition, the proposed project for Sepsis improvement involves the timely identification and evidence-based treatment of patients. A key component of a Sepsis protocol is the timely identification/diagnosis of septic shock/severe sepsis to admit and begin evidence-based treatment. Process improvements implemented for sepsis protocols in the ED support the goal of less than 1 hour for ED admit/ departure (decision time) for critical patients.

We expect the ED Admit time will be reduced by 25% by the end of the waiver.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Category 4: Population-Focused Measures *North Hills Hospital/094105602*				
	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	$21,333	$9,891		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$9,891	$10,581	$11,501
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$9,891	$10,581	$11,501
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			$10,581	$11,501

Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Calendar Year Jan2013- Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		Calendar Year Jan2013- Dec 2013	Calendar Year Jan2014- Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$9,891	$10,581	$11,501
Domain 5: Emergency Department				
Measurement period for report		Calendar Year Jan2013- Dec 2013	Calendar Year Jan2014- Dec 2014	Calendar Year Jan 2015- Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$9,891	$10,581	$11,501
Grand Total Payments Across Category 4	$21,333	$49,455	$52,905	$57,505

Plaza Medical Center
094193202

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Plaza Medical Center Fort Worth/094193202
Unique RHP identification number: 094193202.4.2

Domain Descriptions:
Plaza Medical Center Fort Worth will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Plaza Medical Center Fort Worth healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Plaza Medical Center Fort Worth currently tracks and reports 2 of the 8 measurements for public reporting. Measurements that have not yet been addressed are:

- Congestive heart Failure Admission Rate
- Diabetes Admission Rates
- Behavioral Health and Substance Abuse Admission Rate
- Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate
- Hypertension Admission rate
- Pediatric Asthma

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Plaza Medical Center Fort Worth will expand existing data collecting system and optimize old system for new reporting processes.

Plaza Medical Center Fort Worth does not expect any impact in this Reporting Domain from proposed Category 1, and 2 projects and Category 3 outcomes.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined

that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Plaza Medical Center Fort Worth/094193202
Unique RHP identification number: 094193202.4.3

Domain Descriptions:
Plaza Medical Center Fort Worth will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Plaza Medical Center Fort Worth healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Plaza Medical Center Fort Worth currently tracks and reports 2 of the 7 measurements for public reporting. Measurements that have not yet been addressed are:

- Diabetes: 30-Day Readmissions
- Behavioral Health & Substance Abuse: 30-Day Readmissions
- Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions
- Stroke: 30- Day Readmissions
- Pediatric Asthma: 30-Day Readmissions

Currently, HHSC will provide potentially preventable event data to providers for reporting. In addition, Plaza Medical Center Fort Worth will expand existing data collecting system and optimize old system for new reporting processes.

In addition, DSRIP projects will provide interventions to Plaza Medical Center Fort Worth patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience is intended to implement process improvements to change the patient satisfaction and experience of hospitalization. Key areas of experience can influence the risk of readmission, including communication, care from nurses and doctors and medication management and discharge process. In particular, how well the staff

communicates with patients about medications, and whether key information is provided at discharge can directly impact the risk of readmission for patients.

In addition, the proposed project for Sepsis improvement involves the timely identification/diagnosis of sepsis and evidence-based treatment for patients. It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence-based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management is vital for continued care of sepsis and reduced risk for readmissions.

We expect to see a reduction in readmissions for patients with an initial index admission of Sepsis and those readmitted for Sepsis with initial diagnosis other than Sepsis. Readmissions due to medication management will also be reduced.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Plaza Medical Center Fort Worth/094193202
Unique RHP identification number: 094193202.4.4

Domain Descriptions:
Plaza Medical Center Fort Worth will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Plaza Medical Center Fort Worth healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Currently, 15 of the sixty four measurements are being tracked and reported in a form of public healthcare statistics. All other measures are tracked and reported internally.

Currently, HHSC will make potentially preventable event data to providers. In addition, Plaza Medical Center Fort Worth will expand existing data collecting system and optimize old system for new reporting processes.

In addition, many DSRIP projects will provide interventions to Plaza Medical Center Fort Worth patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain.

The proposed project to implement an innovative program for Sepsis improvement aims to identify /diagnosis Sepsis sooner and begin evidence-based treatment to reduce mortality and complications for septic shock and severe sepsis.

Improved sepsis care reduces complications particularly those common in septic patients such as pulmonary embolism, acute myocardial infarction, venous thrombosis, major liver complications, renal failure with and without Dialysis and encephalopathy. Also, the project will focus on reducing the average length of stay for sepsis patients. Reducing the length of stay of patients diagnosed with sepsis will also impact a reduction in complications. Evidence shows with increased length of stay there is increased risk of preventable complications.

The proposed project to Redesign the Patient Experience will focus on patients satisfaction and experience. Improved patient communication and satisfaction with caregivers has been shown to improve quality and safety of care. Studies have linked patient satisfaction with communication with doctor nurses, responsive to patients' needs and cleanliness to patient perceptions of hospital practices and facility infection rates.

Preventable complications rates are expected to be reduced 5% a year with appropriate Sepsis care for hospitalized patients and improved patient experience.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Plaza Medical Center Fort Worth/094193202
Unique RHP identification number: 094193202.4.5

Domain Descriptions:
Plaza Medical Center Fort Worth will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Plaza Medical Center Fort Worth healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Currently, 2 of the two measurements are being tracked and reported.

Patient Satisfaction is surveyed by Gallup for HCAHPS requirements. It is reported internally each week for preliminary results. As required, final results are report to CMS and posted publically. Publicly reported HCAHPS results are based on four consecutive quarters of patient surveys. CMS publishes participating hospitals' HCAHPS results on the Hospital Compare website (www.hospitalcompare.hhs.gov) four times a year, with the oldest quarter of patient surveys rolling off as the most recent quarter rolls on. Additional HCAHPS results can be found on HCAHPS On-Line, (www.hcahpsonline.org).

Medication management is only reported publically as a required element of certain CORE MEASURES reporting. However, it is tracked and reported internally for all inpatients by the quality department as a patient safety and quality of care measurement.

Plaza Medical Center Fort Worth will expand existing data collecting system and optimize old system for new reporting processes as necessary.

In addition, Plaza Medical Center Fort Worth has proposed several quality-based projects that will provide improvement of care to all Plaza Medical Center Fort Worth patients in multiple areas, resulting in improvement patient satisfaction throughout all measurements in the Reporting Domain.

The proposed project to Redesign Patient Experience is aimed at improving the patient satisfaction of the care received (RD-4 1. Patient Satisfaction).The goal to improve patient satisfaction and experience is also important for improved quality and safety of care provided. Studies have linked patient satisfaction with communication with doctor nurses, responsive to

patients' needs and cleanliness to patient perceptions of hospital practices and facility infection rates.

Another focus for Redesign Patient Experience is medication management (RD-4 2. Medication management). How well the staff communicates with patients about medicines, and whether key information is provided at discharge is critical to successful medication management and patient safety.

The proposed project for process improvement for Sepsis care involves the timely identification/diagnosis of sepsis and evidence-based treatment for patients. Improving processes in this program includes effective communication. The communication between the emergency room, doctors, nurses/ care givers and families for these critically ill patients is vital to the plan of care. Teaching patients and families the cause and symptoms of sepsis is also important for care management . Patient satisfaction is improved with effective communication.

It is also important for Sepsis patients to be placed on the right medications (right antibiotics, vasopressors, etc.) as a part of evidence-based care. To ensure patients know what medications they were on in the hospital and what they must take after discharge, effective medication management if vital for continued care of sepsis.

We expected to improve Patient satisfaction HCAHPS Grand Composite scores to be > 75th percentile by the end of the waiver. Although we are over 95% compliant with Medication Management documentation, we have only earned a 57% on the composite scores on Communication on medications in HCAHPS. We expect effective communication improvement will increase HCAHPS medication scores by 50% by the end of the waiver.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Plaza Medical Center Fort Worth/094193202
Unique RHP identification number: 094193202.4.6

Domain Descriptions:
Plaza Medical Center Fort Worth will report all the measurements in 5 reporting domains starting on the designated reporting year. Initial analysis of the current Plaza Medical Center Fort Worth healthcare reporting system indicates capability to track and report on some of the required measurements. Some measures are able to be tracked and reported but are not consistently produced or reported. Implementation of new data gathering requirements and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Plaza Medical Center Fort Worth currently tracks and reports Admit decision time to ED departure for admitted patients for THE JOINT COMMISSION and internal quality requirements. The current tracking system is already in place and will be modified or improved as necessary to satisfy the requirement of new reporting domain.

In addition, the proposed project for Sepsis improvement involves the timely identification and evidence-based treatment of patients. A key component of a Sepsis protocol is the timely identification/diagnosis of septic shock/severe sepsis to admit and begin evidence-based treatment. Process improvements implemented for sepsis protocols in the ED support the goal of less than 1 hour for ED admit/ departure (decision time) for critical patients.

We expect the ED Admit time will be reduced by 25% by the end of the waiver.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Category 4: Population-Focused Measures *Plaza Medical Center Fort Worth/094193202*				
	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	$78,614	$36,449		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$36,449	$38,992	$42,383
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$36,450	$38,992	$42,383
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			$38,992	$42,383
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Calendar Year Jan 2013-Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015-Dec 2015
Planned Reporting Period: 1 or 2		2	2	2

Medication Management				
Measurement period for report		Calendar Year Jan 2013-Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015-Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$36,449	$38,992	$42,383
Domain 5: Emergency Department				
Measurement period for report		Calendar Year Jan 2013-Dec 2013	Calendar Year Jan 2014- Dec 2014	Calendar Year Jan 2015-Dec 2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$36,449	$38,992	$42,383
Grand Total Payments Across Category 4	$78,614	$182,246	$194,960	$211,915

Huguley Memorial Medical Center
109574702

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702
Unique RHP identification number: 109574702.4.2

Domain Descriptions:
Currently, three of the eight measurements are being tracked and one of the eight won't be due to the volume which we believe is not statistically valid and anticipate that a number of the data fields might be zero (#6 Pediatric Asthma). Measurements that will be address in the near future are Diabetes Admission rate, Behavioral Health and Substance Abuse Admission rate, Hypertension Admission rate. Huguley will establish new protocols for data collecting and reporting, expand existing data collecting system in preparation of the reporting requirements.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 2 projects and Category 3 outcomes.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementation of the CHF project (109574702.2.1) will facilitate the improvement in the HF readmissions and will positively impact the all-cause admission rate as well as the potentially preventable admissions for patients seeking care at Huguley. Implementation of the sepsis resuscitation bundle (109574702.2.2) will facilitate improvement in both sepsis mortality and length of stay and, in so doing, will positively impact the all-cause admission rate as well as the potentially preventable admissions for patients seeking care at Huguley.

Interventions mentioned above will significantly improve all-cause PPA starting in DY4.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

Huguley will begin to report on all required eight measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
Huguley has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702
Unique RHP identification number: 109574702.4.3

Domain Descriptions:
Currently, two of the seven measurements are being tracked, one of the seven won't be due to the volume which we believe is not statistically valid and anticipate that a number of the data fields might be zero (Pediatric Asthma: 30-day readmissions). Measurements that will be address in the near future are Diabetes: 30-Day Readmissions, Behavioral health & Substance Abuse: 30-day Readmissions, Chronic Obstructive Pulmonary Disease (COPD): 30-Day Readmissions, Stroke: 30-day Readmissions. Huguley will establish new protocols for data collecting and reporting, expand existing data collecting system in preparation for the reporting requirements.

All data collection and reporting processes will be performed in compliance with HHSC and AHRQ guidelines. New implementations and any modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match the new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 2 projects, and Category 3 outcomes.

Successful Category 2 interventions will result in various health care improvements during the waiver period. Implementation of the CHF project (109574702.2.1) and the sepsis resuscitation bundle (109574702.2.2) will directly and positively impact the 30-day readmissions. CHF is specifically targeted at doing this and the sepsis resuscitation bundle implementation will decrease the severity of septic patients treated and in so doing, should result in a reduction in 30-day readmissions.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPR rate.

Huguley will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
Huguley has valued Category 4 at15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702
Unique RHP identification number: 109574702.4.4

Domain Descriptions:
Currently, twenty six of the sixty four measurements are being tracked; however, very few of these measures produce statistically valid volumes. The additional 38 measures will be evaluated and if the volume is statistically significant, will be addressed in the near future. Huguley will establish new protocols for data collecting and reporting, expand existing data collecting system in preparation for the reporting requirements.

Some of Huguley's DSRIP projects target specific practices to reduce PPCs. In addition, multiple quality and performance initiatives have been implemented to improve the quality and safety for the patients we serve. Implementation of the CHF project (109574702.2.1) will specifically and positively impact HF conditions and will result in reductions in PPCs. Implementation of the sepsis resuscitation bundle (109574702.2.2) will directly and positively impact occurrence of hospital acquired septicemia and severe infections in the ED and ICU.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 will serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 2 interventions will feed back into Category 4 reporting measures and reduce the corresponding PPC rate.

Huguley will begin to report on all required PPC measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
Huguley has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702
Unique RHP identification number: 109574702.4.5

Domain Descriptions:
Currently, one of the two measurements (Patient Satisfaction) are being tracked and reported by CMS (Patient Satisfaction). The other measure (Medication Management) is also being tracked and reported via Meaningful Use (CMS).

Huguley is involved in a very focused and intentional patient satisfaction/patient experience initiative which will be aided by our DSRIP projects. The implementation and expected outcomes of the CHF project (109574702.2.1) and the sepsis resuscitation bundle (109574702.2.2) over the course of the waiver period will improve and enhance the patient experience.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes.

There is no DSRIP projects focuses on medication management at this time. Therefore no measureable impact is expected on medication management.

Huguley will begin to report the required measures starting in DY4.

Domain Valuation:
Huguley has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702
Unique RHP identification number: 109574702.4.6

Domain Descriptions:
Initial analysis of the current Huguley healthcare reporting system indicates our time tracking system is in place but will be improved to satisfy the requirement of new reporting domain. There is no DSRIP project associated with this reporting domain and therefore no measureable impact is expected for this domain related to the intervention.

Huguley will begin to report this domain to HHSC starting DY3.

Domain Valuation:
Huguley has valued Category 4 at15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 6: Children and Adult Core Measures

Performing Provider Name/TPI: Huguley Memorial Medical Center/109574702
Unique RHP identification number: 109574702.4.7

Domain Descriptions:
The child core measure is a domain that Huguley doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. Huguley does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
Huguley will not report on RD-6 and, as such, no value has been assigned to this domain.

Category 4: Population-Focused Measures Huguley Memorial Medical Center 109574702				
	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	$14,527	$8,474		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$8,474	$9,079	$9,079
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$8,474	$9,079	$9,079
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$9,079	$9,079
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$8,474	$9,079	$9,079
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$8,474	$9,079	$9,079
OPTIONAL Domain 6: Children and Adult Core Measures				

Children Core Measures				
Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				

Measurement period for report				
Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Grand Total Payments Across Category 4	$14,527	$42,370	$45,396	$45,396

THR Fort Worth
112677302

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth/112677302
Unique RHP identification number: 112677302.4.2

Domain Descriptions:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Harris Methodist Fort Worth (THFW) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THFW is not participating in Category 1 interventions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementation of a patient care navigation program (112677302.2.3) will facilitate patient navigation and positively impact all-cause admission rate for patients seeking medical care in the Texas Health network. Expanding diabetes specialty care and patient education in primary care settings (112677302.2.1) will reduce diabetes admission rate. Expanding current capacity for the heart failure clinic (112677302.2.2) will provide additional post-acute care for heart failure patients. Implementation of the sepsis bundle (112677302.2.4) will also have a positive impact on readmissions. Interventions mentioned above will significantly improve all-cause PPA starting in DY4.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate. Implementation of the sepsis bundle (112677302.2.4) will also have a positive impact on readmissions.

THFW will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth/112677302
Unique RHP identification number: 112677302.4.3

Domain Descriptions:
Currently, all RD-2 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THFW will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THFW is not participating in Category 1 interventions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementation of a patient care navigation program (112677302.2.3) will facilitate patient navigation and positively impact all-cause readmission rate for patients seeking medical care in the Texas Health network. Expanding diabetes specialty care and patient education in primary care settings (112677302.2.1) specifically will reduce diabetes readmission rate. Additionally, we expect the heart failure clinic (112677302.2.2) to have a significant impact on CHF readmission rate by providing additional post-acute care for heart failure patients. Implementation of the sepsis bundle (112677302.2.4) will also have a positive impact on readmissions.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPR rate.

THFW will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP

dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth/112677302
Unique RHP identification number: 112677302.4.4

Domain Descriptions:

Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THFW will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THFW is not participating in Category 1 interventions.

Category 2 interventions that will target specific THFW healthcare practices to reduce PPC's include implementation of a patient care navigation program (112677302.2.3) to navigate patients to appropriate health care resources and assist those with chronic health care needs in receiving ongoing care. Implementing and improving compliance with the sepsis resuscitation bundle (112677302.2.4) will directly impact the occurrence of hospital acquired septicemia and severe infections in the ED and ICU.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPC rate.

THFW will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:

THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth/112677302
Unique RHP identification number: 112677302.4.5

Domain Descriptions:
Currently, all RD-4 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THFW will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THFW is not participating in Category 1 interventions.

The only Category 2 intervention that will target this RD specifically is the heart failure clinic (112677302.2.2). A component of this project includes Medication Management as enhanced inpatient screening and discharge processes will verify completion of medication reconciliation and assist patient in understanding and/or obtaining necessary medications prior to discharge.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of the heart failure clinic project will feed back into Category 4 reporting measures and improve overall patient satisfaction scores.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth/112677302
Unique RHP identification number: 112677302.4.6

Domain Descriptions:
Currently, all RD-5 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THFW will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THFW is not participating in Category 1 interventions.

Since this particular measure reports on the decision time to transfer an emergency patient to another facility and not the actual transport time, (decision to make the first call form arrival in transferring ED until call initiated) it is advisable that THR work closely with our Care Connect reporting to determine if additional data fields need to be build and collected so a report can be created to meet this NQF 0497 measure. During our preliminary review, it appears that we may be able to utilize a MU report that does capture NQF 0497 for all THR entities participating in MU. In addition, a clear time frame in which the reporting period should encompass needs to be stated clearly.

We expect the Patient Care Navigation project (112677302.2.3) to have a positive impact on this domain by helping to navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care.

THFW will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 6: **Children and Adult Core Measures**

Performing Provider Name/TPI: Texas Health Harris Methodist Fort Worth/112677302
Unique RHP identification number: 112677302.4.7

Domain Descriptions:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
THR will not report on RD-6 and, as such, no value has been assigned to this domain.

Category 4: Population-Focused Measures Texas Health Harris Methodist Fort Worth / 112677302				
	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	$313,918	$183,119		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$183,119	$196,691	$201,669
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$183,119	$196,691	$201,669
Domain 3: Potentially Preventable Complications (PPCs) **Includes a list of 64 measures identified in the RHP Planning Protocol.**				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$196,691	$201,669
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$183,119	$196,691	$201,669
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1

Domain 5 - Estimated Maximum Incentive Amount		$183,119	$196,691	$201,669
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				
Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				

Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$313,918	$915,595	$980,503	$975,525

THR Southwest Fort Worth
120926804

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest Fort Worth/120726804
Unique RHP identification number: 120726804.4.2

Domain Descriptions:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Southwest Hospital (THSW) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values Category 3 outcomes.

The use of APRNs as intermediate care providers in the extensivist clinic (120726804.2.4) will decrease the admission rates of the described population of patients in the ED and increase the usage of resources within the community for primary care. Primary care capacity, access, and efficiency attained in primary care clinics along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner are foundational to improving patient outcomes. A comprehensive diabetes care management program (120726804.2.1P will empower the target population of Medicaid and uninsured patients better self-manage of their disease. As many of these patients do not have primary care physicians, self-management techniques are extremely important to proactively reduce hospital admissions for diabetes related complications. Implementing the sepsis bundle (120726804.2.2) will reduce admissions through rapid diagnosis and treatment in the ED. Highly skilled case managers in the ED (120726804.2.3) will pair patients without a primary care provider with a physician or clinic to manage their healthcare proactively thus reducing future admissions.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

THSW will begin to report on all required eight measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:

THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest Fort Worth/120726804
Unique RHP identification number: 120726804.4.3

Domain Descriptions:
Currently, all RD-2 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THSW will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will be performed in compliance with HHSC and AHRQ guidelines. New implementations and any modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match the new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

A comprehensive diabetes care management program will empower the target population of Medicaid and uninsured patients with type 1 or type 2 diabetes, pre-diabetes or gestational diabetes better self-management of their disease. As many of these patients do not have primary care physicians, self-management techniques are extremely important to proactively reduce hospital readmissions for diabetes related complications. The use of APRNs as intermediate care providers in the extensivist clinic will decrease the readmission rates of the described population of patients in the ED and increase the usage of resources within the community for primary care. A comprehensive diabetes care management program will empower the target population of Medicaid and uninsured patients better self-manage of their disease. Implementing the sepsis bundle will reduce readmissions through rapid diagnosis and treatment.

THSW will begin to report on all required seven measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP

dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest Fort Worth/120726804
Unique RHP identification number: 120726804.4.4

Domain Descriptions:
Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THSW will prepare its data systems for reporting this domain as well.

Diabetes self-management is the key to proactively managing the disease state and preventing complications. Primary care capacity, access, and efficiency attained in primary care clinics along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner are foundational to improving patient outcomes and preventing potential complications related to chronic disease processes (ED navigation and Extensivist clinic). Highly skilled case managers in the ED will pair patients without a primary care provider with a physician or clinic to manage their healthcare proactively thus reducing potential complications. Implementing the sepsis bundle will reduce complications through rapid diagnosis and treatment in the ED.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 will serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the corresponding PPC rate.

THR will begin to report on all required PPC measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest Fort Worth/120726804
Unique RHP identification number: 120726804.4.5

Domain Descriptions:
Currently, all RD-4 measurements are being tracked and reported as public healthcare statistics. During DY2, THSW will ensure that its data systems are optimized to report this domain.

THSW has proposed quality-based projects with DSRIP that target the improvements of patient satisfaction and disease management.

The THSW project will utilize the Patient Advisory Council to provide additional patient satisfaction trainings to staff, facilitate shared lessons learned to represent voice of the patients. The identified target populations of patients are Medicaid and uninsured patients in need of primary care, disease management and sepsis treatment.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of the THSW projecst will feed back into Category 4 reporting measures and improve overall patient satisfaction scores.

THSW will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest Fort Worth/120726804
Unique RHP identification number: 120726804.4.6

Domain Descriptions:
The use of APRNs as intermediate care providers will decrease inappropriate usage of the described population of patients in the ED and increase the usage of resources within the community for primary care is the focus of this unique project. ED navigation produces a similar reduction in ED usage by pairing patients with a primary care provider. Diabetic patients developing proactive disease management habits will decrease their utilization of the ED for exacerbation of their disease.

Improvement targets for both outcome measures chosen were selected based on populations of patients the project proposes to serve, and align with the goal of decreasing inappropriate utilization of the ED

THSW will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 6: **Children and Adult Core Measures**

Performing Provider Name/TPI: Texas Health Harris Methodist Southwest Fort Worth/120726804
Unique RHP identification number: 120726804.4.7

Domain Descriptions:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
THR will not report on RD-6 and, as such, no value has been assigned to this domain.

Category 4: Population-Focused Measures *Texas Health Harris Methodist Southwest Fort Worth / 120726804*				
	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	$84,965	$49,563		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$49,563	$53,103	$53,103
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$49,563	$53,103	$53,103
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$53,103	$53,103
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$49,563	$53,103	$53,103
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$49,563	$53,103	$53,103
OPTIONAL Domain 6: Children and Adult Core Measures				

Children Core Measures				
Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				

Measurement period for report				
Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$84,965	$247,815	$265,516	$265,516

THR Stephenville
121794503

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Texas Health Harris Methodist Stephenville/121794503
Unique RHP identification number: 121794503.4.2

Domain Descriptions:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Stephenville Hospital (THS) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values Category 3 outcomes.

A comprehensive diabetes care management program will empower the target population of Medicaid and uninsured patients with type 1 or type 2 diabetes, pre-diabetes or gestational diabetes better self-management of their disease. As many of these patients do not have primary care physicians, self-management techniques are extremely important to proactively reduce hospital admissions for diabetes related complications.

Category 3 outcomes: By the end of the waiver, our goal is to have approximately 120 diabetic patients 18 years and older who are uninsured or Medicaid enrolled in the diabetic comprehensive care management program to proactively managed their disease, therefore, decreasing the rate of potential admissions.

This project's Category 4 Reporting Domain includes RD-1 Potentially preventable admissions (PPAs) in low-income, Medicaid, and uninsured Erath County adult population with the reporting measure RD-1.2 Diabetes with short-term complications or uncontrolled diabetes. This project will support, reinforce, and enable other projects through its design and intervention for the above described patient population by adding to best practices and lessons learned.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

THS will begin to report on all required eight measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Texas Health Harris Methodist Stephenville/121794503
Unique RHP identification number: 121794503.4.3

Domain Descriptions:
Currently, all RD-2 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THS will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will be performed in compliance with HHSC and AHRQ guidelines. New implementations and any modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match the new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

A comprehensive diabetes care management program will empower the target population of Medicaid and uninsured patients with type 1 or type 2 diabetes, pre-diabetes or gestational diabetes better self-management of their disease. As many of these patients do not have primary care physicians, self-management techniques are extremely important to proactively reduce hospital readmissions for diabetes related complications.

THS will begin to report on all required seven measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Texas Health Harris Methodist Stephenville/121794503
Unique RHP identification number: 121794503.4.4

Domain Descriptions:
Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THS will prepare its data systems for reporting this domain as well.

Diabetes self-management is the key to proactively managing the disease state and preventing complications. Severe diabetic complications can lead to blindness, amputations and kidney failure. Each of these severe complications leads to reduced quality of life and productivity for the patient. Less severe complications put increased demands on healthcare providers and loss of productivity for patients. The area served by THS does not currently have any diabetic education services other than those provided at the hospital which is not covered by Medicaid and cost prohibitive for the uninsured.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 will serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the corresponding PPC rate.

THR will begin to report on all required PPC measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Texas Health Harris Methodist Stephenville/121794503
Unique RHP identification number: 121794503.4.5

Domain Descriptions:
Currently, all RD-4 measurements are being tracked and reported as public healthcare statistics. During DY2, THS will ensure that its data systems are optimized to report this domain.

THS has proposed a quality-based project with DSRIP that targets the improvements of patient satisfaction and disease management.

The THS project will develop a patient experience focus team within the organization to provide additional patient satisfaction trainings to staff, facilitate shared lessons learned, and expand the Patient Advisory Council to represent voice of the patients. The identified target populations of patients the diabetes management program will service are Medicaid and uninsured patients with type 1 or type 2 diabetes, pre-diabetes or gestational diabetes that do not currently have access to disease management opportunities currently.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of the THS project will feed back into Category 4 reporting measures and improve overall patient satisfaction scores.

THS will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Texas Health Harris Methodist Stephenville/121794503
Unique RHP identification number: 121794503.4.6

Domain Descriptions:
The use of APRNs as intermediate care providers will decrease the admission rates of the described population of patients in the ED and increase the usage of resources within the community for primary care is the focus of this unique project.

Improvement targets for both outcome measures chosen were selected based on populations of patients the project proposes to serve, and align with the goal of decreasing inappropriate utilization of the ED by providing disease self-management education for the targeted population that frequently utilized the ED for services related to diabetes.

THS will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 6: Children and Adult Core Measures

Performing Provider Name/TPI: Texas Health Harris Methodist Stephenville/121794503
Unique RHP identification number: 121794503.4.7

Domain Descriptions:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
THR will not report on RD-6 and, as such, no value has been assigned to this domain.

Category 4: Population-Focused Measures *Texas Health Harris Methodist Stephenville / 121794503*				
	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	$1,266	$738.23		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$738.23	$790.97	$790.97
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$738.23	$790.97	$790.97
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$790.97	$790.97
Domain 4: Patient Centered HealTHSare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$738.23	$790.97	$790.97
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$738.23	$790.97	$790.97
OPTIONAL Domain 6: Children and Adult Core Measures				

Children Core Measures				
Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				

Measurement period for report				
Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$1,266	$3,691	$3,955	$3,955

Ennis Regional Medical Center
121822403

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: PHRC-Ennis LP dba Ennis Regional Medical Center/121822403
Unique RHP identification number: 121822403.4.2

Domain Descriptions:
Ennis Regional Medical Center (ERMC) will report all the measurements in 5 reporting domains starting on the designated reporting year. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Currently, two of the eight measurements, Pneumococcal Immunization and Influenza Immunization are being tracked and reported in a form of public healthcare statistics. Measurements that have not yet been addressed are 1) Congestive Heart Failure Admission Rate, 2) Diabetes Admission Rates, 3) Behavioral Health and Substance Abuse Admission Rate, 4) Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rates, 5) Hypertension Admission Rate and 6) Pediatric Asthma. In addition, many DSRIP projects will provide interventions to ERMC patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data available to providers. In addition, ERMC will establish new protocols for data collecting and reporting and are currently expanding and optimizing our existing data collecting system in order to fully participate. The PPA's will all be impacted positively by the efforts or our Category 1 and 2 projects 121822403.1.1 Expand Primary Care Capacity. Many patients that are currently being seen at ERMC do not have a primary care physician. Efforts by Case Management and discharge planning have struggled to find physicians for patients to follow up after hospitalization, for the appointments to be made without long waits as well as to find primary healthcare for Medicaid patients. What physicians are available in the area have a limit of Medicaid patient volumes. Without regular primary care, a patient may have to be admitted to the hospital as a result of a worsening condition.

All of the additional measures are relevant to ERMC patient population. With improved and expanded data availability ERMC will be able to study these specific patient populations and their specific performance in order to implement focused improvements as identified.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined

that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: PHRC-Ennis LP dba Ennis Regional Medical Center/121822403
Unique RHP identification number: 121822403.4.3

Domain Descriptions:
Ennis Regional Medical Center (ERMC) will report all the measurements in 5 reporting domains starting on the designated reporting year. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 6 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Currently, one of the seven measurements are being tracked and reported in a form of public healthcare statistics. Measurements that have not yet been addressed are 30 Day Readmissions for 1) Diabetes, 2) Behavioral Health & Substance Abuse, 3) Chronic Obstructive Pulmonary Disease, 4) Stroke, 5) Pediatric Asthma and 6) All-Cause. In addition, many DSRIP projects will provide interventions to ERMC patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data available to providers. In addition, ERMC will establish new protocols for data collecting and reporting and are currently expanding and optimizing our existing data collecting system in order to fully participate. The PPR's will all be impacted positively by the efforts or our Category 1 and 2 projects 121822403.1.1 Expand Primary Care Capacity. Many patients that are currently being seen at ERMC do not have a primary care physician. Efforts by Case Management and discharge planning have struggled to find physicians for patients to follow up after hospitalization, for the appointments to be made without long waits as well as to find primary healthcare for Medicaid patients. What physicians are available in the area have a limit of Medicaid patient volumes. Indigent care is also very limited. Without regular primary care, a patient may have to be re-admitted to the hospital as a result of a worsening condition, medications that need to be supervised and other methods of preventing re-admission to the hospital.

All of the additional measures are relevant to ERMC patient population. With improved and expanded data availability ERMC will be able to study these specific patient populations and their specific performance in order to implement focused improvements as identified.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined

that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: PHRC-Ennis LP dba Ennis Regional Medical Center/121822403
Unique RHP identification number: 121822403.4.4

Domain Descriptions:
Ennis Regional Medical Center (ERMC) will report all the measurements in 5 reporting domains starting on the designated reporting year. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 6 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Currently, none of the sixty four measurements are being tracked and reported in a form of public healthcare statistics. The PPC's population will not be affected by the ERMC Category 1, 2 and Category 3 outcomes project. Many DSRIP projects will provide interventions to ERMC patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data available to providers. In addition, ERMC will establish new protocols for data collecting and reporting and are currently expanding and optimizing our existing data collecting system in order to fully participate.

All of the additional measures are relevant to ERMC patient population. With improved and expanded data availability ERMC will be able to study these specific patient populations and their specific performance in order to implement focused improvements as identified.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: PHRC-Ennis LP dba Ennis Regional Medical Center/121822403
Unique RHP identification number: 121822403.4.5

Domain Descriptions:
Ennis Regional Medical Center (ERMC) will report all the measurements in 5 reporting domains starting on the designated reporting year. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 6 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3.

Currently, one of the two measurements are being tracked and reported internally to the Performance Improvement Leadership Organizational Team (PILOT). The Measurement that has not yet been addressed is Medication Management. One of the two patient populations that are considered in these areas would have some minor impact by the ERMC Category 1, 2 and Category 3 outcomes project. For Patient Satisfaction the patient is impacted by the arrangements that are made in their behalf for continuing physician care beyond the hospitalization for which our Category 1 and 2 projects 121822403.1.1 Expand Primary Care Capacity will improve. The Medication Management component would not be impacted by the ERMC Category 1, 2 and Category 3 outcomes project. In addition, ERMC proposed several quality-based projects that will provide improvement of care to all ERMC patients in multiple areas, resulting in improvement of patient satisfaction throughout all measurements in the Reporting Domain. ERMC will establish new protocols for data collecting and reporting and are currently expanding and optimizing our existing data collecting system in order to fully participate.

The additional measure is relevant to ERMC patient population. With improved and expanded data availability ERMC will be able to study these specific patient populations and their specific performance in this area in order to implement focused improvements as identified.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: PHRC-Ennis LP dba Ennis Regional Medical Center/121822403
Unique RHP identification number: 121822403.4.6

Domain Descriptions:
Ennis Regional Medical Center (ERMC) will report all the measurements in 5 reporting domains starting on the designated reporting year. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 6 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability for all Category 1, and 2 projects and Category 3 outcomes by the end of DY3. The Emergency Department Reporting Domain does not relate to and will not have an impact on the ERMC Category 1 and 2 projects and Category 3 outcomes.

A time tracking system is already in place and will be modified or improved to satisfy the requirement of new reporting domains.

With improved and expanded data availability ERMC will be able to study performance and implement focused improvements as identified.

Domain Valuation:
All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Category 4: Population-Focused Measures PHRC-Ennis LP dba Ennis Regional Medical Center/121822403				
	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	$13,006.00	$6,030.00		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$6,030.00	$6,450.00	$7,012.00
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$6,030.00	$6,450.00	$7,012.00
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			$6,450.00	$7,012.00

Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/01/2012-09/30/2013	10/01/13-9/30/2014	10/01/2014-09/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/01/2012-09/30/2013	10/01/13-9/30/2014	10/01/2014-09/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$6,030.00	$6,450.00	$7,012.00
Domain 5: Emergency Department				
Measurement period for report		10/01/2012-09/30/2013	10/01/13-9/30/2014	10/01/2014-09/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$6,030.00	$6,450.00	$7,012.00
Grand Total Payments Across Category 4	$13,006	$30,150	$32,250	35,060

JPS Health Network
126675104

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: JPS Health Network/126675104
Unique RHP identification number: 126675104.4.2

Domain Descriptions:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, JPS will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

Successful Category 1 interventions will lead to health care improvements through out the waiver period. Implementation of a 24-hour nurse call center (126675104.1.2) will facilitate patient navigation and positively impact all-cause admission rate for patients seeking medical care in JPS network. Expanding diabetes specialty care in primary care settings (126675104.2.1) will greatly reduce diabetes admission rate. Establishing a partial hospitalization program (PHP) (126675104.1.4) will provide additional care for behavioral health and substance abuse patients. Interventions mentioned above will significantly improve all-cause PPA starting in DY4.

Many Category 2 interventions will also reduce all-cause PPAs. Embedding a well-trained, specialized healthcare team in homeless shelters (126675104.2.3) will greatly reduce the all-cause admission rate and improve immunization rate among the homeless. Implementation of an advance care PCMH (126675104.2.2) and E-Consult Program will provide specialized care for patients in primary care settings. The Care Transition Program (126675104.2.5) will facilitate patient navigation and therefore reduce avoidable admission rate. Admission rates for chronic diseases such as CHF and diabetes will decrease with Palliative Care and additional support in outpatient setting (126675104.2.4). Continuous care for chronically ill patients can be established by connecting with non-JPS clinics (126675104.2.10). Additional patient education and chronic disease management will be established by first medical responders through the partnership with MedStar (126675104.2.8). Furthermore, integrating virtual psychiatric support (126675104.2.9) and other forms of behavioral health care into primary care settings (126675104.2.6) in conjunction with a behavioral health discharge management program (126675104.2.7) will greatly increase primary and mental health care access for behavioral health and substance abuse patients. Interventions mentioned above will significantly reduce all-cause PPAs starting in DY4.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline

measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

JPS will begin to report on all required eight measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:

JPS has valued Category 4 at 9% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: JPS Health Network/126675104
Unique RHP identification number: 126675104.4.3

Domain Descriptions:
Currently, all RD-2 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, JPS will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will be performed in compliance with HHSC and AHRQ guidelines. New implementations and any modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match the new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

Successful Category 1 interventions will result in various health care improvements during the waiver period. Expanding behavioral health clinic hours (126675104.1.1) will increase the access of care for behavioral health patients and lower the readmission rate for affected populations. Expanding specialty care to the PCMH (126675104.2.2) and establish a nurse staffed call center (126675104.1.2) will decrease the all-cause readmission rate by providing timely care to patients with chronic diseases.

A mental health discharge management program will provide further improvement to reduce behavioral health and substance abuse readmission rate. A partnership with MedStar (126675104.2.8) to establish a nurse triage 9-1-1 program and in-home CHF management program will facilitate patient navigation and encourage self disease management to reduce the CHF readmission rate. Improving patient navigation through the care transitions program (126675104.2.5) and development of an advanced PCMH (126675104.2.2) will facilitate utilization of primary and preventive care in the right setting and time, reducing the all-cause 30-day readmission rate. Connecting chronic patients in the JPS network to non-JPS clinics (126675104.2.10) to provide continuous care will have a significant impact on chronic disease readmission rates. Implementation of inpatient rehabilitation care, palliative care, and pain management program will help reduce all-cause 30 days readmission rate.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPR rate.

JPS will begin to report on all required seven measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:

JPS has valued Category 4 at 9% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: JPS Health Network/126675104
Unique RHP identification number: 126675104.4.4

Domain Descriptions:
Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, JPS will prepare its data systems for reporting this domain as well.

Some of the JPS DSRIP projects target specific JPS healthcare practices to reduce PPCs. The newly developed Innovation and Transformation Center will utilize various data-driven tools such as Lean, Six Sigma and Rapid Cycle Improvements to coordinate the implementation of major organizational performance improvement and transformational activities. The priority during the wavier period will be focusing on reducing the following PPCs: venous thrombosis, surgical site infections, in-hospital trauma and fractures from falls, catheter-associated urinary tract infections, and central line-associated bloodstream infections. Implementing and improving compliance with the sepsis resuscitation bundle (126675104.2.12) will directly impact the occurrence of hospital acquired septicemia and severe infections in the ED and ICU. A specialized wound center established as part of the Expanding Specialty Care project (126675104.1.3) will provide direct interventions to decrease the rate of decubitus ulcer occurrence. The Journey to Life project will reduce associated obstetric complications by promoting perinatal best practices among pregnant women.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 will serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the corresponding PPC rate.

JPS will begin to report on all required PPC measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
JPS has valued Category 4 at 9% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: JPS Health Network/126675104
Unique RHP identification number: 126675104.4.5

Domain Descriptions:
Currently, all RD-4 measurements are being tracked and reported as public healthcare statistics. During DY2, JPS will ensure that its data systems are optimized to report this domain.

JPS has proposed several quality-based projects with DSRIP that target the improvements of patient satisfaction and medication management.

The JPS Cares project (126675104.2.11) will develop a patient experience focus team within the organization to provide additional patient satisfaction trainings to staff, facilitate shared lessons learned, and expand the Patient and Family Advisory Council to represent voice of the patients. In addition, implementation of successful inpatient rehabilitation care, palliative care, and pain management program can indirectly influence patient satisfaction score. Redesigning financial incentive program and establish innovation and transformation center to improve care efficiency can also increase patient satisfaction score. Patient satisfaction scores based on HCAHPS will observe improvements throughout the wavier period.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of JPS Care project will feed back into Category 4 reporting measures and improve overall patient satisfaction scores.

There is no DSRIP projects focuses on medication management at this time. Therefore no measureable impact is expected on medication management.

JPS will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
JPS has valued Category 4 at 9% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: JPS Health Network/126675104
Unique RHP identification number: 126675104.4.6

Domain Descriptions:
Initial analysis of the current JPS healthcare reporting system indicates a time tracking system is already in place and will be modified or improved to satisfy the requirement of this reporting domain. There is no DSRIP project associated with this reporting domain and therefore no measureable impact is expected for this domain related to the intervention.

JPS will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
JPS has valued Category 4 at 9% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 6: Children and Adult Core Measures

Performing Provider Name/TPI: JPS Health Network/126675104
Unique RHP identification number: 126675104.4.7

Domain Descriptions:
JPS will participate in the optional Reporting Domain with separated measurement sets for children and adults. Initial analysis of the current JPS healthcare reporting system indicates this data system is already in place and will be modified or improved to satisfy the requirement of this reporting domain. Many of JPS DSRIP projects will bring improvements to each measurement over the course of the waiver period.

The selected chronic diseases admission rates in RD 6 will be impacted by the same Category 1 and Category 2 projects listed in RD 1 narratives. Plan all-cause readmission rate will be improved by the same projects described in RD 2. Financial incentive redesign project will effect the elective delivery rate and antenatal steroids usage rate. The Journey to Life project aims to promote perinatal care and decrease elective deliveries for all JPS obstetric patients. With increasing perinatal care, the percentage of live births weighing less than 2,500 grams will be significantly reduced. The JPS Health Network-wide care transitions program (126675104.2.5) will produce positive impact on the care transitions measures.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures.

JPS will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
JPS has valued Category 4 at 9% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Category 4: Population-Focused Measures JPS Health Network/126675104				
	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	$ 4,618,106	$ 1,784,387		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$1,784,387	$1,909,730	$2,075,794
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$1,784,387	$1,909,730	$2,075,794
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			$1,909,730	$2,075,794
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$1,784,387	$1,909,730	$2,075,794
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1

Domain 5 - Estimated Maximum Incentive Amount		$1,784,387	$1,909,730	$2,075,794
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				
Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Ambulatory Care: Emergency Department Visits				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Pediatric Intensive Care Unit				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Diabetes, Short-term Complications Admission Rate				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
COPD Admission Rate				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1

CHF Admission Rate				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Adult Asthma Admission Rate				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Elective Delivery				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Antenatal Steroids				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Care Transitions				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 6 - Estimated Maximum Incentive Amount		$1,784,387	$1,909,730	$2,075,794
Grand Total Payments Across Category 4	$4,618,106	$10,706,322	$11,458,380	$12,454,764

THR Azle
127304703

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Texas Health Harris Methodist Azle/ 127304703
Unique RHP identification number: 127304703.4.X

Domain Descriptions:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Harris Methodist Fort Worth (THAZ) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

Successful Category 1 interventions will lead to health care improvements throughout the waiver period. Expanding primary care capacity (127304703.1.1) is critical to expand the medical home model and redesign primary care. Primary care capacity, access, and efficiency attained in primary care clinics along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner are foundational to improve all-cause readmissions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementing our HELP CDSMP-based intervention (127304703.2.1) for uninsured and disadvantaged adults with a serious chronic condition will have a positive impact on all cause admissions.
Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate. Implementation of the sepsis bundle (112677302.2.4) will also have a positive impact on readmissions.

THAZ will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THAZ has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Texas Health Harris Methodist Azle/ 127304703
Unique RHP identification number: 127304703

Domain Descriptions:
Currently, all RD-2 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THAZ will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will be performed in compliance with HHSC and AHRQ guidelines. New implementations and any modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match the new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

Successful Category 1 interventions will lead to health care improvements throughout the waiver period. Expanding primary care capacity (127304703.1.1) is critical to expand the medical home model and redesign primary care. Primary care capacity, access, and efficiency attained in primary care clinics along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner are foundational to improve all-cause PPR.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementing our HELP CDSMP-based intervention (127304703.2.1) for uninsured and disadvantaged adults with a serious chronic condition will have a positive impact on all cause PPR.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPR rate.
THAZ will begin to report on all required seven measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THAZ has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Texas Health Harris Methodist Azle/ 127304703
Unique RHP identification number: 127304703

Domain Descriptions:
Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THAZ will prepare its data systems for reporting this domain as well.

Primary care capacity, access, and efficiency attained in primary care clinics (127304703.1.1) along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner are foundational to improving patient outcomes and preventing potential complications related to chronic disease processes. Additional staff members and providers are necessary to increase capacity to deliver care. We expect that expanding primary care capacity will have a positive impact on PPC's.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 will serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the corresponding PPC rate.

THAZ will begin to report on all required PPC measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THAZ has valued Category 4 at 9% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Texas Health Harris Methodist Azle/ 127304703
Unique RHP identification number: 127304703

Domain Descriptions:
Currently, all RD-4 measurements are being tracked and reported as public healthcare statistics. During DY2, THAZ will ensure that its data systems are optimized to report this domain.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

Expanding primary care access (127304703.1.1) and providing will develop a patient experience focus team within the organization to provide additional patient satisfaction trainings to staff, facilitate shared lessons learned, and expand the Patient and Family Advisory Council to represent voice of the patients. In addition, expanding the scope of the chronic disease self-management patient education can indirectly influence patient satisfaction scores. Patient satisfaction scores based on HCAHPS will observe improvements throughout the wavier period.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of THAZ Care project will feed back into Category 4 reporting measures and improve overall patient satisfaction scores.

THAZ will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
THAZ has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Texas Health Harris Methodist Azle/ 127304703
Unique RHP identification number: 127304703

Domain Descriptions:
Currently, all RD-5 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THAZ will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

Since this particular measure reports on the decision time to transfer an emergency patient to another facility and *not* the actual transport time, (decision to make the first call form arrival in transferring ED until call initiated) it is advisable that THR work closely with our Care Connect reporting to determine if additional data fields need to be build and collected so a report can be created to meet this NQF 0497 measure. During our preliminary review, it appears that we may be able to utilize a MU report that does capture NQF 0497 for all THR entities participating in MU. In addition, a clear time frame in which the reporting period should encompass needs to be stated clearly.

We expect the walk-in care clinic (127304703.1.1) to have a positive impact on this domain by providing appropriate health care resources to assist those with urgent and emergent care needs thereby expanding primary care and urgent care access to patients and increasing capacity in the ED.

THAZ will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
THAZ has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 6: Children and Adult Core Measures

Performing Provider Name/TPI: Texas Health Harris Methodist Azle/ 127304703
Unique RHP identification number: 127304703

Domain Descriptions:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
THR will not report on RD-6 and, as such, no value has been assigned to this domain.

Category 4: Population-Focused Measures *Texas Health Harris Methodist Azle / 127304703*				
	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	$21,728	$12,675		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$12,675	$13,580	$13,580
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$12,675	$13,580	$13,580
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$13,580	$13,580
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$12,675	$13,580	$13,580
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$12,675	$13,580	$13,580
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				

Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				
Measurement period for report				

Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$21,728	$76,048	$81,480	$81,480

Wise Regional
130606006

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Wise Regional Health System/130606006
Unique RHP identification number: 130606006.4.2

Domain Descriptions:
Currently, two of the eight Potentially Preventable Admissions (PPA) measurements are being tracked and reported in a form of public healthcare statistics. Reporting Domain measures RD-1.7 Bacterial Pneumonia Immunization and RD-1.8 Influenza Immunization are being captured and reported as part of Wise Regional Health System's (WRHS) Core Measure requirements. The remaining measurements pertaining to this Reporting Domain have yet to be addressed; these include RD-1.1 Congestive Heart Failure Admission Rate, RD-1.2 Diabetes Admission Rates, RD-1.3 Behavioral Health and Substance Abuse Admission Rate, RD-1.4 Chronic Obstructive Pulmonary Disease or Asthma in Adults Admission Rate, RD-1.5 Hypertension Admission Rate, and RD-1.6 Pediatric Asthma. Many DSRIP projects will provide interventions to WRHS patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data available to providers. In addition, WRHS will take efforts to establish new protocols for data collection and reporting, and optimize our existing data collection system by investing in upgrades and additional software packages designed to expand our ability to obtain the data needed to report these measures.

All eight Reporting Domain measures will be positively impacted through the implementation of the DSRIP projects WRHS has selected. Specifically, project 2.1.1 Enhance/Expand Medical Homes will positively affect RD-1.2 Diabetes Admission Rates. The primary care physicians involved in the Patient Centered Medical Home (PCMH) project will create a registry in which patients diagnosed with either controlled or uncontrolled diabetes will be entered, monitored and maintained using a patient centered approach. The goal of the project is to improve over-all care for these patients, which in turn should reduce diabetes related hospital admissions.

Project 2.13.1 Design and Implement an Intensive Outpatient Program (IOP) for the target population of Behavioral Health/Substance Abuse utilizing a disease model with evidence-based therapies and services, should reduce RD-1.3 Behavioral Health and Substance Abuse Admission Rate. The goal of the IOP is to rehabilitate while promoting an over healthy lifestyle. It is anticipated that participation in this program will lead to good health practices and preventive measures that would reduce the need for hospital admission.

Project 1.1.1 Expand Pediatric Primary Care will positively affect measure RD-1.6 Pediatric Asthma with a measure of pediatric patients that return to the ED for asthma treatment within 15 days. The implementation of this project will reduce this measure by capturing the target population, pediatric patients currently the ED for low-level acute care management or chronic conditions, and redirecting them to pediatric primary care services. In turn pediatric primary care

providers will manage patients with chronic conditions, such as asthma, resulting in a reduction of ED pediatric asthma related visits.

Project 2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions will use measure RD-1.1 Congestive Heart Failure Admission Rate as a reporting metric. It is WRHS' goal to reduce this measure by 10% over the demonstration period. Project 2.12.1 will focus on improving this measure through the implementation of a Care Coordination Program designed to expand and enhance patient education and follow-up care through the organization and expansion of post-discharge resources available through-out the community; while providing guidance and follow-up pertaining to these resources. Special attention will be paid to Congestive Heart Failure patients as the care coordination project is implemented and patients are selected participate.

It is anticipated that there will be an overall steady decline in all Potentially Preventable Admissions as DSRIP projects are implemented. Baseline rates for measure RD1-1, Congestive Heart Failure Admission Rate will be established in DY2. In DY3, baseline rates will be established for the additional 7 RD 1 measures. Also during this year, it is projected that measure RD1-1 will see a 3% reduction. Throughout DY4-5 it is anticipated that those measures directly correlated to our projects, RD1-3 and RD1-1 will see a yearly reduction of approximately 3%. In DY4 and 5, WRHS will measure and report all eight of these metrics to HHSC on an annual basis.

Domain Valuation:

The total combined dollars allocated to Category 4 based on the Funding and Mechanics Protocol (PFM) and based on the individual project values from our three projects were added together to get a Category 4 Total. This total was per year based on the PFM. The amount per demonstration year was divided equally for each eligible domain within the demonstration year.

WRHS has several DSRIP projects that will be implemented throughout the demonstration period. It is anticipated that as these projects are implemented there will be improvement across all Category 4 measures. In addition to the introduction of projects, WRHS will take efforts to establish new protocols for data collection and reporting, and optimize our existing data collection system by investing in upgrades and additional software packages designed to expand our ability to obtain the data need to report all Category 4 measures. It is our assumption that this will be a gradual process that encompasses all 5 demonstration years. Therefore, WRHS has taken the value given to the project and divided it evenly and applied that amount to each demonstration year.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Wise Regional Health System/130606006
Unique RHP identification number: 130606006.4.3

Domain Descriptions:
Currently, one of the seven Potentially Preventable Readmissions measurements, RD-2.1 Congestive Heart Failure 30-Day Readmissions, is being tracked and reported in a form of public healthcare statistics. Measurements pertaining to this domain that are not currently being reported include, RD-2.2 Diabetes 30-Day Readmissions, RD-2.3 Behavioral Health and Substance Abuse 30-Day Readmissions, RD-2.4 Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmissions, RD-2.5 Stroke 30-Day Readmissions, RD-2.6 Pediatric Asthma 30-Day Readmissions and All-Cause 30-Day Readmissions. Many DSRIP projects will provide interventions to Wise Regional Health System patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data available to providers. In addition, WRHS will take efforts to establish new protocols for data collection and reporting, and optimize our existing data collection system by investing in upgrades and additional software packages designed to expand our ability to obtain the data need to report these measures.

All eight Reporting Domain measures will be positively impacted through the implementation of the DSRIP projects WRHS has selected. Specifically, project 2.1.1 Enhance/Expand Medical Homes will positively affect RD-2.2 Diabetes 30-Day Readmissions. The primary care physicians involved in the Patient Centered Medical Home (PCMH) project will create a registry in which patients diagnosed with either controlled or uncontrolled diabetes will be entered, monitored and maintained using a patient centered approach. The goal of the project is to improve over-all care for these patients, which in turn should reduce diabetes related hospital admissions and readmissions.

Project 2.13.1 Design and Implement an Intensive Outpatient Program (IOP) for the target population of Behavioral Health/Substance Abuse utilizing a disease model with evidence-based therapies and services, should reduce RD-2.3 Behavioral Health and Substance Abuse 30-Day Readmissions. The goal of the IOP is to rehabilitate while promoting an overall healthy lifestyle. It is anticipated that participation in this program will lead to good health practices and preventive measures that would reduce the need for hospital admission and readmissions.

It is anticipated that measure RD-2.7 All-Cause 30-Day Readmissions will be directly affected by the implementation of every DSRIP projects. However, Project 2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions will use All-Cause 30-Day Readmissions as a measure to improve upon. It is WRHS' goal to reduce this measure by 10% over the demonstration period. Project 2.12.1 will focus on improving this measure through the implementation of a Care Coordination Program

designed to expand and enhance patient education and follow-up care through the organization and expansion of post-discharge resources available through-out the community; while providing guidance and follow-up pertaining to these resources.

It is anticipated that there will be an overall steady decline in all Potentially Preventable Readmissions as DSRIP projects are implemented. In DY2 baseline will be established for measure RD2-7 All-Cause 30-Day Readmissions, and subsequently in DY 3-5 a reduction in the baseline measure of 3% per year. Baseline measures for the six remaining metrics will be determined in DY3. In DY4 and 5, WRHS will measure and report all eight of these metrics to HHSC on an annual basis.

Based on the data from DY1, October 1, 2011 through September 30, 2012, WRHS is exempt from reporting measure RD-2.6 Pediatric Asthma 30-Day Readmissions, because less than five pediatric asthma readmissions occurred. This exemption qualification was set forth in the RHP Companion Document Section V: DSRIP Projects.

Domain Valuation:

The total combined dollars allocated to Category 4 based on the Funding and Mechanics Protocol (PFM) and based on the individual project values from our three projects were added together to get a Category 4 Total. This total was per year based on the PFM. The amount per demonstration year was divided equally for each eligible domain within the demonstration year.

WRHS has several DSRIP projects that will be implemented throughout the demonstration period. It is anticipated that as these projects are implemented there will be improvement across all Category 4 measures. In addition to the introduction of projects, WRHS will take efforts to establish new protocols for data collection and reporting, and optimize our existing data collection system by investing in upgrades and additional software packages designed to expand our ability to obtain the data need to report all Category 4 measures. It is our assumption that this will be a gradual process that encompasses all 5 demonstration years. Therefore, WRHS has taken the value given to the project and divided it evenly and applied that amount to each demonstration year.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Wise Regional Health System/130606006
Unique RHP identification number: 130606006.4.4

Domain Descriptions:
Wise Regional Health System (WRHS) is not currently tracking or reporting Potentially Preventable Complications (PPCs) in a form of public healthcare statistics or internally maintaining this information. However, WRHS does have access and is aware of the data pertaining to these 64 metrics which is being collected and maintained by HHSC. Many DSRIP projects will provide interventions to WRHS patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data available to providers. In addition, WRHS will determine necessity and if needed establish new protocols for data collecting and reporting Potentially Preventable Complications.

These measures are not directly correlated to any of our Category 2 or 3 projects. However, these measures should see improvement indirectly through the implementation of all of our Category 2 and 3 projects. Project 2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model is designed to further develop and enhance the capabilities of our care management program. In theory, this project indirectly reduces potentially preventable complications through increased communication and continued outreach to the participating patients, paired with improved data collection and tracking capabilities. Project 2.13.1 Design and Implement an Intensive Outpatient Program (IOP) for the target population of Behavioral Health/Substance Abuse utilizing a disease model with evidence-based therapies and services and project 2.1.1 Enhance/Expand Medical Homes promote overall health through patient centered concepts. These models are based on improved communication and documentation, so in theory the implementation of these projects should increase the likelihood of capturing patients susceptible to PPCs and indirectly decrease the number of occurrences.

It is anticipated that there will be an overall steady decline in all Potentially Preventable Complications as DSRIP projects are implemented. ~~Over~~ In DY~~s~~ 2~~-5~~, Wise Regional Health System has determined that efforts will be made to evaluate current processes, establish new protocols for data collecting and reporting, and optimize our existing data collecting system. It is anticipated that through this process improvements will be made and our ability to obtain and report this measure will increase. Baseline measurements will be established in DY3. In DY4 and 5, WRHS will measure and report all eight of these metrics to HHSC on an annual basis.

Domain Valuation:
The total combined dollars allocated to Category 4 based on the Funding and Mechanics Protocol (PFM) and based on the individual project values from our three projects were added

together to get a Category 4 Total. This total was per year based on the PFM. The amount per demonstration year was divided equally for each eligible domain within the demonstration year.

WRHS has several DSRIP projects that will be implemented throughout the demonstration period. It is anticipated that as these projects are implemented there will be improvement across all Category 4 measures. In addition to the introduction of projects, WRHS will take efforts to establish new protocols for data collection and reporting, and optimize our existing data collection system by investing in upgrades and additional software packages designed to expand our ability to obtain the data need to report all Category 4 measures. It is our assumption that this will be a gradual process that encompasses all 5 demonstration years. Therefore, WRHS has taken the value given to the project and divided it evenly and applied that amount to each demonstration year.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Wise Regional Health System/130606006
Unique RHP identification number: 130606006.4.5

Domain Descriptions:
Currently, both measurements, RD-4.1 Patient Satisfaction and RD-4.2 Medication Management are being tracked and reported internally. Wise Regional Health System will take efforts to expand optimize our existing data collection system by evaluation of current data collection, investing in upgrades and additional software packages, in efforts to produce significant and accurate reporting.

These measures are not directly correlated to any of our Category 2 or 3 projects. However, these measures should see improvement indirectly through the implementation of all of our Category 2 and 3 projects. Improved communication will indirectly have a positive effect on RD-4.1 Patient Satisfaction. All of our projects, Project 2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model, Project 2.13.1 Design and Implement an Intensive Outpatient Program (IOP) for the target population of Behavioral Health/Substance Abuse utilizing a disease model with evidence-based therapies and services, Project 2.1.1 Enhance/Expand Medical Homes, and Project 1.1.1 Expand Pediatric Primary Care, are designed to increase communication to appropriate patient populations while fulfilling their needs. While none of these projects are directly correlated with the measure, it is anticipated that improved communication and guidance through appropriate care will increase our patients' overall satisfaction. RD-4.2 Medication Management, should indirectly be increased through the implementation of Project 2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model, which includes the evaluation and improvement of current hospital processes in regard to patient management for predetermined patient populations, including medication management. While this measure is not directly tied to the project, the review and improvement of processes, namely documentation, should have a positive impact on the medication management measure.

~~Over DYs 2-5~~In DY2, Wise Regional Health System has determined that efforts will be made to evaluate current processes, establish new protocols for data collecting and reporting, and optimize our existing data collecting system. It is anticipated that through this process improvements will be made and our ability to obtain and produce significant and accurate reporting in regard to this measure will increase. Baseline measurements will be established in DY3. In DY4 and 5, WRHS will measure and report all eight of these metrics to HHSC on an annual basis.

Domain Valuation:

The total combined dollars allocated to Category 4 based on the Funding and Mechanics Protocol (PFM) and based on the individual project values from our three projects were added together to get a Category 4 Total. This total was per year based on the PFM. The amount per demonstration year was divided equally for each eligible domain within the demonstration year.

WRHS has several DSRIP projects that will be implemented throughout the demonstration period. It is anticipated that as these projects are implemented there will be improvement across all Category 4 measures. In addition to the introduction of projects, WRHS will take efforts to establish new protocols for data collection and reporting, and optimize our existing data collection system by investing in upgrades and additional software packages designed to expand our ability to obtain the data need to report all Category 4 measures. It is our assumption that this will be a gradual process that encompasses all 5 demonstration years. Therefore, WRHS has taken the value given to the project and divided it evenly and applied that amount to each demonstration year.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Wise Regional Health System/130606006
Unique RHP identification number: 130606006.4.6

Domain Descriptions:
A time tracking system is already in place and will be modified or improved to satisfy the requirement of the new Reporting Domain. Wise Regional Health System is currently utilizing a Medhost software package to capture, track and evaluate many Emergency Department related measures. In an effort to better capture the data required for reporting this measure, WRHS will take efforts to evaluate current processes, establish new protocols for data collecting and reporting, and optimize our existing data collecting system.

This measure is not directly correlated to any of our Category 2 or 3 projects. However, this measure should see improvement indirectly through the implementation of all of our Category 2 and 3 projects. RD-5 Emergency Department, should indirectly be improved through the implementation of Project 2.12.1 Develop, implement, and evaluate standardized clinical protocols and evidence-based care delivery model, which includes the evaluation and improvement of current hospital processes with regard to patient management, including Emergency Department admission decision protocol for the patient population targeted by the project. If during the review process, obstacles or more efficient means are determined there will be revisions or new protocols put into place. Any process improvements should positively affect this measure.The remaining three projects, Project 2.13.1 Design and Implement an Intensive Outpatient Program (IOP) for the target population of Behavioral Health/Substance Abuse utilizing a disease model with evidence-based therapies and services, Project 2.1.1 Enhance/Expand Medical Homes, and Project 1.1.1 Expand Pediatric Primary Care, are designed to provide patient care in the appropriate settings, thus decreasing the amount of patients improperly using ED services for non-emergent conditions. In theory, the implementation of these projects will result in increased efficiency through the reduction of demand on ED resources. This will enable our ED providers to increase overall efficiency, theoretically decreasing the measure.

~~Over DYs 2-5~~In DY2, Wise Regional Health System has determined that efforts will be made to evaluate current processes, establish new protocols for data collecting and reporting, and optimize our existing data collecting system. It is anticipated that through this process improvements will be made and our ability to obtain and report this measure will increase. Baseline measurements will be established in DY3. In DY4 and 5, WRHS will measure and report all eight of these metrics to HHSC on an annual basis.

Domain Valuation:
The total combined dollars allocated to Category 4 based on the Funding and Mechanics Protocol (PFM) and based on the individual project values from our three projects were added

together to get a Category 4 Total. This total was per year based on the PFM. The amount per demonstration year was divided equally for each eligible domain within the demonstration year.

WRHS has several DSRIP projects that will be implemented throughout the demonstration period. It is anticipated that as these projects are implemented there will be improvement across all Category 4 measures. In addition to the introduction of projects, WRHS will take efforts to establish new protocols for data collection and reporting, and optimize our existing data collection system by investing in upgrades and additional software packages designed to expand our ability to obtain the data need to report all Category 4 measures. It is our assumption that this will be a gradual process that encompasses all 5 demonstration years. Therefore, WRHS has taken the value given to the project and divided it evenly and applied that amount to each demonstration year.

Category 4: Population-Focused Measures *Wise Regional Health System TPI 130606006*				
	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	$344,265.29	$159,619.36		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2				
Domain 1 - Estimated Maximum Incentive Amount		$159,619.36	$170,755.31	$185,603
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2				
Domain 2 - Estimated Maximum Incentive Amount		$159,619.36	$170,755.31	$185,603
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2				
Domain 3 - Estimated Maximum Incentive Amount			$170,755.31	$185,603
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 4 - Estimated Maximum Incentive Amount		$159,619.36	$170,755.31	$185,603
Domain 5: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2				

Domain 5 - Estimated Maximum Incentive Amount		$159,619.36	$170,755.31	$185,603.92
Grand Total Payments Across Category 4	$344,265	$798,097	$853,777	$928,016

THR Arlington Memorial
13614405

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Texas Health Arlington Memorial (THAM)/130614405
Unique RHP identification number: 130614405.4.2

Domain Descriptions:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Arlington Memorial (THAM) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THAM is not participating in Category 1 interventions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementation of a patient care navigation program (130614405.2.4) will facilitate patient navigation and positively impact all-cause admission rate for patients seeking medical care in the Texas Health network. Expanding diabetes specialty care and patient education in primary care settings (130614405.2.1) will reduce diabetes admission rate. Establishing a heart failure clinic (130614405.2.2) will provide additional post-acute care for heart failure patients. Interventions mentioned above will significantly improve all-cause PPA starting in DY4.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

THAM will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Texas Health Arlington Memorial (THAM)/130614405
Unique RHP identification number: 130614405.4.3

Domain Descriptions:
Currently, all RD-2 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THAM will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THAM is not participating in Category 1 interventions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementation of a patient care navigation program (130614405.2.4) will facilitate patient navigation and positively impact all-cause readmission rate for patients seeking medical care in the Texas Health network. Expanding diabetes specialty care and patient education in primary care settings (130614405.2.1) specifically will reduce diabetes readmission rate. Additionally, we expect the heart failure clinic (130614405.2.2) to have a significant impact on CHF readmission rate by providing additional post-acute care for heart failure patients.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPR rate.

THAM will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Texas Health Arlington Memorial (THAM)/130614405
Unique RHP identification number: 130614405.4.4

Domain Descriptions:
Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THAM will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THAM is not participating in Category 1 interventions.

Category 2 interventions that will target specific THAM healthcare practices to reduce PPC's include implement innovative evidence-based strategies to reduce low birth weight and preterm birth (130614405.2.3). The Prenatal Clinic provides an avenue for those who might not otherwise obtain prenatal care to receive this care. Complications associated with obstetrics can be reduced through the provision of prenatal care and early identification of/intervention with patients at risk for obstetrical complications.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPC rate.

THAM will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Texas Health Arlington Memorial (THAM)/130614405

Unique RHP identification number: 130614405.4.5

Domain Descriptions:
Currently, all RD-4 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THAM will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THAM is not participating in Category 1 interventions.

The only Category 2 intervention that will target this RD specifically is the heart failure clinic (130614405.2.2). A component of this project includes Medication Management as enhanced inpatient screening and discharge processes will verify completion of medication reconciliation and assist patient in understanding and/or obtaining necessary medications prior to discharge.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of the heart failure clinic project will feed back into Category 4 reporting measures and improve overall patient satisfaction scores.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Texas Health Arlington Memorial (THAM)/130614405
Unique RHP identification number: 130614405.4.6

Domain Descriptions:
Currently, all RD-5 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THAM will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THAM is not participating in Category 1 interventions.

Since this particular measure reports on the decision time to transfer an emergency patient to another facility and not the actual transport time, (decision to make the first call form arrival in transferring ED until call initiated) it is advisable that THR work closely with our Care Connect reporting to determine if additional data fields need to be build and collected so a report can be created to meet this NQF 0497 measure. During our preliminary review, it appears that we may be able to utilize a MU report that does capture NQF 0497 for all THR entities participating in MU. In addition, a clear time frame in which the reporting period should encompass needs to be stated clearly.

We expect the Patient Care Navigation project (130614405.2.4) to have a positive impact on this domain by helping to navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care.

THAM will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 6: **Children and Adult Core Measures**

Performing Provider Name/TPI: Texas Health Arlington Memorial (THAM)/130614405
Unique RHP identification number: 130614405.4.7

Domain Descriptions:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
THR will not report on RD-6 and, as such, no value has been assigned to this domain.

Category 4: Population-Focused Measures Texas Health Arlington Memorial / 130614405				
	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	$137,915	$80,451		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$80,451	$86,197	$86,197
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$80,451	$86,197	$86,197
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$86,197	$86,197
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Medication Management				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$80,451	$86,197	$86,197
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$80,451	$86,197	$86,197
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				

Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				
Measurement period for report				

Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$137,915	$402,252	$430,985	$430,985

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Texas Health Harris Methodist Cleburne / 131036903
Unique RHP identification number: 131036903

Domain Descriptions:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Cleburne Hospital (THC) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values Category 3 outcomes.

The use of APRNs (131036903.1.1) as intermediate care providers will decrease the admission rates of the described population of patients in the ED and increase the usage of resources within the community for primary care. Expanding primary care capacity is critical to expand the medical home model and redesign primary care. Primary care capacity, access, and efficiency attained in primary care clinics along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner are foundational to improving patient outcomes.

Category 3 outcomes: By the end of the waiver, our goal is to have ≥10% of patients 18 years and older who are uninsured or underfunded seen in a primary care setting (either a THC based urgent care clinic or the JC HOPE Clinic), therefore decreasing the rate of potential admissions.

This project's Category 4 Reporting Domain includes RD-1 Potentially preventable admissions (PPAs) in low-income, Medicaid, and uninsured Johnson County adult population with the reporting measures of RD-1.1 CHF, RD-1.2 Diabetes with short-term complications or uncontrolled diabetes, and RD-1.4 COPD or asthma. This project will support, reinforce, and enable other projects through its design and intervention for the above described patient population by adding to best practices and lessons learned.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

THC will begin to report on all required eight measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:

THC and Texas Health Resources have valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Texas Health Harris Methodist Cleburne / 131036903
Unique RHP identification number: 131036903

Domain Descriptions:
Currently, all RD-2 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THC will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will be performed in compliance with HHSC and AHRQ guidelines. New implementations and any modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match the new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

The use of APRNs (131036903.1.1) as intermediate care providers will decrease the readmission rates of the described population of patients in the ED and increase the usage of resources within the community for primary care. Expanding primary care capacity is critical to expand the medical home model and redesign primary care.
Target population: The identified target populations of patients the urgent care clinic will service are Non-Funded /self-pay without access to additional resources and high frequency of inpatient admissions and ER visits within the last 6 months. The identified target populations of patients the urgent care clinic will service are:

a) Diagnoses to include COPD, heart failure, diabetes
b) Non-funded/self-pay without access to additional resources
c) High frequency of inpatient admissions and ED visits within the last six months

THC will begin to report on all required seven measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications
Unique Project ID: 131036903.1.1
Performing Provider Name/TPI: Texas Health Harris Methodist Cleburne / 131036903

Domain Descriptions:
Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THC will prepare its data systems for reporting this domain as well.

Primary care capacity, access, and efficiency attained in primary care clinics (131036903.1.1) along with restructuring primary care to be delivered in a proactive, organized, population-health focused manner are foundational to improving patient outcomes and preventing potential complications related to chronic disease processes. Additional staff members and providers are necessary to increase capacity to deliver care.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 will serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the corresponding PPC rate.

THR will begin to report on all required PPC measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Unique Project ID: 131036903.1.1
Performing Provider Name/TPI: Texas Health Harris Methodist Cleburne / 131036903

Domain Descriptions:
Currently, all RD-4 measurements are being tracked and reported as public healthcare statistics. During DY2, THC will ensure that its data systems are optimized to report this domain.

THC has proposed several quality-based projects with DSRIP that target the improvements of patient satisfaction and medication management.

The THC Unique Project ID 131036903.1.1 will develop a patient experience focus team within the organization to provide additional patient satisfaction trainings to staff, facilitate shared lessons learned, and expand the Patient Advisory Council to represent voice of the patients. The identified target populations of patients the urgent care clinic will service are Non-Funded /self-pay without access to additional resources and high frequency of inpatient admissions and ER visits within the last 6 months.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of the THC project will feed back into Category 4 reporting measures and improve overall patient satisfaction scores.

THC will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
THC has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department
Unique Project ID: 131036903.1.1
Performing Provider Name/TPI: Texas Health Harris Methodist Cleburne / 131036903

Domain Descriptions:
The use of APRNs as intermediate care providers will decrease the admission rates of the described population of patients in the ED and increase the usage of resources within the community for primary care is the focus of this unique project.

Improvement targets for both outcome measures chosen were selected based on populations of patients the project proposes to serve, and align with the goal of decreasing inappropriate utilization of the ED by providing an alternative in an urgent care clinic (131036903.1.1) managed by APRNs, and partnering with the JC HOPE clinic to provide primary care resources for patients who currently do not have access to primary care.
THC will begin to report the required measures, during reporting period 1 annually to HHSC, starting in DY3 as required.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 6: Children and Adult Core Measures
Unique Project ID: 131036903.1.1
Performing Provider Name/TPI: Texas Health Harris Methodist Cleburne / 131036903

Domain Descriptions:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
THR will not report on RD-6 and, as such, no value has been assigned to this domain.

Category 4: Population-Focused Measures *Texas Health Harris Methodist Cleburne Hospital / 131036903*				
	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	$13,266	$7,739		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$7,739	$8,291	$8,291
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$7,739	$8,291	$8,291
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$8,291	$8,291
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$7,739	$8,291	$8,291
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$7,739	$8,291	$8,291
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				

Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				
Measurement period for report				

Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$13,266	$38,693	$41,457	$41,457

Baylor All-Saints Medical Center at Fort Worth
135036506

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth/135036506
Unique RHP identification number: 135036506.4.2

Domain Descriptions:
Baylor All Saints Medical Center at Fort Worth will report all the measurements starting on the designated reporting year. Initial analysis of the current Baylor All Saints Medical Center at Fort Worth healthcare reporting system indicates further refinement and definition will be required for some of the required metrics. The reporting system has the capability to track and report the required measurements but will require additional work to get the exact required specifications. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Currently, 8 of the eight measurements are being tracked and reported at Baylor All Saints Medical Center at Fort Worth. In addition, many regional DSRIP projects will provide interventions to Baylor All Saints Medical Center at Fort Worth patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor All Saints Medical Center at Fort Worth will expand the existing data collecting system, and optimize the old system for new reporting processes.

The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor All Saints Medical Center has chosen will be 10/1 to 3/31.

The PPA domain in Category 4 has 8 components. Although the impact of the Baylor All Saints Medical Center at Fort Worth's DSRIP projects on the PPA domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPA domain. The projects and outcomes listed below will help to reduce/prevent PPAs in patients who engage in these programs, are actively managed and have their conditions under control.

The table below summarizes the projects and outcomes that potentially relate to the PPA domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD1- PPA						
Cat 1, 2, & 3	1.1	1.2	1.3	1.4	1.5	1.7	1.8
135036506.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X		X	X	X	X
IT 1.7 Controlling high blood pressure					X		
IT 12.5 Influenza Vaccination rate							X

135036506.1.2 :Improve Access to Specialty Care-Expand Specialty care Services				X			
IT 11.1 Asthma management for underserved				X			
135036506.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X	X		X	X		
IT 1.10 Diabetes HbA1c poor control		X					
IT 1.11 Diabetes BP control		X					
IT 1.13 Diabetes Foot exam		X					
135036506.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X		
135036506.2.2 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X	X	X	X		X	X
IT 11.1 Diabetes Management for underserved with BH diagnoses		X					
IT 11.3 improve utilization rate of clinical preventive services f or BH			X				

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPAs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPAs.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

All of the required reporting domains are pertinent in transforming the healthcare of RHP 10. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor All Saints Medical Center at Fort Worth, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth/135036506
Unique RHP identification number: 135036506.4.3

Domain Descriptions:
Baylor All Saints Medical Center at Fort Worth will report all the measurements starting on the designated reporting year. Initial analysis of the current Baylor All Saints Medical Center at Fort Worth healthcare reporting system indicates further refinement and definition will be required for some of the required metrics. The reporting system has the capability to track and report the required measurements but will require additional work to get the exact required specifications. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Currently, 7 of the seven measurements are being tracked and reported at Baylor All Saints Medical Center at Fort Worth. In addition, many regional DSRIP projects will provide interventions to Baylor All Saints Medical Center at Fort Worth patients in multiple areas, resulting in improvement of PPRs throughout all measurements in the Reporting Domain. One note is that PPRs are reported within Baylor Health Care System only. Thus, if a patient presents at a Baylor facility and then is readmitted at another provider's facility, we cannot capture that data.

Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor All Saints Medical Center at Fort Worth will expand the existing data collecting system, and optimize the old system for new reporting processes.

The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor All Saints Medical Center has chosen will be 10/1 to 3/31.

The PPR domain in Category 4 has 7 components. Although the impact of the Baylor All Saints Medical Center at Fort Worth's DSRIP projects on the PPR domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPR domain. The projects and outcomes listed below will help to reduce/prevent PPRs in patients who engage in these programs, are actively managed and have their conditions under control.

The table below summarizes the projects and outcomes that potentially relate to the PPR domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD2- PPR					
Cat 1, 2, & 3	2.1	2.2	2.3	2.4	2.5	2.7
135036506.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X	X	X	X	X	X
IT 1.7 Controlling high blood pressure					X	
135036506.1.2 :Improve Access to Specialty Care- Expand Specialty care Services				X		
IT 11.1 Asthma management for underserved				X		
135036506.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X	X		X	X	
IT 1.10 Diabetes HbA1c poor control		X				
IT 1.11 Diabetes BP control		X				
IT 1.13 Diabetes Foot exam		X				
135036506.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X	X	X	X	X
135036506.2.2 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment			X			
IT 11.1 Diabetes Management for underserved with BH diagnoses		X				
IT 11.3 improve utilization rate of clinical preventive services for BH			X			

We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPRs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPRs.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

All of the required reporting domains are pertinent in transforming the healthcare of RHP 10. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor All Saints Medical Center at Fort Worth, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth/135036506
Unique RHP identification number: 135036506.4.4

Domain Descriptions:
Baylor All Saints Medical Center at Fort Worth will report all the measurements starting on the designated reporting year. Initial analysis of the current Baylor All Saints Medical Center at Fort Worth healthcare reporting system indicates further refinement and definition will be required for some of the required metrics. The reporting system has the capability to track and report the required measurements but will require additional work to get the exact required specifications. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Currently, many of the sixty four measurements are being tracked and reported at Baylor All Saints Medical Center at Fort Worth. In addition, many regional DSRIP projects will provide interventions to Baylor All Saints Medical Center at Fort Worth patients in multiple areas, resulting in improvement of PPCs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Baylor All Saints Medical Center at Fort Worth will expand the existing data collecting system, and optimize the old system for new reporting processes.

The measurement period for this domain per HHSC will be the calendar year and the reporting period Baylor All Saints Medical Center has chosen will be 10/1 to 3/31.

The PPC domain in Category 4 has 1 component with 64 reportable measures. Although the impact of the Baylor All Saints Medical Center at Fort Worth's DSRIP projects on the PPC domain will not be known until the latter years of the waiver, the projects we have chosen will help to facilitate improvements in the PPC domain. The projects and outcomes listed below will help to reduce/prevent PPCs in patients who engage in these programs, are actively managed and have their conditions under control. We expect that once patients are under the care of a PCMH and have their clinical and social needs met, that PPCs should improve. Getting patients into a PCMH, managing their chronic diseases, behavioral health, specialty care and care coordination needs will help to reduce PPCs in the inpatient setting. For example, helping a patient control their diabetes in the outpatient setting may help to reduce PPC # 26: Diabetic Ketoacidosis and Coma or PPC #38 Post Operative Infection and Deep Wound Disruption with Procedure (if a patient has well controlled diabetes, they may be less susceptible to post operative infections).The correlation between outpatient management and PPCs is weak and the overall impact of outpatient interventions on PPCs may be minimal.

The table below summarizes the projects and outcomes that potentially relate to the PPC domain. Whether marked improvement will occur at a population level is uncertain.

Category 4	RD3-PPCs
Cat 1, 2, & 3	
135036506.1.1: Expand Primary Care Capacity- Baylor Clinic Capacity Expansion	X
IT 1.7 Controlling high blood pressure	X
135036506.1.2 :Improve Access to Specialty Care- Expand Specialty care Services	X
IT 11.1 Asthma management for underserved	X
IT 12.2 Cervical Cancer Screening	X
IT 12.3 Colorectal Cancer Screening	X
135036506.2.1: Expand Chronic Care Management Model-Create Chronic Disease management and Prevention Program	X
IT 1.10 Diabetes HbA1c poor control	X
IT 1.11 Diabetes BP control	X
IT 1.13 Diabetes Foot exam	X
135036506.2.2 : Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals- Behavioral Health Counseling, Screening and Treatment	X
IT 11.1 Diabetes Management for underserved with BH diagnoses	X
IT 11.3 improve utilization rate of clinical preventive services for BH	X

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

All of the required reporting domains are pertinent in transforming the healthcare of RHP 10. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor All Saints Medical Center at Fort Worth, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.
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Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth/135036506
Unique RHP identification number: 135036506.4.5

Domain Descriptions:

Baylor All Saints Medical Center at Fort Worth will report all the measurements starting on the designated reporting year. Initial analysis of the current Baylor All Saints Medical Center at Fort Worth healthcare reporting system indicates further refinement and definition will be required for some of the required metrics. The reporting system has the capability to track and report the required measurements but will require additional work to get the exact required specifications. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Currently, 2 of the two measurements are being tracked and reported internally within the Baylor Healthcare System's Office of Patient Centeredness and Quality Reporting and Analytics departments. Although Baylor All Saints Medical Center at Fort Worth does not have any projects directly related to patient satisfaction in the inpatient realm, one of our care navigation projects will most likely positively impact inpatient patient satisfaction. Baylor All Saints Medical Center at Fort Worth will expand existing data collecting systems, and optimize the old system for new reporting processes.

Baylor All Saints Medical Center at Fort Worth does not have any projects that directly address patient satisfaction measures in the inpatient setting. We do have projects in the ambulatory realm which will measure the impact of patient satisfaction. We do believe that the Care Connect project mentioned in the table below will help improve patient satisfaction scores in the inpatient setting through providing care coordination and continuity of care services.

Category 4	RD4- IP Pat Sat	
Cat 1, 2, & 3	4.1	4.2
135036506.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect	X	X
IT 9.2 ED appropriate utilization	X	X

We expect to see improvements in patient satisfaction for those patients who have engaged in the Care Connect program. Historically, we have not measured this impact of the program and thus do not have any data on the direct impact on patient satisfaction.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

All of the required reporting domains are pertinent in transforming the healthcare of RHP 10. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor All Saints Medical Center at Fort Worth, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Baylor All Saints Medical Center at Fort Worth/135036506
Unique RHP identification number: 135036506.4.6

Domain Descriptions:
Baylor All Saints Medical Center at Fort Worth will report all the measurements starting on the designated reporting year. Initial analysis of the current Baylor All Saints Medical Center at Fort Worth healthcare reporting system indicates further refinement and definition will be required for some of the required metrics. The reporting system has the capability to track and report the required measurements but will require additional work to get the exact required specifications. New system implementation and improvement of the current reporting infrastructure to fulfill reporting requirement for each of the 5 Category 4 domains will be carried out during DY2 and DY3. We anticipate having full Category 4 reporting capability by the end of DY3.

Baylor All Saints Medical Center at Fort Worth has the data infrastructure and processes to track admit decision time to discharge. Some modification may be required to satisfy the requirement of new reporting domain.

This domain only has 1 component which measures the time between admit decision to discharge in the ED. The majority of our projects are not physically located in the hospital other than our Care Connect program. We anticipate that if a patient is identified as a candidate for Care Connect in the ED, they can be triaged to community based or non-hospital based resource more quickly, leading to a shorter admit to discharge time duration.

Category 4	RD5-ED
135036506.2.3: Establish/Expand a Patient Care Navigation Program- Care Connect	X
IT 5.1 Improve cost savings	
IT 9.2 ED appropriate utilization	X

We expect that as the Care Connect program develops and expands that the time patients spend in the ED will decrease. Care Connect entails a comprehensive care coordination and case management system which can help to move patients to appropriate care settings more quickly.

Domain Valuation:

All Region 10 providers required to participate in Category 4 reporting have taken no more than the 10% allocation and forgone the optional reporting domain. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

All of the required reporting domains are pertinent in transforming the healthcare of RHP 10. Each domain focuses on outcomes that will positively impact the community and each of the performing providers. At Baylor All Saints Medical Center at Fort Worth, the rigor of data collection is the same for each domain. Thus, we valued each of the outcome domains at the same dollar amount.

Category 4: Population-Focused Measures *Baylor All Saints Medical Center at Fort Worth/135036506*				
	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	$ 177,606	$ 0		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 1 - Estimated Maximum Incentive Amount		$ 102,934	$ 88,093	$ 95,753
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1:10/1/ 2016-3/31/ 2017
Domain 2 - Estimated Maximum Incentive Amount		$102.934	$ 88,093	$ 95,753
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1: 10/1/ 2015-3/31/2016	1:10/1/ 2016-3/31/ 2017
Domain 3 - Estimated Maximum Incentive Amount			$ 88,093	$ 95,753
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Medication Management				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-	1: 10/1/ 2016-3/31/

			3/31/2016	2017
Domain 4 - Estimated Maximum Incentive Amount		$102,934	$ 88,093	$ 95,753
Domain 5: Emergency Department				
Measurement period for report		10/1/2013-9/30/2014	10/1/2014-9/30/2014	10/1/2015-9/30/2016
Planned Reporting Period: 1 or 2		1: 10/1/2014-3/31/2015	1: 10/1/ 2015-3/31/2016	1: 10/1/ 2016-3/31/ 2017
Domain 5 - Estimated Maximum Incentive Amount		$102,934	$ 88,093	$ 95,753
Grand Total Payments Across Category 4	$ 177,606	$ 411,737	$ 440,463	$ 478,764

THR Hurst-Euless-Bedford
136326908

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Texas Health Harris Methodist Hurst Euless Bedford/136326908
Unique RHP identification number: 136326908.4.2

Domain Descriptions:
Currently, all RD-1 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, Texas Health Harris Methodist HEB (THHEB) will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THHEB is not participating in Category 1 interventions.

Successful Category 2 interventions will lead to health care improvements throughout the waiver period. Implementation of a patient care navigation program (136326908.2.4) will facilitate patient navigation and positively impact all-cause admission rate for patients seeking medical care in the Texas Health network. Expanding diabetes specialty care and patient education in primary care settings (136326908.2.1) will reduce diabetes admission rate. Expanding current capacity for the heart failure clinic (136326908.2.2) will provide additional post-acute care for heart failure patients. Furthermore, integrating behavioral health services into primary care settings (136326908.2.3) will greatly increase primary and mental health care access for behavioral health and substance abuse patients. Interventions mentioned above will significantly improve all-cause PPA starting in DY4.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPA rate.

THHEB will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP

dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Texas Health Harris Methodist Hurst Euless Bedford/136326908
Unique RHP identification number: 136326908.4.3

Domain Descriptions:
Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THHEB will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THHEB is not participating in Category 1 interventions.

A mental health discharge management program will provide further improvement to reduce behavioral health and substance abuse readmission rate (136326908.2.3). Other Category 2 interventions will lead to health care improvements throughout the waiver period. Implementation of a patient care navigation program (136326908.2.4) will facilitate patient navigation and positively impact all-cause readmission rate for patients seeking medical care in the Texas Health network. Expanding diabetes specialty care and patient education in primary care settings (136326908.2.1) specifically will reduce diabetes readmission rate. Additionally, we expect the heart failure clinic (136326908.2.2) to have a significant impact on CHF readmission rate by providing additional post-acute care for heart failure patients.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPC rate.

THHEB will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP

dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Texas Health Harris Methodist Hurst Euless Bedford/136326908

Unique RHP identification number: 136326908.4.4

Domain Descriptions:

Currently, all RD-3 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THHEB will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THHEB is not participating in Category 1 interventions.

Category 2 interventions that will target specific THHEB healthcare practices to reduce PPC's include implementation of a patient care navigation program (136326908.2.4) to navigate patients to appropriate health care resources and assist those with chronic health care needs in receiving ongoing care.

Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through Category 1 and 2 interventions will feed back into Category 4 reporting measures and reduce the overall all-cause PPC rate.

THHEB will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:

THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Texas Health Harris Methodist Hurst Euless Bedford/136326908
Unique RHP identification number: 136326908.4.5

Domain Descriptions:
Currently, all RD-4 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THHEB will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THHEB is not participating in Category 1 interventions.

The only Category 2 intervention that will target this RD specifically is the heart failure clinic (136326908.2.2). A component of this project includes Medication Management as enhanced inpatient screening and discharge processes will verify completion of medication reconciliation and assist patient in understanding and/or obtaining necessary medications prior to discharge.

Patient satisfaction Category 3 outcomes and Category 4 reporting measures reinforce each other by sharing similar measurements. The initial reporting value in DY3 from Category 4 can serve as baseline measurements for Category 3 outcomes. In DY4 the improvements in Category 3 outcomes achieved through the successful administration of the heart failure clinic project will feed back into Category 4 reporting measures and improve overall patient satisfaction scores.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Texas Health Harris Methodist Hurst Euless Bedford/136326908
Unique RHP identification number: 136326908.4.6

Domain Descriptions:
Currently, all RD-5 measurements are being tracked and reported as public healthcare statistics. In conjunction with the HHSC-provided PPA/PPR/PPC numbers, THHEB will prepare its data systems for reporting this domain as well.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will take place during DY2 and DY 3 to optimize system compatibility to match new reporting demands. New protocols will be installed to ensure proper reporting functions. Initial reporting data can be used to establish baseline values for Category 1, and 2 projects, and Category 3 outcomes.

THHEB is not participating in Category 1 interventions.

Since this particular measure reports on the decision time to transfer an emergency patient to another facility and *not* the actual transport time, (decision to make the first call form arrival in transferring ED until call initiated) it is advisable that THR work closely with our Care Connect reporting to determine if additional data fields need to be build and collected so a report can be created to meet this NQF 0497 measure. During our preliminary review, it appears that we may be able to utilize a MU report that does capture NQF 0497 for all THR entities participating in MU. In addition, a clear time frame in which the reporting period should encompass needs to be stated clearly.

We expect the Patient Care Navigation project (136326908.2.3) to have a positive impact on this domain by helping to navigate patients to appropriate health care resources to assist those with chronic health care needs in receiving ongoing care.

THHEB will begin to report on all required measurements in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
THR has valued Category 4 at 15% of the total DSRIP allocation for this hospital. As a region, it was determined that each reporting domain was to be valued equally; thus, prescribed DSRIP dollars per DY were divided by the number of reporting domains to calculate the value for each domain and DY.

Reporting Domain 6: Children and Adult Core Measures

Performing Provider Name/TPI: Texas Health Harris Methodist Hurst Euless Bedford/136326908
Unique RHP identification number: 136326908.4.7

Domain Descriptions:
The child core measure is a domain that THR doesn't have an enough volume to reliably report or for the measurement to be stable and a domain that would not be statistically significant. THR does not meet the minimum volume requirements for publication of these measures by CMS.

Domain Valuation:
THR will not report on RD-6 and, as such, no value has been assigned to this domain.

Category 4: Population-Focused Measures Texas Health Harris Methodist Hurst Euless Bedford / 136326908				
	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	$65,697	$38,323.50		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$38,323.50	$41,060.89	$41,060.89
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$38,323.50	$41,060.89	$41,060.89
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$41,060.89	$41,060.89
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$38,323.50	$41,060.89	$41,060.89
Domain 5: Emergency Department				
Measurement period for report		10/1/2012-9/30/1/2013	10/1/2013-9/30/2014	10/1/2014-9/30/2015
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$38,323.50	$41,060.89	$41,060.89
OPTIONAL Domain 6: Children and Adult Core Measures				
Children Core Measures				

Percentage of Live Births Weighing less than 2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean Rate for Nulliparous Singleton Vertex				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Ambulatory Care: Emergency Department Visits				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Central-Line Associated Bloodstream Infections – Neonatal Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric Intensive Care Unit				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adults Core Measures				
Plan All-Cause Readmission				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Diabetes, Short-term Complications Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
COPD Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
CHF Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Adult Asthma Admission Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective Delivery				
Measurement period for report				

Planned Reporting Period: 1 or 2				
Antenatal Steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Care Transitions				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$65,697	$191,618	$205,304	$205,304

Children's Medical Center at Dallas
138910807

-Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.1

Domain Descriptions:

Children's has been reporting and tracking these statistics through Child Health Corporation of America (CHCA), now called Children's Hospital Association (CHA) for comparison with other stand-alone pediatric hospitals.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will occur during DY2 and DY3 to optimize system compatibility and to meet new reporting requirements. New processes will be implemented to ensure complete and accurate data collection. Category 1 and 2 projects and Category 3 outcomes will use available data to establish baseline and milestone metrics.

Children's successful implementation of Category 1 interventions will lead to health care improvements during and after the waiver period. Expanding MyChildren's hours at the Grapevine location (138910807.1.1) will improve access to care by making primary care office visits available outside of the regular office hours. Potentially Preventable Admissions can be avoided with regular primary care. Studies have shown that use of a pediatric nurse triage phone system (138910807.1.1) can reduce unnecessary trips to the emergency room by two thirds while increasing the use of the emergency department or urgent care in 15% of families who would have otherwise stayed at home. Appropriate escalation of care to the most effective setting will decrease the Potentially Preventable Admissions. By implementing disease management programs in the MyChildren's practice and in school-based clinics in RHP 10 (138910807.1.2), chronic diseases such as asthma can be managed locally with exacerbations of symptoms reduced and thus Potentially Avoidable Admissions prevented. Access to behavioral health services in the MyChildren's (138910807.1.3) will also decrease Potentially Preventable Admissions, particularly when coupled with disease management for chronic illness. Children with chronic illness are at much higher risk of increased incidence of mental illness which can result increased inpatient admissions.

The Category 2 project to transform the MyChildren's primary care office into a patient-centered medical home certified by the NCQA (138910807.2.1) will provide timely, effective, culturally sensitive primary care services which will reduce Potentially Preventable Admissions by proactively identifying and treating health issues which could result in hospital admissions.

Improvements in Category 3 outcomes will influence the Category 4 reporting measures by demonstrating the effects of proactively treating health concerns to avoid escalation of care needs including emergency room use and hospital admissions.

All Category 1 and 2 projects and Category 3 outcome measures will support improvements in Category 4 reporting measures including Potentially Preventable Admissions.

Children's will report on all pediatric-appropriate measures in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document and influence pediatric healthcare outcomes.

Reporting Domain 2: Potentially Preventable Readmissions:

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.2

Domain Descriptions:

Children's has been reporting and tracking these statistics through Child Health Corporation of America (CHCA), now called Children's Hospital Association (CHA) for comparison with other stand-alone pediatric hospitals.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will occur during DY2 and DY3 to optimize system compatibility and to meet new reporting requirements. New processes will be implemented to ensure complete and accurate data collection. Category 1 and 2 projects and Category 3 outcomes will use available data to establish baseline and milestone metrics.

Children's successful implementation of Category 1 interventions will lead to health care improvements for pediatric patients during and after the waiver period including long-term health improvements into adulthood. It is important that children receive appropriate outpatient follow-up care after a hospitalization. Anecdotally, discharges at Children's are often delayed due to the need to secure an outpatient follow-up post discharge, particularly for those patients on Medicaid, CHIP or uninsured. MyChildren's offices are placed in locations where there are limited number or no pediatricians who accept Medicaid and CHIP. Expanding MyChildren's hours at the Grapevine location (138910807.1.1) will make more appointments available at times convenient to parents thus increasing the ability to make a follow-up appointment post discharge and lessen the potential for a preventable readmission. Studies have shown that use of a pediatric nurse triage phone system (138910807.1.1) can increase the use of the emergency department for urgent care in 15% of families who would have otherwise stayed at home, unaware of the urgency of their child's medical condition. Appropriate escalation of care to the most effective setting post inpatient discharge will decrease the Potentially Preventable Readmissions. Many children are hospitalized for chronic disease conditions. Children can be enrolled in the disease management program through the MyChildren's practice and in school-based clinics in RHP 10 (138910807.1.2) during their inpatient stay. Post discharge, the chronic condition such as asthma can be managed locally with exacerbations of symptoms reduced and thus Potentially Avoidable Readmissions prevented. Access to behavioral health services in the MyChildren's (138910807.1.3) will also decrease Potentially Preventable Readmissions, particularly when coupled with disease management for chronic illness. Children with chronic

illness are at much higher risk of increased incidence of mental illness which can result in increased inpatient admissions.

The Category 2 project to transform the MyChildren's primary care office into a patient-centered medical home certified by the NCQA (138910807.2.1) will provide timely, effective, culturally sensitive primary care services. Since the medical home is designed to manage a child's medical condition holistically, missed follow-up appointments post discharge will be flagged for further contact with the family. Also, the medical home practice will be proactively following patients who have had a recent inpatient stay, thereby reducing Potentially Preventable Readmissions.

Improvements in Category 3 outcomes will influence the Category 4 reporting measures by demonstrating the effects of proactively treating health concerns to avoid escalation of care needs including emergency room use and hospital admissions and readmissions.

All Category 1 and 2 projects and Category 3 outcome measures will support improvements in Category 4 reporting measures including Potentially Preventable Readmissions.

Children's will report on all pediatric-appropriate measures in RD2 in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document, influence and improve pediatric healthcare outcomes.

Reporting Domain 3: Potentially Preventable Complications:

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.3

Domain Descriptions:

Children's has been reporting and tracking these statistics through Child Health Corporation of America (CHCA), now called Children's Hospital Association (CHA), for comparison with other stand-alone pediatric hospitals.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will occur during DY2 and DY3 to optimize system compatibility and to meet new reporting requirements. New processes will be implemented to ensure complete and accurate data collection. Category 1 and 2 projects and Category 3 outcomes will use available data to establish baseline and milestone metrics.

There are no DSRIP projects proposed by Children's that will directly influence outcomes for RD3. However, Children's successful implementation of Category 1 and Category 2 interventions will lead to health care improvements for pediatric patients during and after the waiver period including long-term health improvements into adulthood. One of the outcomes of the Category 1 and Category 2 interventions will be a more health-literate patient and family. Teaching families to be the advocates for their children's health will be of part of a patient-centered medical home (138910807.2.1), disease management (138910807.1.2) and behavioral health services (138910807.1.3). Families who are an active member of their child's health care team when that child is hospitalized can greatly influence and reduce Potentially Preventable Complications by questioning care providers and escalating concerns to receive appropriate intervention. By expanding MyChildren's hours at the Grapevine location (138910807.1.1) and making more appointments available at times convenient to parents, the likelihood of a potentially avoidable admission is decreased thereby eliminating potentially preventable complications during an inpatient stay. Studies have shown that use of a pediatric nurse triage phone system (138910807.1.1) can increase the use of the emergency department or urgent care in 15% of families who would have otherwise stayed at home, unaware of the urgency of their child's medical condition. Appropriate escalation of care to the most effective setting will decrease the potentially preventable admissions thereby eliminating the potential for complications during an inpatient stay.

All Category 1 and 2 projects and Category 3 outcome measures will support improvments in Category 4 reporting measures by improving health and patient/family health advocacy thereby reducing potentially preventable complications during an inpatient stay.

Children's will report on all pediatric-appropriate measures in RD3 in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document, influence and improve pediatric healthcare outcomes.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.4

Domain Descriptions:

Children's has been reporting and tracking these statistics through Child Health Corporation of America (CHCA), now called Children's Hospital Association (CHA) for comparison with other stand-alone pediatric hospitals.

All data collection and reporting processes will comply with HHSC and AHRQ guidelines. New implementations and modification of the current reporting system will occur during DY2 and DY3 to optimize system compatibility and to meet new reporting requirements. New processes will be implemented to ensure complete and accurate data collection. Category 1 and 2 projects and Category 3 outcomes will use available data to establish baseline and milestone metrics.

There are no DSRIP projects proposed by Children's that will directly influence outcomes in RD 4. However, Children's successful implementation of Category 1 and Category 2 interventions will lead to improvements for pediatric patients during and after the waiver period including long-term health improvements into adulthood. One of the outcomes of the Category 1 and Category 2 interventions will be a more health-literate patient and family. Teaching families to be the advocates for their children's health will be of part of a patient-centered medical home (138910807.2.1), disease management (138910807.1.2) and behavioral health services (138910807.1.3). Families who are an active member of their child's health care team when that child is hospitalized can be more satisfied with the care their child received while hospitalized and can be proactive in requesting medication reconciliation at discharge.

Improvements in Category 3 outcomes will influence the Category 4 reporting measures by demonstrating the effects of proactively treating health concerns to avoid escalation of care needs including emergency room use and hospital admissions and readmissions.

All Category 1 and 2 projects and Category 3 outcome measures will support improvements in Category 4 reporting measures by improving health and patient/family health advocacy thereby patient and family satisfaction and medication management during an inpatient stay.

Children's will report on all pediatric-appropriate measures in RD4 in compliance with the HHSC provided risk-adjusted 3M tool annually starting in DY3.

Domain Valuation:

As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document, influence and improve pediatric healthcare outcomes.

Reporting Domain 5: Emergency Department:

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.5

Domain Descriptions:

Children's Medical Center of Dallas is a designated Pediatric Level 1 trauma center. There are transfers of patients from Children's Emergency Department at its Legacy campus in Plano, TX (RHP 18) to the Dallas campus. It is extremely rare for a patient in Children's emergency department in Dallas to be transferred to another facility. Transfers primarily occur when adult patients present to Children's emergency department. All EMTALA guidelines are followed to triage and stabilize adult patients prior to transfer to an adult facility. There are no DSRIP projects associated with this reporting domain and therefore no measureable impact is expected for this domain related to the interventions.

Children's will report on the required measures annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document and influence pediatric healthcare outcomes.

Reporting Domain 6: Children and Adult Core Measures

Performing Provider Name/TPI: Children's Medical Center of Dallas/138910807
Unique RHP identification number: 138910807.4.6

Domain Descriptions:
Children's will participate in the optional Reporting Domain with separated measurement sets for children and adults. Since Children's is a pediatric facility, limited information will be available for the adult data set.

Children's does not provide prenatal or birthing services, therefore Measure 1 through 4 of the Initial Core Set of Children's Health Care Quality Measures will not be influenced by Children's Category 1 and 2 projects. Category 1 intervention 138910807.1.1 and Category 2 intervention 138908072.1 are based in the primary care environment and will positively influence Measures 5 through 18. Category 1 intervention 1389108071.2 provides expansion of disease management services and will positively influence Measures 20 and 22. Category 1 intervention 138910807.1.3 will increase behavioral health services and will positively impact Measures 21 and 23. The DSRIP projects are all designed to improve patient and family satisfaction and therefore should positively influence Measure 24. The DSRIP projects will not directly address Measure 19.

Children's will report on the required measures annually starting in DY3.

Domain Valuation:
As per HHSC and CMS guidelines, Children's has valued Category 4 at the maximum allowed values of 10% for DY2 and 15% for DY3, DY4 and DY5. This maximum valuation reflects Children's commitment to providing data to document and influence pediatric healthcare outcomes.

Category 4: Population-Focused Measures *Children's Medical Center of Dallas/138910807*				
	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	$93,750.00	$ 46,875.00		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$ 46,875.00	$ 46,875.00	$ 46,875.00
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$ 46,875.00	$ 46,875.00	$$ 46,875.00
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$ 46,875.00	$ 46,875.00
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1/1/2013 to 12/31/2013	1/1/2014 to 12/31/2014	1/1/2015 to 12/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		1/1/2013 to 12/31/2013	1/1/2014 to 12/31/2014	1/1/2015 to 12/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$ 46,875.00	$$ 46,875.00	$ 46,875.00

Domain 5: Emergency Department				
Measurement period for report		1/1/2013 to 12/31/2013	1/1/2014 to 12/31/2014	1/1/2015 to 12/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$ 46,875.00	$ 46,875.00	$ 46,875.00
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		1/1/2013 to 12/31/2013	1/1/2014 to 12/31/2014	1/1/2015 to 12/31/2015
Planned Reporting Period: 1 or 2		2	2	2
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)		$ 46,875.00	$ 46,875.00	$ 46,875.00
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$93,750	$281,250	$281,250	$281,250

Methodist Mansfield
186221101

Reporting Domain 1: Potentially Preventable Admissions:

Performing Provider Name/TPI: Methodist Mansfield Medical Center/186221101

Unique RHP identification number: 186221101.4.2

Domain Descriptions:

Currently, eight of the eight measurements are being tracked and reported in a form of public healthcare statistics. In addition, many DSRIP projects will provide interventions to Methodist Mansfield Medical Center patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Methodist Mansfield Medical Center will establish new protocols for data collecting and reporting, expand existing data collecting systems, and optimize old systems for new reporting processes.

The patient navigation program will reduce potentially preventable admissions for RD1.1 (CHF), RD1.2 (Diabetes), RD1.4 (COPD) and RD1.5 (Hypertension) by identifying frequent users of the ED who often use the ED as a care site for these chronic conditions. The navigator will present education and alternative care site solutions for these patients. The result should be better chronic care management and fewer admissions.

There will be improvements in DYs2-5 for the potentially preventable admissions category 4 measures.

Domain Valuation:

The value for each domain above is based on the combined efforts of Region 10 and Region 9 healthcare systems to perform research on empirical studies for potential value of each clinical condition on the cost of care, individual impact and community impact. The funding allocation for Category 4 compared to Categories 1-3 was weighted by 5% in DY2 and 10% in DY3-DY5 considering that Domain 6 will not be reported. The funding allocation is weighted more heavily in DY4 and DY5 to be consistent with the emphasis on outcome results.

The patient navigation program will provide services to all frequent users of the ED. Therefore the program will impact all of the clinical conditions identified in the domains above. The value of each domain was treated equally and the impact of the navigation program patients' treated will be consistent during DY2 to DY5.

Reporting Domain 2: Potentially Preventable Readmissions

Performing Provider Name/TPI: Methodist Mansfield Medical Center/186221101
Unique RHP identification number: 186221101.4.3

Domain Descriptions:
Currently, seven of the seven measurements are being tracked and reported in a form of public healthcare statistics. In addition, many DSRIP projects will provide interventions to Methodist Mansfield Medical Center patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Methodist Mansfield Medical Center will establish new protocols for data collecting and reporting, expand existing data collecting systems, and optimize old systems for new reporting processes.

The patient navigation program will reduce 30 day readmissions for RD1.1 (CHF), RD1.2 (Diabetes), RD1.4 (COPD) and RD1.5 (Hypertension) by identifying frequent users of the ED who often use the ED as a care site for these chronic conditions. The navigator will present education and alternative care site solutions for these patients. The result should be better chronic care management, fewer admissions and fewer readmissions.

There will be improvements in DYs2-5 for the potentially preventable 30 day readmissions category 4 measures.

Domain Valuation:
The value for each domain above is based on the combined efforts of Region 10 and Region 9 healthcare systems to perform research on empirical studies for potential value of each clinical condition on the cost of care, individual impact and community impact. The funding allocation for Category 4 compared to Categories 1-3 was weighted by 5% in DY2 and 10% in DY3-DY5 considering that Domain 6 will not be reported. The funding allocation is weighted more heavily in DY4 and DY5 to be consistent with the emphasis on outcome results.

The patient navigation program will provide services to all frequent users of the ED. Therefore the program will impact all of the clinical conditions identified in the domains above. The value of each domain was treated equally and the impact of the navigation program patients' treated will be consistent during DY2 to DY5.

Reporting Domain 3: Potentially Preventable Complications

Performing Provider Name/TPI: Methodist Mansfield Medical Center/186221101
Unique RHP identification number: 186221101.4.4

Domain Descriptions:
Currently, sixty-four of the sixty-four measurements are being tracked and reported in a form of public healthcare statistics. In addition, many DSRIP projects will provide interventions to Methodist Mansfield Medical Center patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Methodist Mansfield Medical Center will establish new protocols for data collecting and reporting, expand existing data collecting systems, and optimize old systems for new reporting processes.

The patient navigator and chronic condition – diabetes projects provide better resources and patient care pathways that will allow clinical care givers to impact the potentially preventable complications.

There will be improvements in DYs2-5 for the potentially preventable complications category 4 measures.

Domain Valuation:
The value for each domain above is based on the combined efforts of Region 10 and Region 9 healthcare systems to perform research on empirical studies for potential value of each clinical condition on the cost of care, individual impact and community impact. The funding allocation for Category 4 compared to Categories 1-3 was weighted by 5% in DY2 and 10% in DY3-DY5 considering that Domain 6 will not be reported. The funding allocation is weighted more heavily in DY4 and DY5 to be consistent with the emphasis on outcome results.

The patient navigation program will provide services to all frequent users of the ED. Therefore the program will impact all of the clinical conditions identified in the domains above. The value of each domain was treated equally and the impact of the navigation program patients' treated will be consistent during DY2 to DY5.

Reporting Domain 4: Patient-Centered Healthcare

Performing Provider Name/TPI: Methodist Mansfield Medical Center/186221101
Unique RHP identification number: 186221101.4.5

Domain Descriptions:
Currently, two of the two measurements are being tracked and reported in a form of public healthcare statistics. In addition, many DSRIP projects will provide interventions to Methodist Mansfield Medical Center patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Methodist Mansfield Medical Center will establish new protocols for data collecting and reporting, expand existing data collecting systems, and optimize old systems for new reporting processes.

The patient navigator and chronic condition – diabetes projects provide better resources and patient care pathways that will allow clinical care givers to impact the patient centered healthcare measures.

There will be improvements in DYs2-5 for the Patient Centered Healthcare category 4 measures.

Domain Valuation:
The value for each domain above is based on the combined efforts of Region 10 and Region 9 healthcare systems to perform research on empirical studies for potential value of each clinical condition on the cost of care, individual impact and community impact. The funding allocation for Category 4 compared to Categories 1-3 was weighted by 5% in DY2 and 10% in DY3-DY5 considering that Domain 6 will not be reported. The funding allocation is weighted more heavily in DY4 and DY5 to be consistent with the emphasis on outcome results.

The patient navigation program will provide services to all frequent users of the ED. Therefore the program will impact all of the clinical conditions identified in the domains above. The value of each domain was treated equally and the impact of the navigation program patients' treated will be consistent during DY2 to DY5.

Reporting Domain 5: Emergency Department

Performing Provider Name/TPI: Methodist Mansfield Medical Center/186221101
Unique RHP identification number: 186221101.4.6

Domain Descriptions:
Currently, the one measurement is being tracked and reported in a form of public healthcare statistics. In addition, many DSRIP projects will provide interventions to Methodist Mansfield Medical Center patients in multiple areas, resulting in improvement of PPAs throughout all measurements in the Reporting Domain. Currently, HHSC will make potentially preventable event data to providers. In addition, Methodist Mansfield Medical Center will establish new protocols for data collecting and reporting, expand existing data collecting systems, and optimize old systems for new reporting processes.

The patient navigator and chronic condition – diabetes projects provide better resources and patient care pathways that will allow clinical care givers to impact the decision time to admit in the emergency room.

There will be improvements in DYs2-5 for the Emergency Department category 4 measure.

Domain Valuation:
The value for each domain above is based on the combined efforts of Region 10 and Region 9 healthcare systems to perform research on empirical studies for potential value of each clinical condition on the cost of care, individual impact and community impact. The funding allocation for Category 4 compared to Categories 1-3 was weighted by 5% in DY2 and 10% in DY3-DY5 considering that Domain 6 will not be reported. The funding allocation is weighted more heavily in DY4 and DY5 to be consistent with the emphasis on outcome results.

The patient navigation program will provide services to all frequent users of the ED. Therefore the program will impact all of the clinical conditions identified in the domains above. The value of each domain was treated equally and the impact of the navigation program patients' treated will be consistent during DY2 to DY5.

Category 4: Population-Focused Measures *Methodist Mansfield Medical Center/186221101*				
	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	$36,923	$17,119		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$17,119	$18,314	$19,906
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$17,119	$18,314	$19,906
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			$18,314	$19,906
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		10/1/2013 – 9/30/14	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		10/1/2013 – 9/30/14	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$17,119	$18,314	$19,906
Domain 5: Emergency Department				
Measurement period for report		10/1/2013 – 9/30/14	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016
Planned Reporting Period: 1 or 2		2	2	2

Domain 5 - Estimated Maximum Incentive Amount		$17,119	$18,314	$19,906
Grand Total Payments Across Category 4	$36,923	$85,597	$91,568	$99,531

Glen Rose Medical Center
2016719901

Exempt

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Section VI: RHP Plan Certifications

Regional Healthcare Partnership

Region 10

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Signature	Name	Organization
	Kathleen Sweeney	Medical Center of Arlington

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Signature	Name	Organization
	LARRY TUBBS	COOK CHILDREN'S HEALTH CARE SYSTEM

FOR TARRANT COUNTY PUBLIC HEALTH

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Signature	Name	Organization
B. Glen Whitley	B. Glen Whitley	Tarrant County

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Signature	Name	Organization
[illegible]	DONNA MARTIN	MHMR of Tarrant County

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Signature	Name	Organization
	Kathleen Sweeney	North Hills Hospital

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Signature	Name	Organization
Kathleen Sweeney	Kathleen Sweeney	Plaza Medical Center Fort Worth

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Signature	Name	Organization
	KENNETH A. FINCH	Huguley Memorial Medical Ctr.

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Signature	Name	Organization
	Lillie Buggins	THF-W

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Signature	Name	Organization
	Brett S. McClung	Texas Health Southwest

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Signature	Name	Organization
	Christopher Lee	Texas Health Stephenville

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Signature	Name	Organization

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Signature	Name	Organization
	John Delaney	Lakes Regional MHMR

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Signature	Name	Organization
	David C Salisbury	JPS Health Network

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Signature	Name	Organization
[illegible]	Bob S. Gilley	Texas Health Methodist Hospital Azle

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Signature	Name	Organization
	Raymond "Roddy" Atkins	Helen Farabee Centers

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Signature	Name	Organization
	STEPHEN M SUMMERS	Wise Regional Health System

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Signature	Name	Organization
Kirk King	KIRK KING	TEXAS HEALTH ARLINGTON MEMORIAL

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[redacted]		
	Coke Beatty	Pecan Valley Centers

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Signature	Name	Organization
Blake Kretz	Blake Kretz	Texas Health Cleburne

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Signature	Name	Organization
	Fred Savelsbergh, CFO	Baylor All Saints Medical Center at Fort Worth

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[redacted]	[redacted]	[redacted]
[illegible]	Deborah A. Pegarelli	Texas Health HEB

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Signature	Name	Organization
	Ray Dziarinski, CFO	Children's Medical Center

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Signature	Name	Organization
	Scott Russ	UNTHSC

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Signature	Name	Organization
[illegible]	Tammy Walsh	JPS Physician Group

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Signature	Name	Organization
Michael J. Schaefer	Michael J. Schaefer	Methodist Mansfield Medical Center

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Region 10

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Signature	Name	Organization
	STEPHEN M SWAMEES	Wise Clinical Care Associates

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Region 10

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Signature	Name	Organization
[illegible]	Ray Reynolds	Glen Rose Medical Center

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Signature	Name	Organization
	Fred Savelsbergh, CFO	Baylor Medical Center at Waxahachie

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Signature	Name	Organization
	Fred Savelsbergh, CFO	Baylor Regional Medical Center at Grapevine

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Signature	Name	Organization
	Vee Gutierrez	Lake Granbury Medical Center

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Signature	Name	Organization
	XAVIER VILLARREAL	NAVARRO REGIONAL HOSP

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- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Signature	Name	Organization
Carol Bush	Carol Bush	Ellis County

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Region 10

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- 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.

[redacted]	Mike Ford	Somervell County

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Signature	Name	Organization
Darrell Cockerham	Darrell Cockerham	Hood County

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Region 10

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- 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
Roger Harmon	Roger Harmon - County Judge	Johnson Co.

12-10-12

Regional Healthcare Partnership

Region 10

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- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Signature	Name	Organization
B. Glen Whitley	B. Glen Whitley	Tarrant County

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- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Signature	Name	Organization
	A.M. Davenport, Jr.	Navarro County

Section VII. Addendums

Section VII. Addendums

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Appendix A:
Certifications

Please see hospital certifications in attached ZIP file for:
Children's Medical Center of Dallas
Glen Rose Medical Center
Cook Children's Medical Center
North Texas Community Hospital
Ennis Regional Medical Center

Please see governmental entity certifications in attached ZIP file for:
Lakes Regional MHMR
MHMR Tarrant County
Helen Farabee Centers
Pecan Valley Centers
Hood County
Navarro County
Tarrant County
Ellis County
Somervell County
JPS Physician Group
Decatur Hospital Authority dba Wise Regional Health System
Wise Clinical Care Associates

Appendix B:
DSRIP Projects Considered But Not Selected

Category 1 and 2 Projects Considered		
Project Label	**Provider**	**Project Title**
1.7.1	Medical Center of Arlington	Introduce, Expand or Enhance Telemedicine/Telehealth
2.9.X	Medical Center of Arlington	Establish/Expand a Patient Care Navigation Program
1.7.1	North Hills Hospital	Introduce, Expand or Enhance Telemedicine/Telehealth
2.12.2	North Hills Hospital	Implement/Expand Care Transition Programs
2.4.1	North Hills Hospital	Redesign to Improve Patient Experience
2.9.x	North Hills Hospital	Establish/Expand a Patient Care Navigation Program
1.7.1	Plaza Medical Center Fort Worth	Introduce, Expand or Enhance Telemedicine/Telehealth
2.12.2	Plaza Medical Center Fort Worth	Implement/Expand Care Transition Programs
2.9.x	Plaza Medical Center Fort Worth	Establish/Expand a Patient Care Navigation Program
2.7.1	Tarrant County Public Health	West Nile Virus Surveillance Project
2.7.2	Tarrant County Public Health	Tobacco Intervention Education
2.9.2	Tarrant County Public Health	TN nurse navigator
1.1.1	Texas Health Harris Methodist Hospital Azle	Walk-in-Care Center
2.2.1	Texas Health Harris Methodist Hospital Azle	Health Education and Lifestyles Program and the Chronic Disease Self-Management Program
2.8.11	Texas Health Harris Methodist Hospital Hurst Euless Bedford	Implementation of the sepsis resuscitation bundle
2.11.C	THR – Huguley Memorial Medical Center	Medication Management
2.1.1	Wise Regional Health System	Enhance/Expand Medical Homes: Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards
1.1.1	Baylor Waxahachie	Create Primary Care Capacity- Establish Primary Care Clinic Space
1.9.8	Baylor Waxahachie	Improve Access to Specialty Care
2.2.4	Baylor Waxahachie	Chronic Disease Management and Prevention Programs
2.6.1	Cook's children	Build on Cook Children's branded "Checkup Challenge" working with the Boys and Girls Club of Greater Fort Worth, The LaDainian Tomlinson Touching Lives Foundation and the Fort Worth Independent School District After-school Program to combat Childhood OBESITY by promoting healthy lifestyle behaviors using on-line self-reporting augmented with social media and text messaging. Expand outside of Tarrant County to the other Region 10 Counties upon demonstrated success.
2.6.2	Cook's children	Develop a plan to improve the use of individualized asthma action plans (home management plan of care documentation) to all families and caregivers following National Heart, Lung and Blood Institute [NHLBI] guidelines. Begin as a demonstration project in a targeted population and expand to the other Region 10 Counties upon demonstrated success.
1.7.2	HCA MCA	Provide patient consultations using telecommunications
2.1.9	HCA MCA	Implement other evidence-based project to enhance primary care capacity in an innovative manner, (Implement a coverage plan for

		patients for expanding medical home access.)
2.8.3	HCA MCA	Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
2.9.2	HCA MCA	Establish/expand health care navigation services
2.12.4	HCA MCA	Implement discharge planning and post discharge support program
1.7.2	HCA NHH	Provide patient consultations using telecommunications
2.1.9	HCA NHH	Implement other evidence-based project to enhance primary care capacity in an innovative manner, (Implement a coverage plan for patients for expanding medical home access.)
2.8.3	HCA NHH	Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
2.9.2	HCA NHH	Establish/expand health care navigation services
2.12.4	HCA NHH	Implement discharge planning and post discharge support program
1.7.2	HCA PMC	Provide patient consultations using telecommunications
2.1.9	HCA PMC	Implement other evidence-based project to enhance primary care capacity in an innovative manner, (Implement a coverage plan for patients for expanding medical home access.)
2.8.3	HCA PMC	Design, develop, and implement a program of continuous, rapid process improvement that will address issues of safety, quality, and efficiency.
2.9.2	HCA PMC	Establish/expand health care navigation services
2.12.4	HCA PMC	Implement discharge planning and post discharge support program
1.10.3	MHMRTC	Enhance improvement capacity within systems
1.11.8	MHMRTC	Develop administrative and clinical protocols that will serve as a manual of telemedicine or telehealth operations.
1.11.9	MHMRTC	Conduct a small scale pilot of the telehealth, telemonitoring, telementoring, or telemedicine operations to ensure that the procedures and processes spelled out in the protocol are working as intended. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications.
1.14.2	MHMRTC	Develop plan to remediate gaps identified and data reporting mechanism to assess progress toward goal.
2.13.4	MHMRTC	Design models which include an appropriate range of community-based services and residential supports.
2.13.4	MHMRTC	Design models which include an appropriate range of community-based services and residential supports.
2.13.4	MHMRTC	Design models which include an appropriate range of community-based services and residential supports.
2.13.4	MHMRTC	Expand and enhance the capacity of behavioral health to better meet the needs of the population.
2.13.4	MHMRTC	Design models which include an appropriate range of community-based services and residential supports.
2.15.2	MHMRTC	Facilitate the development of provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.
2.19.5	MHMRTC	Identify and implement specific disease management guidelines for high prevalence disorders, e.g., cardiovascular diseased, diabetes, depression, asthma

1.9.8	Pecan Valley	Improve Access to specialty care (psychiatry)
2.15.1	Pecan Valley	Identify sites for integrated projects, which would have the potential to benefit a significant number of patients in the community
1.1.3	TCPH	Expand primary clinical hours
1.1.4	TCPH	Expand primary clinical staffing
2.6.A	TCPH	Implement evidence-based health promotion programs
2.12.2	TCPH	Integrate information systems that continuity of care for patients is enabled
2.7.H	TCPH	Engage Community Health Workers in evidence-based programs to increase health literacy of the targeted population
2.7.2	TCPH	Implement innovative evidence-based strategies to reduce tobacco use. (Tobacco Intervention Education- TIE)
2.9.1	TCPH	Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care
2.9.4	TCPH	Connect patients to primary and preventive care
2.9.5	TCPH	Increase Access to care management and or chronic care management including education in chronic disease self-management
3.1.x	TCPH	Implement the sepsis resuscitation bundle, Management Bundle, Assess resulting improvements
3.7.x	TCPH	Implement evidence-based clinical services strategies and referrals for targeted populations, facilitating disease intervention and prevention.
3.4.x	TCPH	Chronic Disease Self-Management Program using Community Health Workers
2.11.C	THR – Huguley Memorial Medical Center	Implement a medication management program
3.5.B	THR – Huguley Memorial Medical Center	Pre-39 week elective inductions
2.2.1	THAM	Redesign the outpatient delivery system to coordinate care for patients with Diabetes
2.9.1	THAM	Provide navigation services to targeted patients who are at high risk of disconnect
3.1.1	THAM	Severe Sepsis Resuscitation and Management
1.1.D	THAZ	Expand primary care clinic staffing
2.2.A	THAZ	Increase Training of Primary Care Workforce
3.1.1	THAZ	Severe Sepsis Resuscitation and Management
3.1.1	THC	Severe Sepsis Resuscitation and Management
2.9.1	THHEB	Provide navigation services to targeted patients who are at high risk of disconnect
3.1.A	THHEB	Severe Sepsis Resuscitation and Management
3.1.A	THS	Severe Sepsis Resuscitation and Management
1.1.1	Wise Regional Health System	Establish more primary care clinics
1.1.3	Wise Regional Health System	Expand primary care clinic hours
1.3.1	Wise Regional Health System	Implement/Enhance and utilize chronic disease management registry functionalities
1.7.2	Wise Regional Health System	Provide patient consultations using telecommunications
1.7.4	Wise Regional Health System	Establish a telehealth program/network to provide additional health care services based on population need
1.9.4	Wise Regional Health System	Establish or expand initiatives to increase the availability of

		targeted specialty providers__
2.1.3	Wise Regional Health System	Conduct feasibility studies to determine the necessary steps to achieve NCQA PCMA status
2.4.1	Wise Regional Health System	Organizational integration and prioritization of patient experience
2.7.1	Wise Regional Health System	Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations
2.12.4	Wise Regional Health System	Implement discharge planning program and post discharge support program
2.12.5	Wise Regional Health System	Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers and home care providers
1.1	Baylor All Saints	Baylor Community Care- Community Patient Expansion
1.2A	Baylor Waxahachie	Create Primary Care Capacity
1.3	Baylor Waxahachie	Specialty Care Access Expansion
2.4A	Baylor Waxahachie	Chronic Disease Management and Wellness Program
3.2G	Cook's children	Diagnosis and management of asthma
6.1	Cook's children	Engage in population based campaigns or programs to promote healthy lifestyle using evidence-based methodologies including social media and text messaging in an identified population.
1.9.8	Glen Rose	Improve access to specialty care
1.10.1	Glen Rose	Enhance improvement capacity within people
2.8.1	Glen Rose	Provide training and education to clinical and administrative staff on process improvement strategies, methodologies and culture
1.7A	HCA MCA	Expand/Establish telemedicine
1.8B	HCA MCA	Implement HIPAA 5010 transaction sets and convert to ICD-10 code sets
2.2	HCA MCA	Implement other evidence-based project to develop or enhance patient-centered medical home model
2.7A	HCA MCA	Establish/Expand a patient navigation care program
2.12D	HCA MCA	Implement discharge planning and post discharge support program
1.7A	HCA NHH	Expand/Establish telemedicine
1.8B	HCA NHH	Implement HIPAA 5010 transaction sets and convert to ICD-10 code sets
2.2	HCA NHH	Implement other evidence-based project to develop or enhance patient-centered medical home model
2.7A	HCA NHH	Establish/Expand a patient navigation care program
2.12D	HCA NHH	Implement discharge planning and post discharge support program
1.7A	HCA PMC	Expand/Establish telemedicine
1.8B	HCA PMC	Implement HIPAA 5010 transaction sets and convert to ICD-10 code sets
2.2	HCA PMC	Implement other evidence-based project to develop or enhance patient-centered medical home model
2.7A	HCA PMC	Establish/Expand a patient navigation care program
2.12D	HCA PMC	Implement discharge planning and post discharge support program
1.1B	Helen Farabee	Expand Behavioral Health Capacity
9	Helen Farabee	Expand Specialty Care Capacity
11.5E	Helen Farabee	Expand Behavioral Health Capacity
2.6A	MHMRTC	Expand and enhance the capacity of behavioral health to better meet the needs of the population (Intensive Support)
2.6A	MHMRTC	Expand and enhance the capacity of behavioral health to better meet the needs of the population (CRU Expansion)

2.6A	MHMRTC	Expand and enhance the capacity of behavioral health to better meet the needs of the population (Telemedicine)
2.6A	MHMRTC	Expand and enhance the capacity of behavioral health to better meet the needs of the population (Law Liaison)
2.6A	MHMRTC	Expand and enhance the capacity of behavioral health to better meet the needs of the population
2.6A	MHMRTC	Expand and enhance the capacity of behavioral health to better meet the needs of the population (Detox Unit Expansion)
2.8B	MHMRTC	Implement continuous performance improvement in order to improve efficiencies, improve quality, improve experience, reduce inefficiencies, and eliminate waste and redundancies. – Measure continuous improvement
1.9.8	Pecan Valley	Improve access to specialty care (psychiatry)
2.5B	Pecan Valley	Co-locate Primary and Behavioral Health care Services
2.11.3	THR – Huguley Memorial Medical Center	Implement a medication management program
3.5.2	THR – Huguley Memorial Medical Center	Pre-39 Week Elective Inductions
3.3.8	THR – Huguley Memorial Medical Center	PPA/Influenza Screening and Immunization
2.9.1	THAM	Provide navigation services to targeted patients who are at high risk of disconnect
3.3.B	THAM	Potentially Preventable Readmissions: Congestive Heart Failure Readmission rate
3.2.I	THAM	Influenza Vaccination
2.2.2	THAM	Establish Diabetes Management Program
3.3.2	THAM	Congestive Heart Failure Readmission Rate – identification of baseline rates, priority areas, interventions and milestones
3.1.1	THAM	Severe Sepsis Resuscitation and Management
3.1.1	THAZ	Implementation of the Sepsis Resuscitation Bundle
3.3.8	THAZ	Influenza Vaccination
3.3.2	THAZ	Reduce Preventable Readmissions for CHF/ Hypertension/ Diabetes and Hyperlipidemia Patients
3.3.8	THC	Influenza Immunization
3.3.2	THC	Potentially Preventable Readmissions
3.1.1	THC	Implementation of the Sepsis Resuscitation Bundle
2.9.1	THFW	Expand and develop the ED Liaison Collaboration
3.3.8	THFW	Influenza Vaccination
3.1 A-C	THHEB	Implement Sepsis Bundle, Assess Reliability Through the Assessment of Process Measures, and Measure Outcomes
3.3.8	THHEB	Influenza Vaccination
3.3.1	THHEB	Severe Sepsis Resuscitation and Management
2.9.2	THS	Provide navigation services to targeted patients who are at high risk of disconnect
3.1.1	THS	Severe Sepsis Resuscitation and Management
3.3.2	THS	Potentially Preventable Readmissions/CHF
3.3.8	THS	Influenza Vaccination
3.3.8	THSW	Influenza Vaccination
3 ii	UNTHSC	Preventing re-hospitalizations for vulnerable adults
3	UNTHSC	Potentially Preventable Admissions

1.1	Baylor All Saints	Baylor Community Care Community-Patient Expansion
2.7	Baylor – TBD	Expansion of Vulnerable Patient Network (VPN) Program
2.13F	Cook's children	Build on Cook Children's branded "Checkup Challenge" working with the Boys and Girls Club of Greater Fort Worth, The LaDainian Tomlinson Touching Lives Foundation and the Fort Worth Independent School District After-school Program to combat Childhood OBESITY by promoting healthy lifestyle behaviors using on-line self-reporting augmented with social media and text messaging. Expand outside of Tarrant County to the other Region 10 Counties upon demonstrated success.
3.2G	Cook's Children	Individualized Pediatric Asthma Action Plan [Home Management Plan of Care Document] Given to Patient / Caregiver following NHLBI guidelines
3.5.A-C	Ennis Regional	Perinatal Outcomes
1.8C	Glen Rose	Implement processes and environmental changes to enhance coding and documentation of diagnoses, procedures, and process and outcome measure
1.9A	Glen Rose	Identify high impact/most impacted specialty services and gaps in care coordination and expand high impact specialty care capacity in most impacted medical specialties
1.10A	Glen Rose	Enhance improvement capacity with technology
2.2F	Glen Rose	Apply a care management model to patients identified as having high-risk health care needs
2.6A	Glen Rose	Expand and enhance the capacity of behavioral health to better meet the needs of the population
2.7B	Glen Rose	Provide navigation services to targeted patients who are at high risk of disconnect as well as identify frequent ED utilizers and use navigators as part of a preventable ED reduction program.
2.8B	Glen Rose	Measure continuous improvement
2.9A-C	Glen Rose	Analyze ED throughput, Increase ED throughput and Develop and implement ED triage protocol
2.12A	Glen Rose	Develop standardized clinical protocols and care delivery model
1.7A	HCA MCA	Expand/Establish Telemedicine/Telehealth Program to help fill significant gaps in service
1.8B	HCA MCA	Implement HIPAA 5010 transaction sets and convert to ICD 10 codes.
2.7A	HCA MCA	Establish/expand health care navigation services
2.12A	HCA MCA	Implement discharge planning and postdischarge support program
3.2	HCA MCA	Potentially Preventable Admissions: Congestive Heart Failure
1.7A	HCA NHH	Expand/Establish Telemedicine/Telehealth Program to help fill significant gaps in service
1.8B	HCA NHH	Implement HIPAA 5010 transaction sets and convert to ICD 10 codes.
2.7A	HCA NHH	Establish/expand health care navigation services
2.12A	HCA NHH	Implement discharge planning and postdischarge support program
3.2	HCA NHH	Potentially Preventable Admissions: Congestive Heart Failure
1.7A	HCA PMC	Expand/Establish Telemedicine/Telehealth Program to help fill significant gaps in service
1.8B	HCA PMC	Implement HIPAA 5010 transaction sets and convert to ICD 10 codes.
2.7A	HCA PMC	Establish/expand health care navigation services
2.12A	HCA PMC	Implement discharge planning and postdischarge support program
3.2	HCA PMC	Potentially Preventable Admissions: Congestive Heart Failure

1.4.11	JPS	Enhance service availability (i.e., hours, clinic locations, transportation, and mobile clinics) to appropriate levels of care.
2.4.12	JPS	Develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days
1.1C	Lake Granbury	Bring Gero Psych to Granbury. Construct 10 room unit to service population
1.1D	Lake Granbury	Provide a Crisis/Stabilization unit in Granbury
1.2A	Lake Granbury	School Clinical Program with Granbury ISD
1.3C	Lake Granbury	Bring Teleneuro to Granbury
2.1A	Lake Granbury	Develop Care Coordinator Model
2.6A.i	MHMRTC	Expand Behavioral Health Access
2.6A.vii	MHMRTC	Law Liaison
2.6D	MHMRTC	Develop a Medical Home
2.6J.i	MHMRTC	Telemedicine
2.6J.ii	MHMRTC	Crisis Residential Unit Expansion
2.6J.iii	MHMRTC	Intensive Support Team
2.10B	MHMRTC	Data Driven Decision Making
2.6C	Pecan Valley	Develop individual care management strategies to improve access and coordination
2.6E	Pecan Valley	Train primary care providers in behavioral health care
1.12B	TCPH	Integrate information so that the continuity of care is enabled
2.13HG	TCPH	Community Health Workers
2.11C	THR – Huguley Memorial Medical Center	Implement a medication management program
3.5B	THR – Huguley Memorial Medical Center	Pre-39 Week Elective Inductions
2.2A	THR	Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes
2.7A	THR	Identify frequent ED utilizers and use navigators as part of a preventable ED reduction program.
3.3B	THR	Reduce Preventable Readmissions for CHF patients
2.13D i	UNTHSC	Reduce costs associated with poor birth outcomes
2.2D	UNTHSC	Maximizing Adherence and Treatment Efficacy in Cancer Care
2.6J	UNTHSC	Integrate Physical and Behavioral Health Care
2.12D	UNTHSC	Expand Care Transitions Program
1.1C	Wise Regional Health System	Expand primary care clinic hours
1.7A	Wise Regional Health System	Expand/establish telemedicine/telehealth program to help fill significant gaps in services
1.8C	Wise Regional Health System	Improve coding and documentation for ICD-10
1.9B	Wise Regional Health System	Expand high impact specialty care capacity in most impacted medical specialties
2.1B	Wise Regional Health System	Establish/Expand Medical Homes
2.2D	Wise Regional Health System	Expand Chronic Care Management Models
2.6A	Wise Regional Health System	Expand and enhance the capacity of behavioral health to better meet the needs of the population
2.7A	Wise Regional Health System	Establish/expand health care navigation services

Appendix C: Affiliation Agreements

C-1: Signed agreements of small hospitals participating in a collaboration in Pass 1 as allowed in the PFM Protocol, paragraph 25.c.iii.

Please see the attached addendums for affiliation agreements from:

- Wise Regional Medical Center and North Texas Community Hospital
- Baylor All-Saints Medical Center Fort Worth, Baylor Regional Medical Center at Grapevine, and Baylor Medical Center at Waxahachie

C-2: Signed agreements of Tier 3 and 4 Performing Providers that combined their Pass 1 allocations as allowed in the PFM Protocol, paragraph 25.c.iv.

Not applicable for Region 10 RHP.

C-3: Signed agreements of Performing Providers that combined their Pass 2 allocations as allowed in the PFM Protocol, paragraph 25.d.iii.

- Wise Regional Health System and Wise CCA

Appendix D:
Additional Community Health Needs Assessment Information

D-1: Community Profile

Figure D-1.1 Map of Region 10 Area

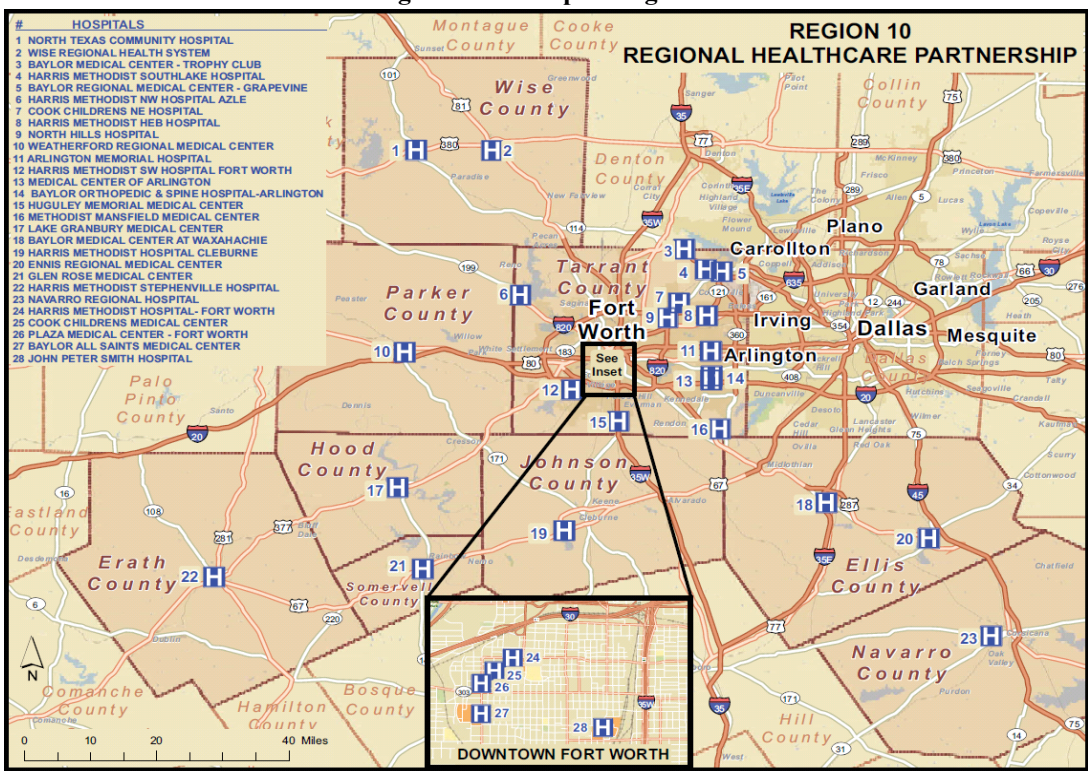

Figure D-1.2: 2010 Population by Race and Ethnicity

	White	Hispanic/ Latino	Black	Asian / Pacific Islander	American Indian / Alaska Native	Two or more races	Other
U.S.	64.0%	16.0%	12.0%	5.0%	1.0%	2.0%	7.0%
Texas	42.0%	40.0%	11.0%	5.0%	0%	1.0%	6.0%
RHP 10	57.9%	24.4%	11.9%	3.8%	0.4%	1.6%	0.1%
Ellis	65.5%	23.5%	8.8%	0.6%	0.4%	1.1%	0.1%
Erath	77.5%	19.2%	1.1%	0.6%	0.4%	0.9%	0.0%
Hood	87.1%	10.2%	0.4%	0.7%	0.6%	0.9%	0.1%
Johnson	76.6%	18.1%	2.5%	0.9%	0.5%	1.3%	0.1%
Navarro	59.9%	23.8%	13.6%	1.3%	0.3%	1.0%	0.1%
Parker	85.3%	10.6%	1.6%	0.5%	0.7%	1.3%	0.1%
Somervell	77.7%	19.2%	0.6%	0.5%	0.5%	1.2%	0.3%
Tarrant	51.8%	26.7%	14.5%	4.8%	0.4%	1.7%	0.1%

Wise	79.7%	17.1%	1.0%	0.4%	0.6%	1.2%	0.1%

Source: United States Census Bureau 2010, Kaiser Health Foundation, 2010

Figure D-1.3: 2011 National and State Totals and RHP 10 Population by Age, 2011 Current and 2016 Projections

	Total Population for 2011											
U.S.	**311,591,917**											
Texas	**25,674,681**											
	Total Population			**Children (0-18 years)**			**Adult (18-64 years)**			**Seniors (65+ years)**		
	2011	**2016**	**Δ%**	**2011**	**2016**	**Δ%**	**2011**	**2016**	**Δ%**	**2011**	**2016**	**Δ%**
U.S.				75,596,680	78,091,453		193,707,411	197,037,935		41,346,659	47,902,230	
Texas				7,091,699	7,607,608		15,645,996	16,527,932		2,697,616	3,258,281	
RHP 10	**2,444,642**	**2,674,022**	**9%**	**683,196**	**743,625**	**9%**	**1,518,294**	**1,622,314**	**7%**	**244,752**	**308,083**	**26%**
Ellis	163,972	186,721	14%	48,230	53,234	10%	100,752	111,620	11%	16,590	21,867	32%
Erath	35,565	36,944	4%	8,327	8,713	5%	22,671	23,105	2%	4,567	5,126	12%
Hood	54,128	59,318	10%	11,967	13,220	10%	31,304	32,935	5%	10,857	13,163	21%
Johnson	170,881	187,136	10%	46,151	49,439	7%	104,660	112,358	7%	20,070	25,339	26%
Navarro	49,839	51,961	4%	13,397	13,894	4%	29,444	30,181	3%	6,998	7,886	13%
Parker	107,263	119,320	11%	27,583	29,303	6%	66,506	72,563	9%	13,174	17,454	32%
Somervell	7,584	8,188	8%	1,988	2,047	3%	4,419	4,698	6%	1,177	1,443	23%
Tarrant	1,797,679	1,961,608	9%	510,706	558,225	9%	1,122,631	1,196,495	7%	164,342	206,888	26%
Wise	57,731	62,826	9%	14,847	15,550	5%	35,907	38,359	7%	6,977	8,917	28%

*Data pending Source: Thomson Reuters, 2011**311,591,91725,674,681**

Figure D-1.4: Population by Education, 2010

	Non-High School Graduate	High School Diploma	Bachelor's Degree	Graduate Education
U.S.	14.4%	49.8%	17.7%	10.4%
Texas	19.3%	48.4%	17.3%	8.6%
RHP 10	**16.9%**	**54.9%**	**15.5%**	**6.2%**
Ellis	17.0%	55.2%	15.0%	6.0%
Erath	20.5%	51.1%	16.3%	7.7%
Hood	13.8%	55.5%	16.8%	7.1%
Johnson	18.4%	59.6%	11.8%	4.3%
Navarro	23.6%	54.1%	10.3%	5.4%
Parker	12.6%	57.6%	15.4%	6.9%
Somervell	12.7%	51.7%	22.5%	5.9%
Tarrant	16.0%	48.4%	20.1%	8.5%
Wise	17.4%	60.7%	11.7%	4.2%

Source: U.S. Census Bureau

D-2: Health care Infrastructure

Figure D-2.1: Current Physician Supply (FTE) vs. Projected Physician Demand (% Increase from 2010-2015)

	RHP 10		Ellis		Erath		Hood		Johnson		Navarro		Parker		Somervell		Tarrant		Wise	
	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand	2011 # Physicians	Projected Demand
Allergy/Immunology	22	30%	0	31%	0	40%	0	29%	1	27%	1	35%	0	29%	0	28%	21	28%	0	27%
Cardio/Thoracic Surgery	19	33%	0	36%	0	33%	0	29%	0	32%	0	33%	0	34%	0	31%	19	35%	0	33%
Cardiology	118	34%	1	41%	2	22%	2	27%	6	37%	1	23%	1	40%	0	28%	105	40%	1	37%
Colorectal Surgery	15	32%	1	32%	0	42%	0	30%	0	30%	0	41%	0	31%	0	31%	14	31%	0	30%
Dermatology	58	30%	0	34%	0	26%	1	26%	2	30%	3	26%	0	32%	0	26%	52	31%	0	30%
Emergency/Critical Care	212	27%	6	26%	0	31%	3	30%	10	25%	5	31%	9	25%	0	28%	176	26%	4	28%
Endocrinology	20	31%	0	31%	0	43%	0	30%	2	29%	0	39%	0	30%	0	31%	18	29%	0	29%
Gastroenterology	77	32%	1	32%	0	40%	1	30%	5	30%	2	39%	2	31%	0	31%	65	31%	0	30%
General Surgery	149	32%	7	34%	5	28%	2	28%	8	32%	2	31%	4	33%	0	27%	117	34%	5	32%
General/Family Practice	737	31%	35	33%	10	31%	15	27%	33	30%	9	31%	23	31%	4	27%	587	32%	22	30%
Hematology/Oncology	69	34%	0	40%	0	26%	2	28%	2	36%	0	26%	3	39%	0	30%	62	38%	1	35%
Infectious Disease	17	32%	0	34%	0	36%	0	29%	0	31%	0	35%	0	33%	0	30%	17	33%	0	32%
Internal Medicine	489	32%	19	35%	8	33%	10	28%	23	32%	5	32%	10	34%	2	29%	408	34%	5	33%
Nephrology	44	34%	0	39%	0	28%	0	29%	0	36%	1	28%	0	38%	0	30%	42	38%	1	35%
Neurology	61	32%	0	34%	1	34%	0	28%	0	31%	0	33%	2	33%	0	28%	58	33%	1	32%
Neurosurgery	34	31%	0	32%	0	41%	0	29%	0	29%	0	39%	0	30%	0	30%	34	31%	0	29%
Obstetrics/Gynecology	290	36%	8	36%	3	49%	4	30%	11	34%	4	43%	6	35%	0	30%	249	37%	5	36%
Ophthalmology	83	33%	2	38%	2	30%	2	28%	2	34%	2	29%	2	36%	1	30%	70	36%	0	34%
Orthopedic Surgery	172	32%	5	34%	3	37%	4	29%	6	31%	1	35%	5	32%	0	29%	144	33%	5	31%
Other Pediatric Subspecialti	37	26%	0	29%	0	28%	0	27%	0	25%	0	23%	0	25%	0	20%	37	26%	0	23%
Otolaryngology	54	32%	3	33%	1	41%	2	30%	3	30%	1	37%	1	31%	1	29%	43	31%	1	30%
Pain Management	17	32%	2	34%	0	33%	0	29%	0	32%	0	34%	0	34%	0	30%	15	34%	0	32%
Pediatric Cardiology	15	27%	0	30%	0	30%	0	28%	0	26%	0	25%	0	26%	0	21%	15	27%	0	24%
Pediatric EMCC	46	22%	0	24%	0	20%	0	23%	0	22%	0	16%	0	20%	0	15%	46	23%	0	18%
Pediatric Endocrinology	4	26%	0	29%	0	28%	0	27%	0	25%	0	23%	0	25%	0	20%	4	26%	0	23%
Pediatric Pulmonology	6	26%	0	29%	0	27%	0	27%	0	25%	0	23%	0	25%	0	20%	6	26%	0	23%
Pediatrics	287	26%	14	30%	3	27%	5	27%	9	25%	4	23%	7	25%	0	21%	241	26%	4	23%
Physical Medicine/Rehab	53	32%	5	33%	0	36%	0	29%	1	31%	0	35%	0	33%	0	30%	46	32%	1	31%
Plastic Surgery	40	30%	0	30%	0	39%	0	30%	2	28%	0	37%	0	29%	0	29%	37	28%	1	28%
Psychiatry	139	30%	2	28%	2	52%	0	31%	5	26%	0	44%	4	27%	0	30%	125	27%	2	26%
Pulmonology	50	33%	0	37%	0	32%	1	29%	4	33%	1	31%	1	36%	0	30%	42	35%	1	33%
Radiology	191	*	0	*	2	*	3	*	3	*	2	*	7	*	0	*	171	*	2	*
Rheumatology	20	32%	0	35%	0	35%	0	29%	1	32%	0	33%	1	34%	0	30%	18	33%	0	32%
Urology	65	34%	2	37%	1	36%	1	29%	1	34%	3	33%	1	36%	0	30%	55	36%	1	33%
Vascular	16	35%	0	40%	1	26%	0	29%	1	37%	0	27%	0	40%	0	30%	14	38%	0	36%

Source: Thompson Reuters, 2011

Figure D-2.2: Regional Stakeholder Survey Summary Results

The Regional stakeholder survey was distributed to participants during the months of April and June to solicit feedback on access to care, care coordination and population health.

REGIONAL STAKEHOLDER SURVEY SUMMARY

Region 10 RHP Community Health Needs Assessment

June 2012

Stakeholder Survey

- Designed to gather qualitative information and feedback to evaluate the health care system within Region 10
- Represents feedback from broad spectrum of stakeholders, focusing on barriers to care, access and health care issues pertinent to the Region 10 RHP planning process
- Surveys were collected over a period of one month, using a web-based survey tool
- The survey is the first step in the community health needs assessment process

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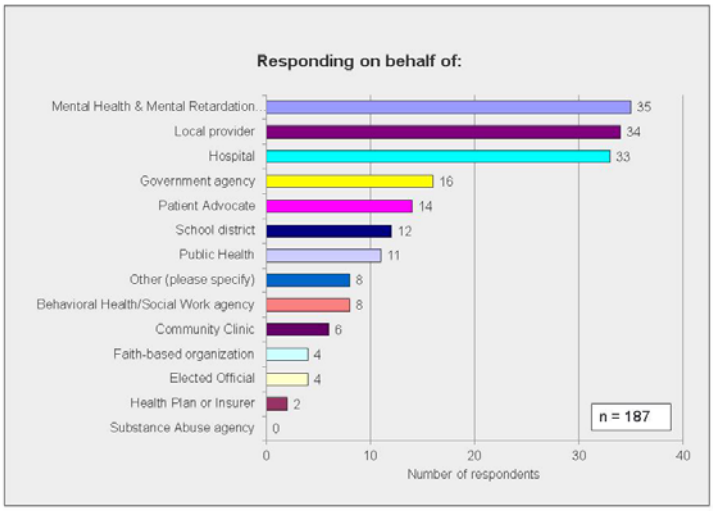
SUMMARY OF RESPONDENTS

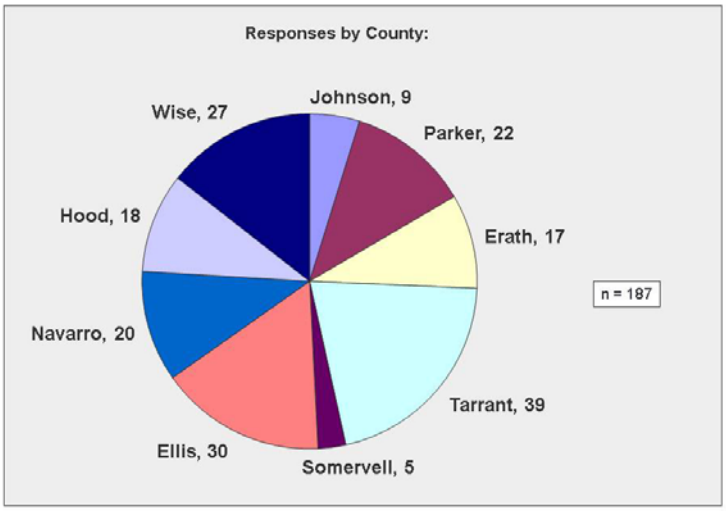
6/8/2012 3

Question 1



6/8/2012 4

Question 2



6/8/2012 5

SUMMARY OF RESPONSES: ACCESS TO CARE

6/8/2012 6

Question format

1) Respondents were asked to **rate** the difficulty low-income patients faced when trying to access care

2) Respondents were then asked to **rank** potential barriers to care from 1 – 8.

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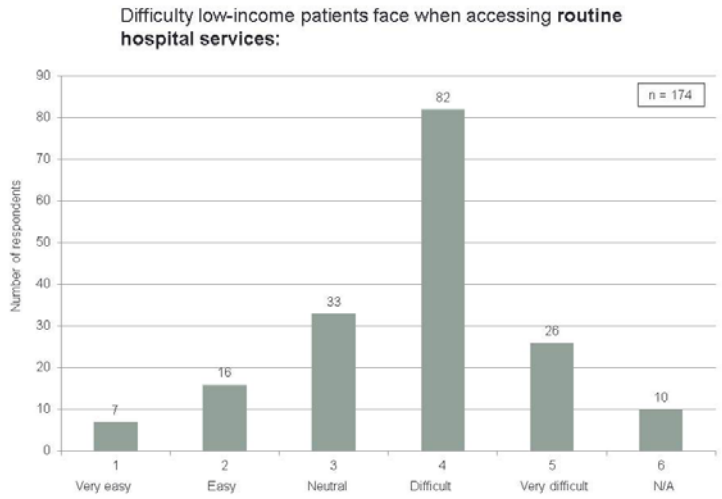
Question 3a



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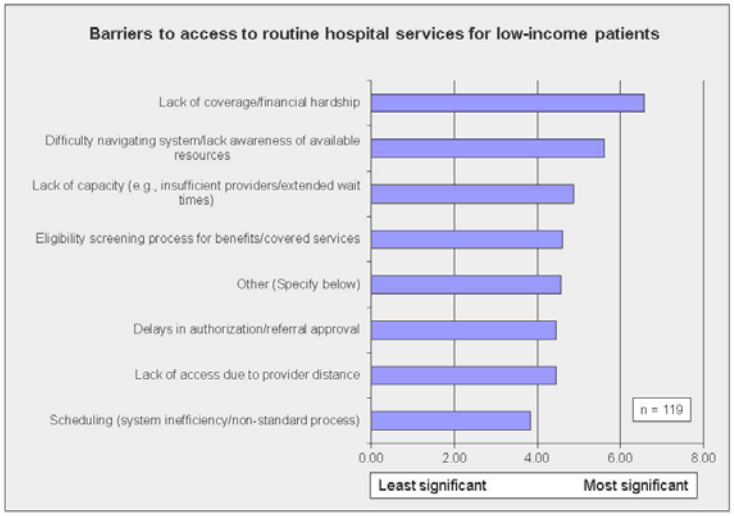
3

Question 3b



6/8/2012 9

Question 3b, cont.

"Other" responses

- "Limited specialty services and limited indigent eligibility"
- "Because access for 'routine hospital services' is 'difficult,' EDs (the most expensive location to receive medical services) is overused."
- "Providers not well informed of various programs and how they work"
- "Without insurance, unable to get treatment until condition is emergent/life threatening"

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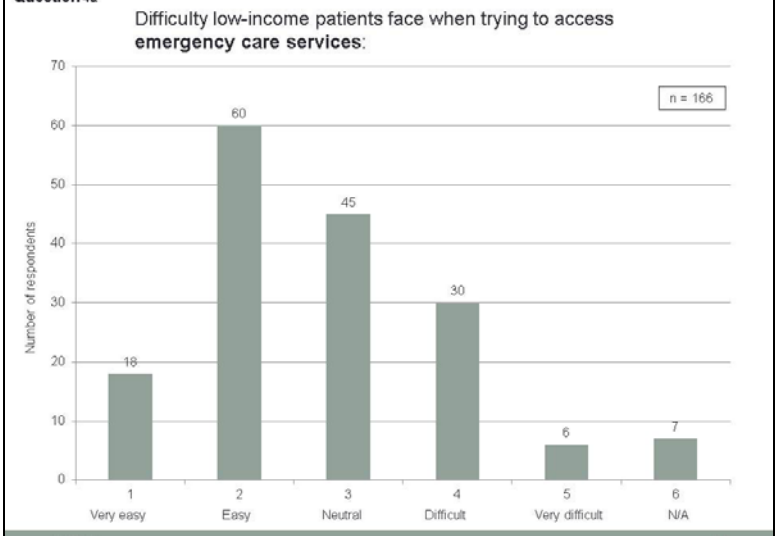
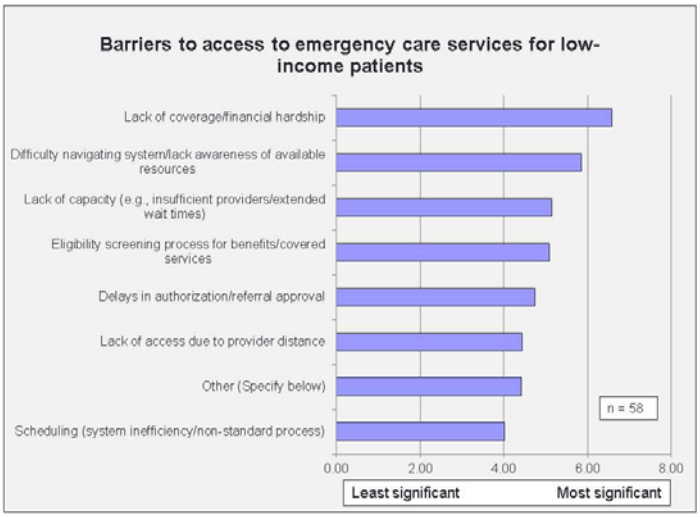
Question 4a



6/8/2012 11

Question 4b



6/8/2012 12

Question 4b, cont.

"Other" responses

- "Using emergency medical is easy…, but is it NOT be BEST way for them to receive medical care."
- "Lack of psychiatric availability for dual diagnosed (MH/MR individuals. Also lack of substance abuse treatment capacity."
- "Limited number of area providers."

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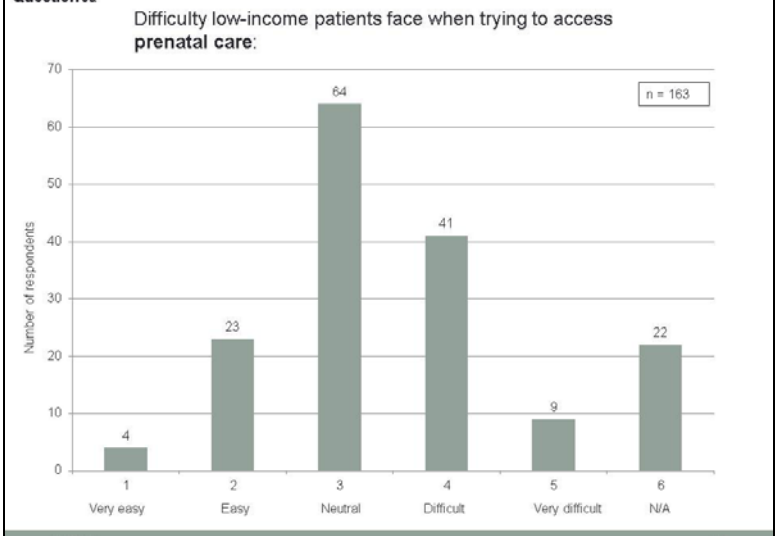
Question 5a



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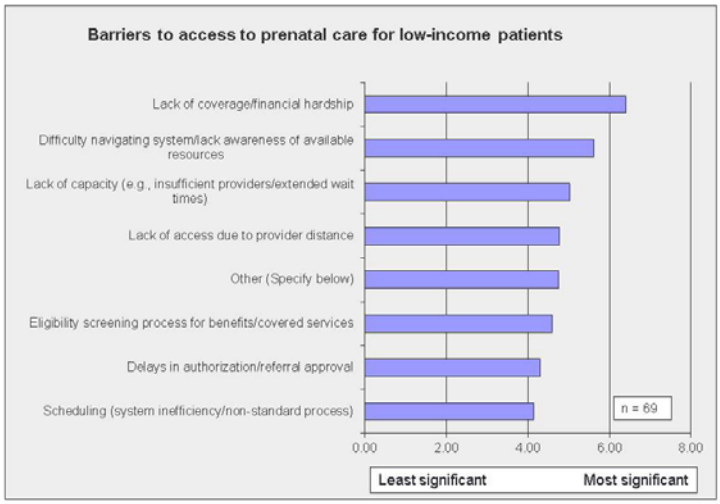
Question 5b



6/8/2012 15

Question 5b, cont.

"Other" responses

- "Local Hospital does not provide."
- "No OB physicians or services at hospital."
- "Lack of knowledge about resources available."

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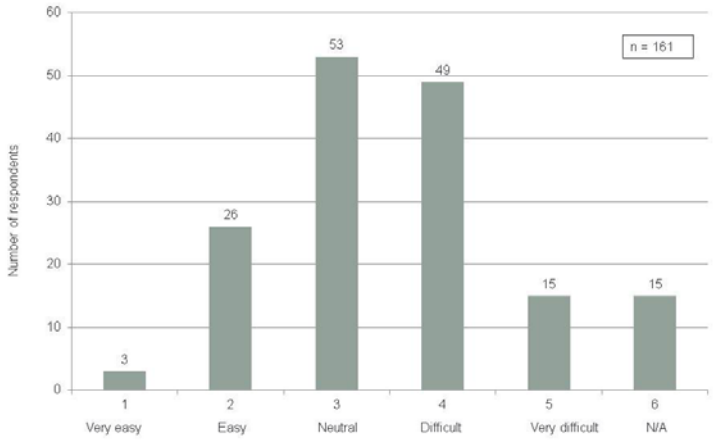
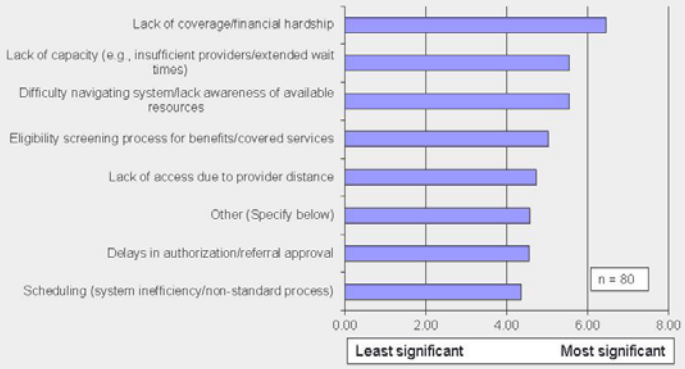
Question 6a

Difficulty low-income patients face when trying to access **pediatric/well-child services**:



Question 6b

Barriers to access to pediatric/well-child services for low-income patients



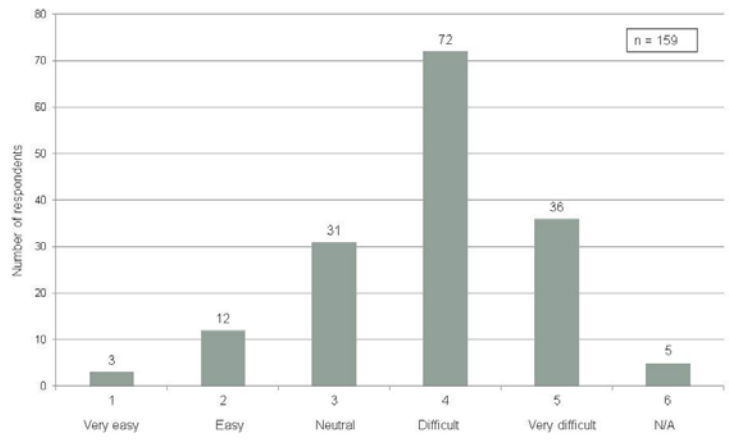
Question 6b, cont.

"Other" responses

- "Some area physicians are not providing immunization services."
- "Low reimbursement makes me unable to allow scheduling of Medicaid patients. It is easy for cash paying patients to get a visit and be seen in my office."
- "Physician offices/Providers do not offer non traditional hours, for example: after work and on weekends."

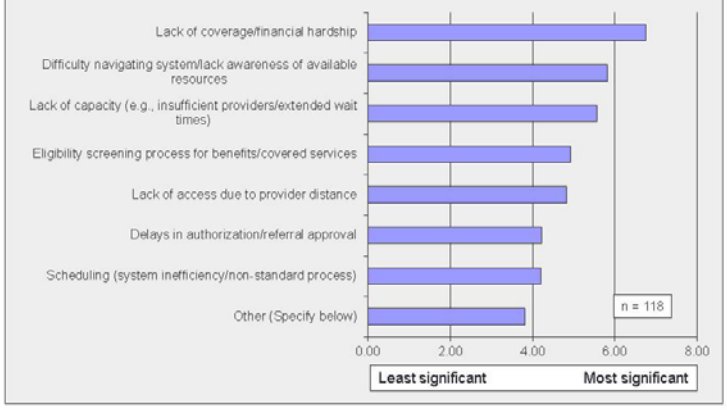
Question 7a

Difficulty low-income patients face when trying to access **routine primary/preventive care**:



Question 7b

Barriers to access to routine primary/preventive care for low-income patients

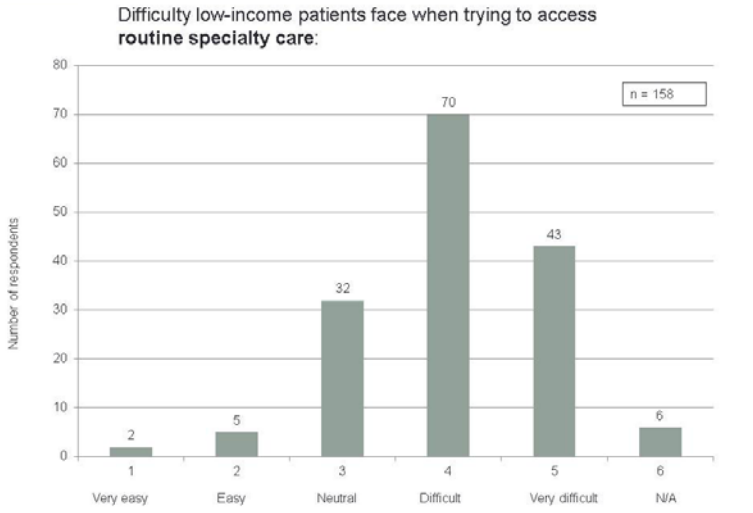


Question 7b, cont.

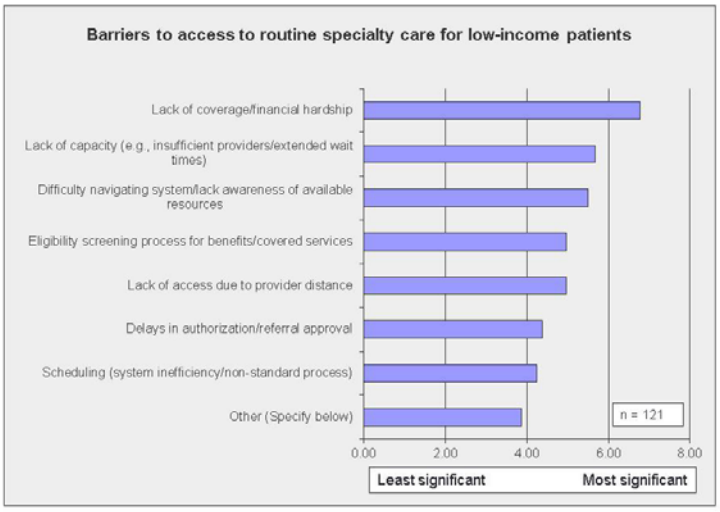
"Other" responses

- "A glaring issue for individuals with disabilities who are often living below the poverty level is transportation. Many individuals who depend on public transportation are stuck in one area and unable to cross transportation lines due to a lack of providers able to cross into other areas. This is especially relevant for those in rural areas or those living outside of the city of Fort Worth."

Question 8a



Question 8b

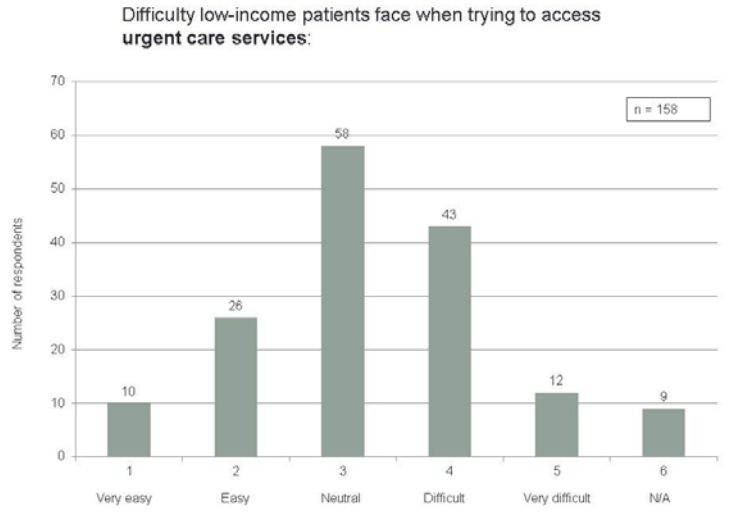


Question 8b, cont.

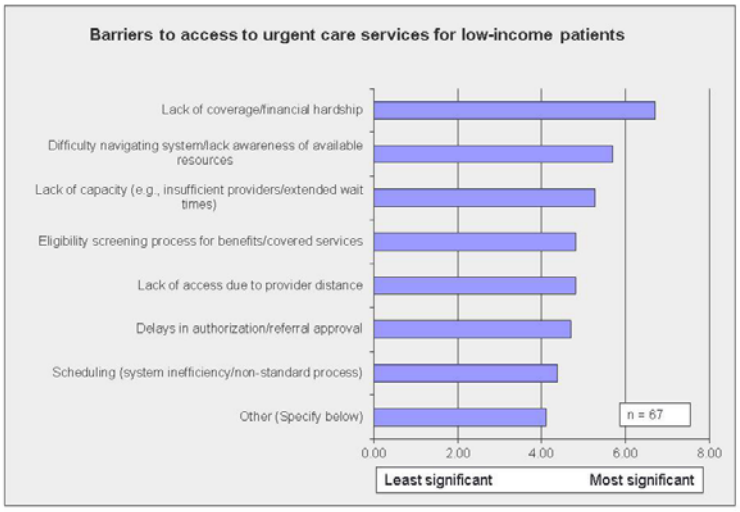
"Other" responses

- "Lack of providers of specialty care for Behavioral Health and Children and Adults with behavioral disorders."
- "[Lack of] transportation to Specialty practices in another county"
- "Specialists will not accept patients with no resources."

Question 9a



Question 9b



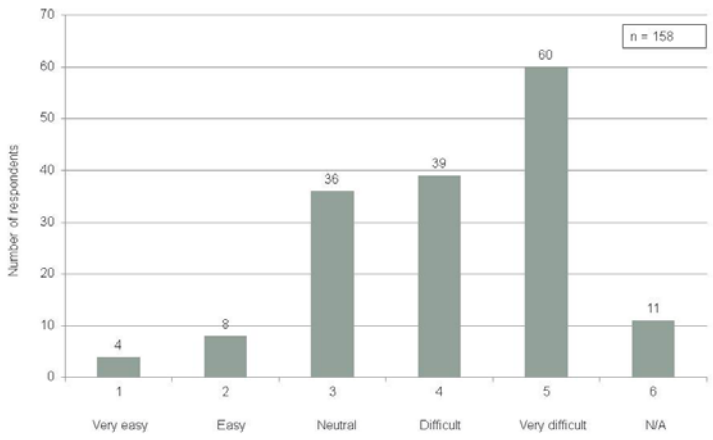
Question 9b, cont.

"Other" responses

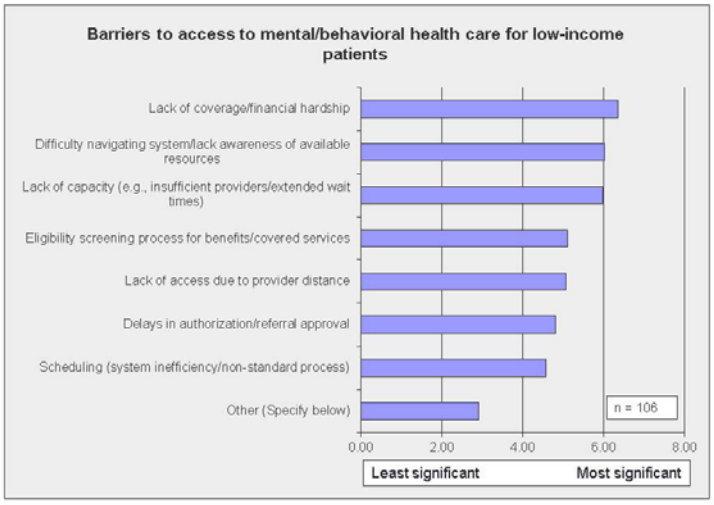
- "Many individuals with intellectual disabilities are unaware of other urgent care facilities and most are dependent on assistive transportation resulting in a higher incident of costly ER usage for medical needs."
- "Lack of knowledge regarding resources that are available at low or no cost"

Question 10a

Difficulty low-income patients face when trying to access **mental/behavioral health care:**



Question 10b



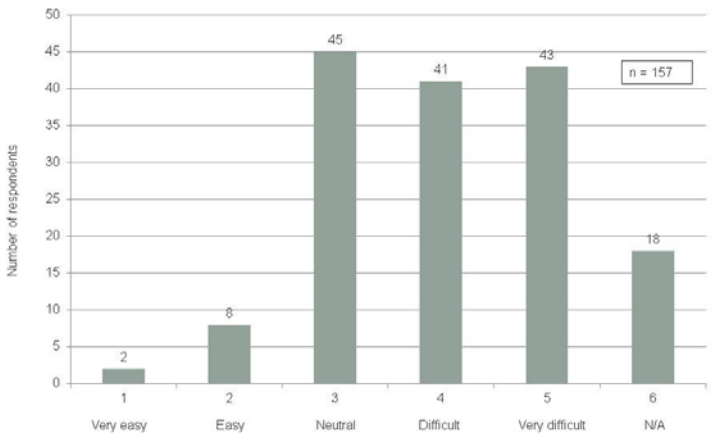
Question 10b, cont.

"Other" responses

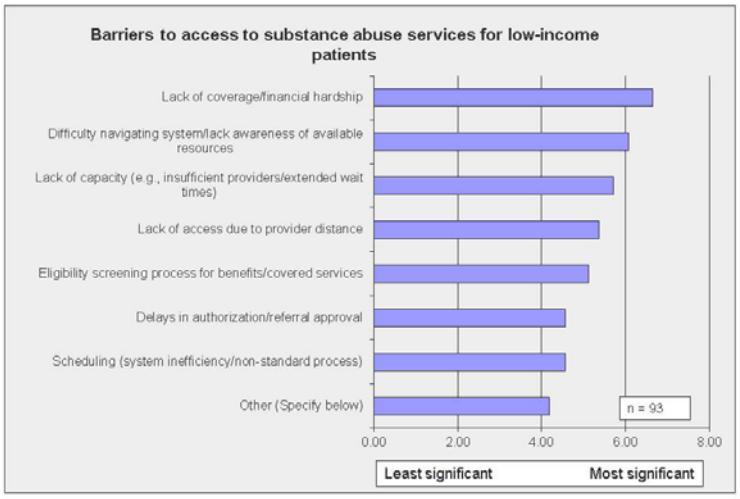
- "Lack of Bilingual and Culturally Sensitive Mental Health Professions"
- "Limited provider base. No substance abuse treatment available. Limited Crisis Respite and Psychiatric Beds available. Limited resources for specialty populations i.e. MH/MR, Autism, SED, children with multiple disabilities."

Question 11a

Difficulty low-income patients face when trying to access **substance abuse services:**



Question 11b



Question 11b, cont.

"Other" responses

- "Lack of providers. No residential treatment, or intensive outpatient services available."
- "Lack of Cultural and Bilingual Professional Staff."
- "[I am] unaware of any local services available for low income patients in need."

Access to Care: Key Takeaways

- The top three barriers for access to all types of care:
  - Lack of coverage/financial hardship (#1 for all types)
  - Difficulty navigating the system/lack of awareness of available resources
  - Lack of capacity (e.g. insufficient provider/extended wait times)

Access to Care: Key Takeaways

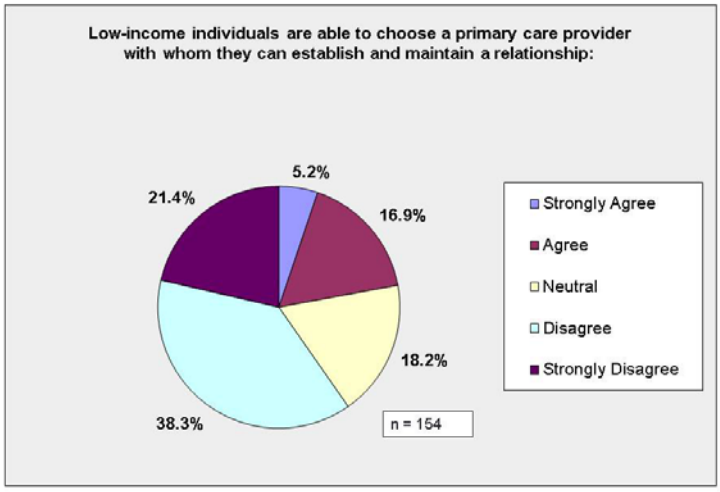
- For routine hospital care, routine primary/preventive care and routine specialty care the majority of respondents rated them as "difficult" to access
- For Mental/behavioral health care the majority of respondents rated it as "very difficult" to access
- Emergency care was rated by most respondents as "easy" to access

SUMMARY OF RESPONSES: CARE COORDINATION

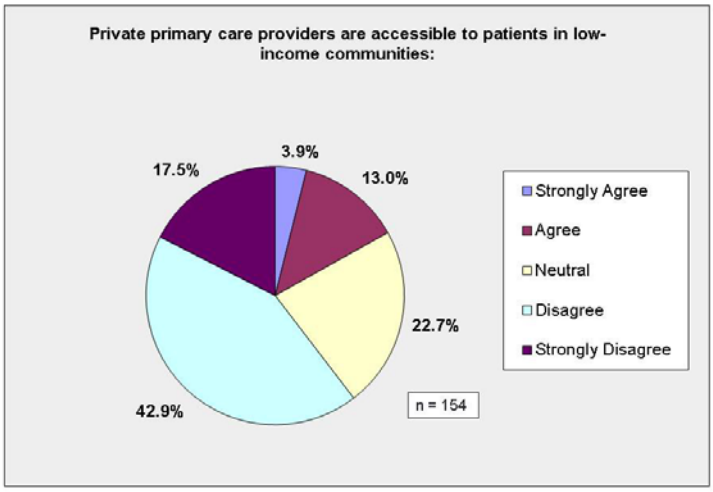
Question Format

1. Respondents were asked to state whether they agreed or disagreed that their county had certain types of care coordination
2. Respondents were then asked to rate the effectiveness of certain types of care coordination

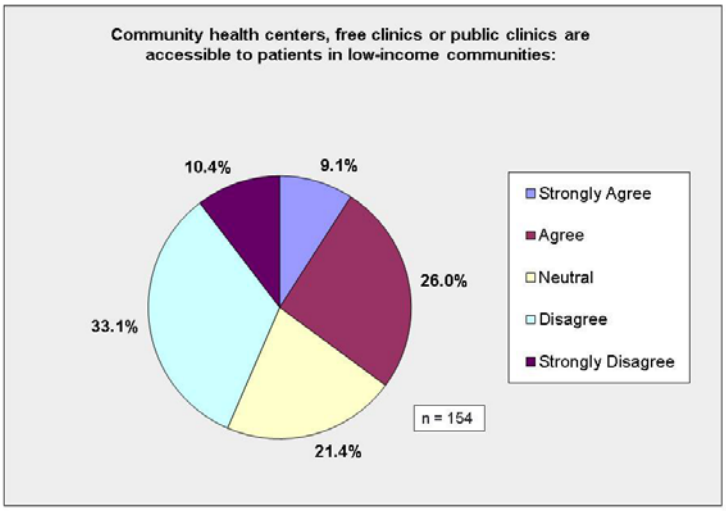
Question 12



Question 13



Question 14



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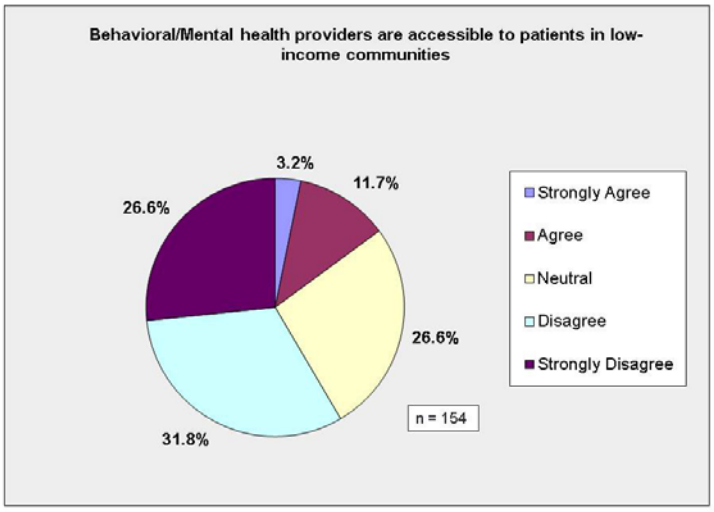
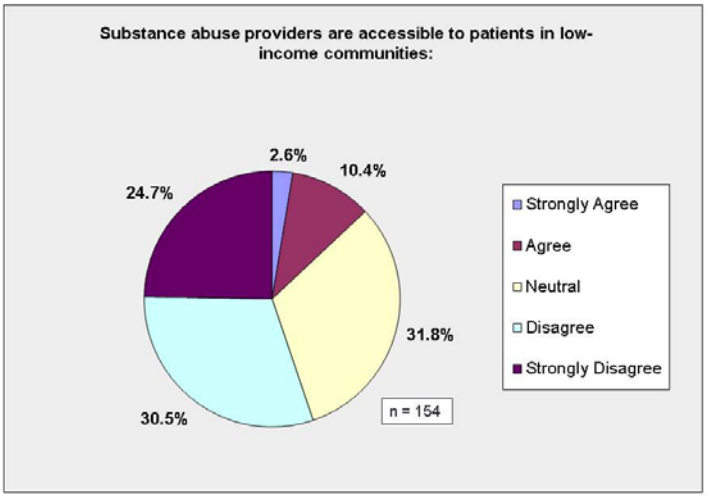
Question 15



6/8/2012 42

Question 16



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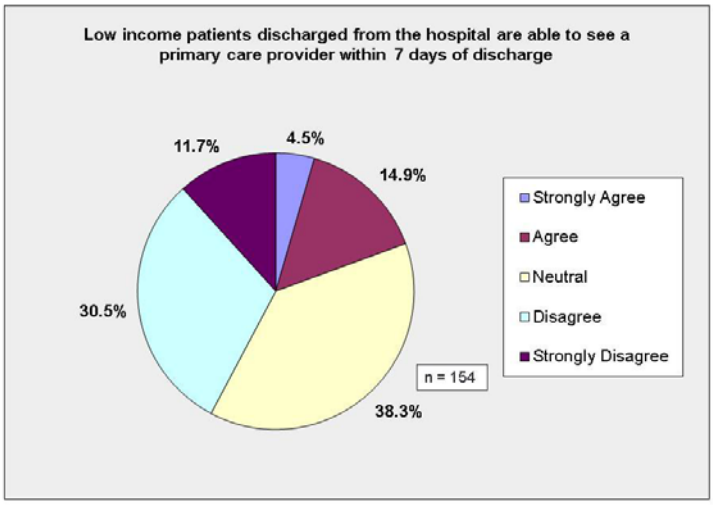
Question 17



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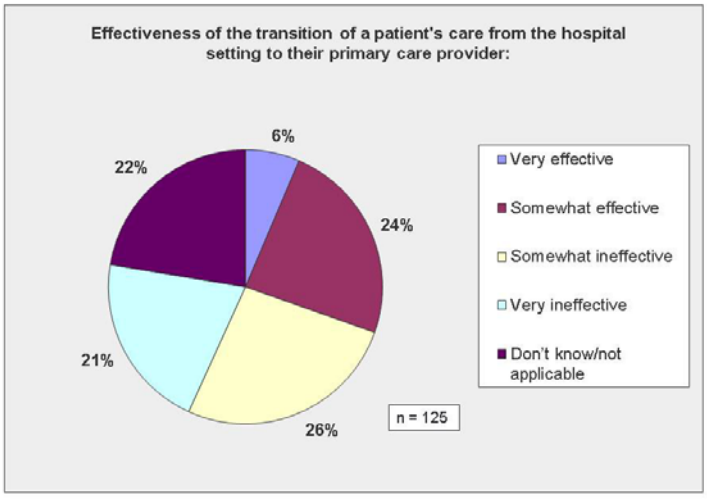
Question 18



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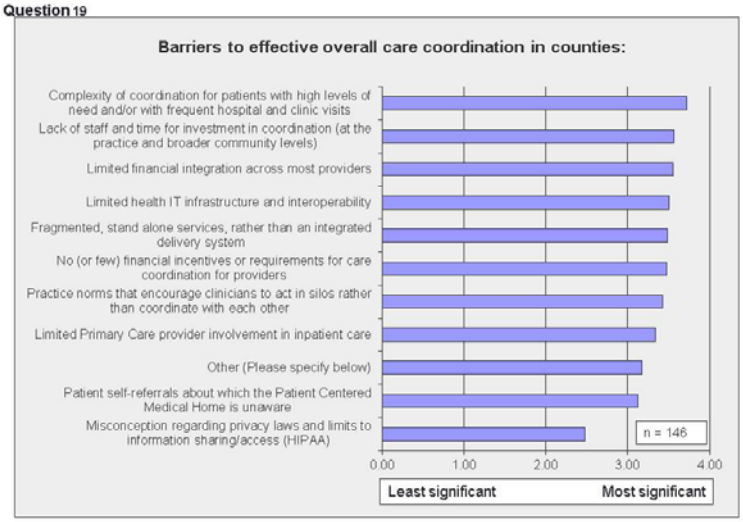
Question 19



6/8/2012 46

Question 19, cont.

"Other" responses

- "Clients cannot sit and wait for hours and miss more work when they have a limited income."
- "General lack of primary care physicians, and FPs not paid well to see their own patients in the hospital (eliminates need to 'coordinate' care)"
- "Poor patient compliance with recommended follow-up, they are discharged from hospital or ER and just plan on returning to ER when their condition gets out-of-hand again"
- "Rate of reimbursement too low and government requirements too time consuming"

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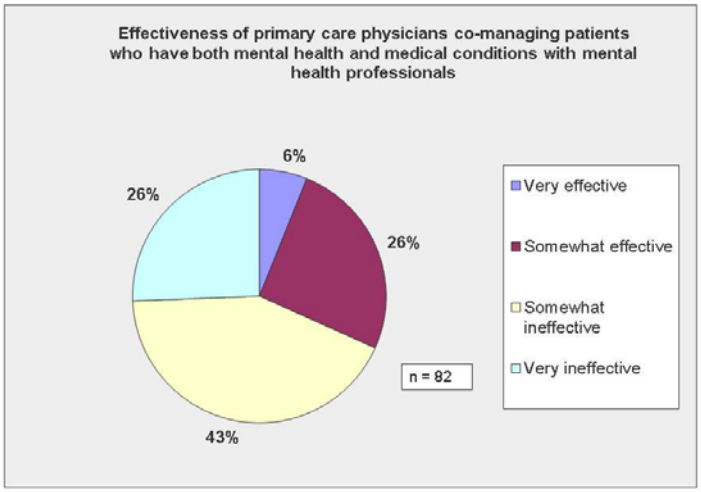
Question 20



6/8/2012 48

Question 20, cont.

Comments

- "Doctors don't seem to talk with other physicians and work together to find a solution to health problems. Rather they "bounce" the patient from this specialist to that specialist…"
- "Many of the mental health patient's do not even know what medications they are currently on. The primary care must rely on the patient to tell them."

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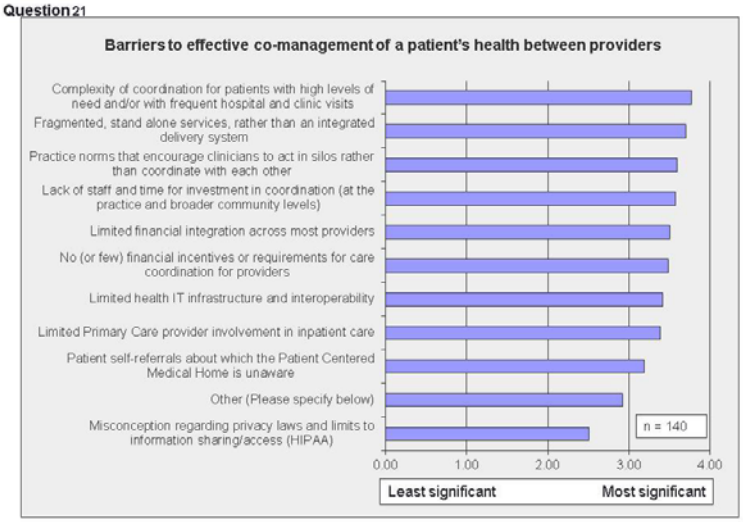
Question 20, cont.

Comments (Continued)

- "Lack of communication. Patients are either seen/treated for a medical condition or a psychiatric condition. It does not seem that both are addressed. It is whichever is prevalent at the time in crisis."
- "The mental health resources are limited at best. MHMR is flooded with people with substance abuse issues and cannot adequately respond. This creates a system where physicians are often put in a tough place of diagnosing mental health issues as well as other physical ailments without anyone local to refer patients to for counseling."

6/8/2012 50

Question 21



6/8/2012 51

Question 21, cont.

"Other" responses

- "Not enough family physicians in community, who are not paid fairly to care for complex patients."
- "Limited primary care involvement is not related to only inpatient care - PCPs and Mental Health Professionals each treat the patient in a silo...there is no 'co-management'...each does their own part."

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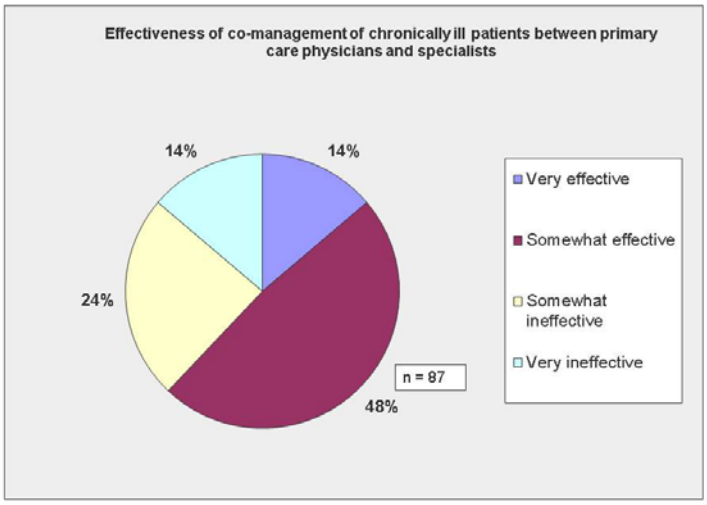
Question 22



Question 22, cont.

Comments

- "Providers work in silos and do not have incentives to coordinate care; additionally, there may be language barriers for clients when utilizing the systems that are in place."
- "Difficulty getting specialists to accept patients on programs that have low pay rates or are unfamiliar to the providers."
- "No system appears to be in place to assure communication across providers."

Care Coordination: Key Takeaways

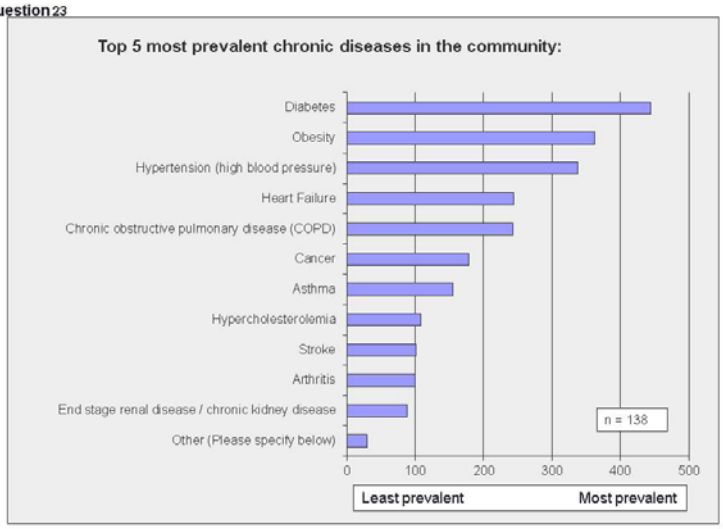
- In general, respondents felt neutral or did not feel that there was effective care coordination among physicians, specialists, hospitals and other providers for mental health, etc.
- However, respondents did feel that care coordination for chronically-ill patients between primary and specialty care patients was somewhat effective

SUMMARY RESPONSES: COMMUNITY HEALTH

Question format

1. Respondents were asked to choose the top five conditions prevalent in their county.

Question 23



Question 23, cont.

"Other" responses

- Alzheimer's Disease
- "All of these diseases are prevalent in our community"
- Dental needs/infection

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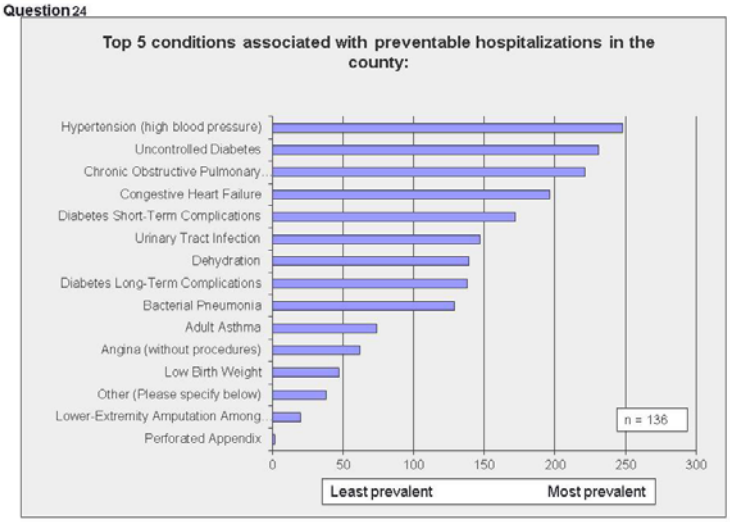
Question 24



6/8/2012 60

Question 24, cont.

"Other" responses

- Mental Health - Bipolar, Schizophrenia, etc.
- Child Asthma
- Congestive heart failure
- "Any disease or disorder that requires lifestyle changes and preventative action often become worse due to the lack of follow-up care and coordination of caregiver roles and the patient's inability to maintain the proper health regimen. This is also compounded by communication disorders or differing awareness levels of physical wellbeing among the disabled making early diagnosis difficult at times."

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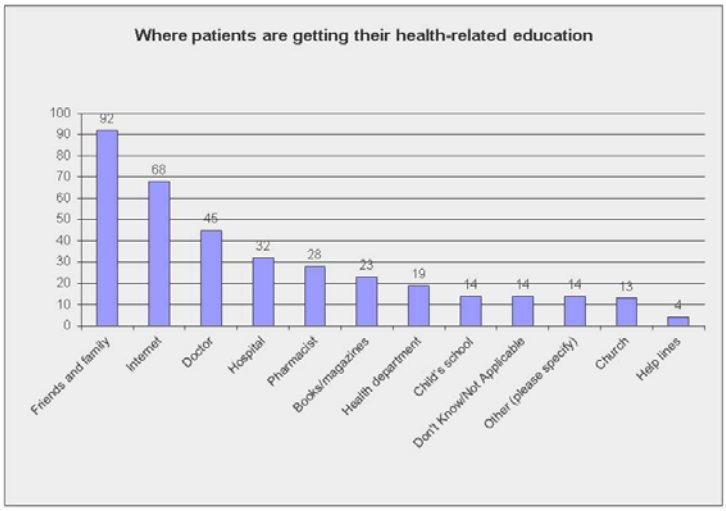
Question 25



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Question 25, cont.

"Other" responses

- Community health clinics
- Health fairs
- University health center and counseling center
- Provider nurses
- Case managers
- Television
- Dr. Oz
- Agrilife Extension Office
- Home health agencies

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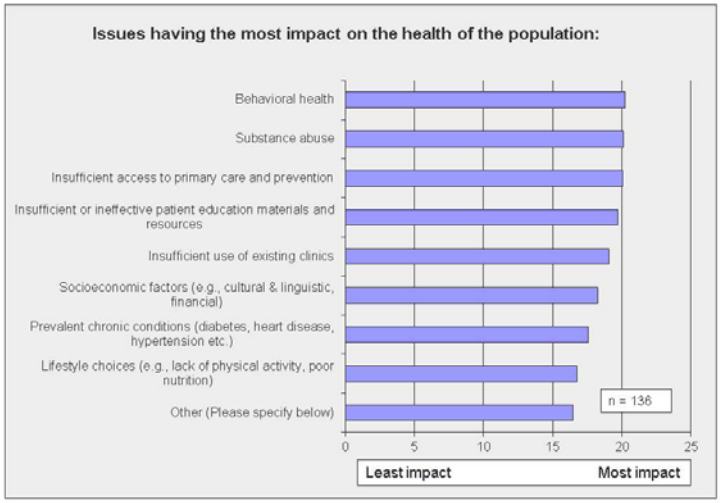
Question 26



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Question 26, cont.

"Other" responses

- "Environmental quality and the built environment"
- "Not treating the history of trauma and anxiety"
- "Poor nutrition due to the inability to purchase healthy foods because they cost so much more than the unhealthier options"
- "Lack of transportation to get to needed medical care"

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Community Health: Key Takeaways

- The top health conditions affecting Region 10 patients were diabetes, obesity, hypertension, COPD and congestive heart failure.
- Patients mostly get their health education from friends, family, the internet and their doctor.
- Behavioral health and substance abuse were the top issues impacting the patient population.

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ADDITIONAL COMMENTS

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Additional Comments

"County lacks physicians who will take Medicaid patients. Patients need more transportation to other counties with specialists."

"Our county has a wealth or resources for its' residents. Many simply are unaware that these resources are available."

"There should be some discussion about population health, health equity and undocumented patients."

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Additional Comments (cont'd)

"Most families have no where to go to get assessments completed or medication management for their children or adult children to get help with the behaviors they exhibit due to their dual diagnosis. Mental health practitioners in the community refuse to see them because of their mental retardation diagnosis and they have to end up going to Dallas and or staying here and paying out of pocket extremely high payments just to get medications or assessments."

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Additional Comments (cont'd)

"[Both] insured and uninsured patients are not incentivized to pursue preventive care and maintain appropriate follow-up care."

"The clients must receive both mental and physical health care in one location. The piece meal system no longer works."

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FINAL TAKEAWAYS

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Respondents overwhelmingly listed a lack of coverage/financial hardship as a barrier to care for low-income patients.

Write-in comments in the survey indicated an overuse of the emergency department services and an inability for patients to access primary/preventive care (due to difficulty navigating the system and a lack of capacity, according to responses).

In general, respondents did not feel that there was strong care coordination between primary care providers, hospitals and specialists.

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D-3: Key Health Challenges

Figure D-3.1: Causes of Morbidity in Region 10 Counties in 2011

	Ellis	Erath	Johnson	Tarrant	Wise	Navarro	Parker	Somervell	Hood
Tuberculosis	2.0	2.8	2.5	6.2	3.4	2.0	1.7	0.0	0.0
All Cancer	447.8	403.8	439.9	446.6	424.6	485.4	462.1	469.8	485.4
Breast	61	58.4	58.3	70.4	43.2	55.5	74.7	N/A	63.9
Lung	71.4	N/A	70.0	60.4	74.2	72.0	74.5	N/A	55.2
Diabetes	8.3	8.8	10.0	8.4	8.6	9.7	9.3	9.3	8.7
HIV	4.6	0.0	3.8	14.6	0.0	10.1	5.2	12.2	9.7
Obesity	29.5	27.6	29.6	26.8	29.8	29.5	27.5	26.9	27.1

Source: Community Health Rankings (Rates per 100,000 people, *Data Pending)

Figure D-3.2: Communicable Diseases Rates per 100,000 people in Region 10 in 2009

	U.S.	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Tuberculosis Cases	11,549	1,477	122.0	3	1	0	4	1	2	0	109	2
Tuberculosis Rate	3.80	6.0	2.3	2	2.6	0	2.4	2	1.8	0	6.1	3.4
AIDS Cases	34,247	2,286	134.0	6	0	2	10	4	3	0	109	0
AIDS Rate	**	9.2	3.4	3.9	0	3.8	6.1	7.9	2.7	0	6.1	0
Varicella (Chickenpox) Cases	**	4,445	454.0	13	9	68	34	4	18	0	298	10
Varicella (Chickenpox) Rate	**	17.9	26.3	8.5	23	127.9	20.7	7.9	15.6	0	16.7	16.6
Pertussis (Whooping Cough) Cases	16,858	3,358	268.0	10	2	9	22	0	14	2	207	2
Pertussis (Whooping Cough) Rate	5.54	13.5	10.3	6.5	5.1	16.9	13.4	0	12.2	23.8	11.6	3.3

Source: Centers for Disease Control

Figure D-3.3: Region 10 Sexually Transmitted Diseases in 2009

	Nation	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Primary and Secondary Syphilis Cases	44,828	1,231	172.0	16	0	0	1	2	2	0	151	0
Primary and Secondary Syphilis Rate	14.74	4.9	2.7	10	0	0	0.6	3.9	1.7	0	8.3	0
Gonorrhea Cases	301,174	31,453	3,504.0	803	5	3	57	73	10	2	2,537	14
Gonorrhea Rate	99.05	124	99.0	504.1	12.6	5.5	33.7	141.4	8.4	23.3	139	22.7
Chlamydia Cases	1,244,180	118,577	13,368.0	4,356	74	103	355	279	207	15	7,879	100
Chlamydia Rate	409.19	467.3	533.7	2,734.8	186.4	188.5	209.6	540.5	174.8	174.5	431.6	162.4

Source: Centers for Disease Control (Rates per 100,000)

Figure D-3.4: Natality in Region 10 in 2008

	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Total Live Births (Cases)	405,242	37,852	2,097	509	585	2,210	709	1,390	111	29,424	817
Adolescent Mothers under 18 Years of Age (Cases)	19,775	1,622	91	17	18	99	44	57	6	1259	31
Adolescent Mothers under 18 Years of Age (%)	4.9%	4.3%	4.3%	3.3%	3.1%	4.5%	6.2%	4.1%	5.4%	4.3%	3.8%
Low Birth Weight (Cases)	34,228	3,056	162	31	36	161	58	93	8	2452	55
Low Birth Weight (%)	8.4	7.2%	7.7%	6.1%	6.2%	7.3%	8.2%	6.7%	7.2%	8.3%	6.7%
Onset of Prenatal Care within First Trimester (Cases)	223,961	19,584	1,136	285	385	1264	303	798	64	14912	437
Onset of Prenatal Care within First Trimester (%)	60.1%	58.1%	54.0%	57.7%	64.8%	63.6%	42.1%	59.4%	68.8%	53.5%	59.0 %

Source: Texas CHS (*Data Pending)

Figure D-3.5: Mortality Rates per 100,000 persons in Region 10 in 2009

	Texas	U.S.	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise	RHP 10
Total Deaths	162,792	2,437,163	997	321	520	1,126	509	857	89	10,478	476	15,373
Disease of the Heart	38,008	599,413	238	84	102	287	98	196	19	2,413	117	3,554
Cerebrovascular Disease	9,118	128,842	54	36	37	77	24	59	4	635	19	945
Malignant Neoplasms	35,531	567,628	225	63	123	267	139	200	22	2,349	116	3,504
Chronic Lower Respiratory disease	8,624	137,353	51	19	32	76	32	72	4	625	40	951
Nephritis, Nephrotic Syndrome and Nephrosis	*	*	17	3	10	26	6	18	2	217	8	307
Accidents	9,310	118,021	45	23	28	61	16	54	10	537	33	807
Diabetes			29	4	11	29	25	16	1	273	10	398
Alzheimer's	5,062	79,003	36	8	39	14	30	43	5	287	17	479
Influenza and pneumonia	*	*	11	5	10	27	10	23	0	194	9	289
Assault	*	*	11	0	3	1	4	2	0	70	1	92
Suicide	*	*	13	1	9	21	8	12	2	170	9	245
Septicemia	*	*	15	1	7	7	8	7	0	176	6	227
Chronic liver disease and Cirrhosis	*	*	14	5	7	13	6	14	2	162	7	230
Infant death			15	2	4	19	3	11	1	194	3	252
Fetal deaths			6	1	7	13	0	12	0	189	2	230

*Data Pending

Source: Texas CHS

Figure D-3.6: Preventable Hospitalizations in Region 10 in 2010

	Region 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Bacterial Pneumonia Cases	4,628	360	79	109	544	137	288	0	2,951	160
Rates	135.2	118.3	174.2	127.0	169.6	310.0	136.0	0	126.8	208.0
Dehydration Cases	837	66	15	27	86	31	48	0	534	30
Rates	43.2	32.8	26.4	23.4	66.3	75.4	53.9	0	41.6	44.0
Urinary Tract Infection Cases	3,287	177	66	65	256	148	159	0	2,293	123
Rates	81.7	67.5	58.1	66.4	109.3	140.4	83.8	0	81.0	55.8
Angina (without procedures) Cases	247	16	0	10	28	15	20	0	150	8
Rates	190.4	240.6	208.5	213.0	360.4	287.0	246.3	0	163.1	270.6
Congestive Heart Failure Cases	4,736	294	77	122	471	187	223	8	3,271	83
Rates	194.8	196.5	203.2	238.4	312.1	391.7	190.7	94.2	180.8	140.4
Hypertension Cases	1049	49	10	12	100	36	63	0	753	26
Rates	46.7	36.8	44.9	23.4	62.9	60.8	38.5	0	47.3	45.7
Asthma Cases	1,558	115	21	18	220	32	85	6	1,033	28
Rates	34.4	44.1	39.6	52.8	57.0	64.9	41.1	0	29.5	50.7

	Region 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Chronic Obstructive Pulmonary Disease Cases	3,300	198	55	99	367	164	225	6	2,090	96
Rates	10.2	10.7	0	19.5	18.6	31.4	17.1	0	8.3	13.5
Diabetes Short-term Complications Cases	1,136	55	17	12	95	29	45	0	856	27
Rates	135.8	132.3	145.2	193.4	243.2	343.6	192.4	70.7	115.5	162.4
Diabetes Long-term Complications Cases	1,986	101	22	34	165	67	98	0	1,466	33
Rates	64.1	76.9	55.4	35.2	145.8	67.0	72.7	70.7	57.1	47.4
Total	**22,764**	**1,431**	**362**	**508**	**2,332**	**846**	**1,254**	**20**	**15,397**	**614**

Source: Texas CHS

Figure D-3.7: Health Outcomes in Region 10 in 2009

	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Poor or Fair Health	19%	**17%**	13%	14%	NA	21%	NA	18%	NA	16%	19%
Poor Physical Health Days*	3.6	**3.49**	25	22	5	4.8	4.1	3.2	NA	3.1	3
Poor Mental Health Days*	3.3	**3.39**	2.5	2.7	3.4	4.9	3.7	2.9	NA	3.1	3.9

*in the past 30 days

Source: County Health Rankings 2010

Figure D-3.1: Region 10 Health Behaviors, by County, in 2011

	U.S.	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Adult Smoking	14%	19%	19%	20%	12%	22%	23%	N/A	18%	N/A	18%	20%
Adult Obesity	25%	29%	30%	30%	28%	30%	32%	32%	32%	29%	28%	32%
Physical Inactivity	21%	25%	28%	25%	26%	26%	30%	31%	30%	28%	22%	30%
Excessive Drinking	8%	16%	15%	18%	16%	17%	17%	9%	13%	N/A	15%	N/A

Source: Community Health Rankings

Figure D-3.2: Access to Healthy Foods, 2012

	U.S.	Texas	RHP 10	Ellis	Erath	Hood	Johnson	Navarro	Parker	Somervell	Tarrant	Wise
Limited Access to Healthy Foods % population with low income and do not live close to a grocery store	N/A	12%	10%	16%	3%	1%	18%	4%	19%	0%	8%	21%
Fast Food Restaurants Percent of all restaurants that are fast food establishments	25%	53%	52%	56%	53%	47%	60%	56%	57%	44%	56%	43%

Source: Community Health Rankings

D-4: County-specific findings

As part of the outreach process for the RHP, county visioning sessions were held throughout the Region. The purpose of these sessions are to bring together local leadership, stakeholders and performing providers to discuss local health care needs, resources and gaps in the current delivery system, develop a local vision and goals for health care delivery and identify potential opportunities for county and Regional collaboration. The county visioning sessions were also a means to facilitate discussions between providers in the same county about the current health data presented and what their perceived experiences in their service area. These discussions provided a qualitative look at local health care needs and are intended to supplement the quantitative findings in this report. We also aggregated information from various assessments, reports and data that were submitted by Regional providers.

ELLIS COUNTY

Health care Needs[xxxi]

- Increased psychiatry patients
- Lack of Communicable Disease Management Programs
- Tremendous shortage to Dental care
- Lack of substance abuse services
- Lack of Transportation
- Lack of Care Management Programs
- High need for Behavioral Health Programs
- Lack of Urgent Care
- Increase need for Medicare Providers
- 85% patients have Diabetes
- Lack of geriatric beds

Workforce Needs

- Mobile Services staff
- Psychiatry Physicians
- Medicare/Medicaid providers

HOOD COUNTY

Health care Needs

- Lack of on site psychiatrist
  - Currently have telemedicine psychiatrists
- Fragmented care coordination between primary care and psychiatry
- Uninsured/underinsured do not have access to care
- Lack of patient education programs
- Language barriers between patients and providers
- Affordability of care
- Increased group of Latino population need care
- Asthma is highly prevalent in Hood county

Workforce Needs

- Psychiatric nurses
- OR nurses
- Fully trained nurses

JOHNSON COUNTY

Health care Needs

- Need for additional Mental Health Professionals (Only one in County)
- CMHC: over utilization → 600 patients
- Limited access to MHMR
- Lack of access to urgent care

SOMERVELL COUNTY

Health care Needs

- Increasing need for Metal Health Providers
- Lack Substance Abuse
  - No plans for residential treatment → MHMR looking at outpatient service
  - Not funded through State → Medicaid or private pay
  - No services for non paying patients
- Catastrophic injuries that are not funded → very expensive
- Medically complex patients are missing care at Somervell County → they are going somewhere else for care
- Need for ICU (5% transfer from ED → Baylor, THR)
- Need postdischarge support for target-based populations: No formal process in place
- Lack of substance abuse programs
- No OB services
- Need on-site psychiatrists
- Need physical therapists

ERATH COUNTY

Health care Needs

- Diabetes Management Program
- Lack of coverage/financial hardship
- Lack of access due to provider distance
- Difficulty navigating the system/lack of awareness of available resources
- Access to routine hospital care, routine primary/preventive care and routine specialty care rated as "difficult" to access in stakeholder survey
- For Mental/behavioral health care the majority of respondents rated it as "very difficult" to access
- Lack of care coordination
- Not enough emergency department beds to meet demand
- Not confident in ability to coordinate with MHMR for postdischarge support and care transitions

NAVARRO COUNTY

Health care Needs

- Lack of access due to provider distance
- Limited financial integration
- Fragmented, stand-alone services
- Lack of staff time
- Ineffective care coordination

PARKER COUNTY

Health care needs

- Difficult to access: (1) Emergency care, (2) Pediatric care, and (3) Specialty care
- Difficulty navigating the system/lack of awareness of available resources
- Lack of capacity (e.g., insufficient provider/extended wait times)
- Eligibility screening process
- Limited health care IT
- Lack of care coordination
- Large number of the patients have no insurance and no access to primary care
- Need to integrate primary care and behavioral health

WISE COUNTY

Health Care Needs

- Routine hospital care, primary care and specialty care are "difficult" to access
- Lack of coverage/financial hardship
- Eligibility screening process
- Limited primary care access
- Lack of some 24 hour specialty care
- Limited care coordination with all physicians
- Lack of population-focused programs
- Long delays in being able to get the patient an appointment for MHMR

TARRANT COUNTY

Health care Needs

- Lack of care coordination due to limited staff time
- Limited Primary care provider involvement in patient care
- Limited Health care IT infrastructure
- Mental/behavioral and substance abuse services are "very difficult" to access
- Lack of capacity (e.g., insufficient provider/extended wait times)

JPS/United Way Community Health Needs Assessments

As part of this community health needs assessment, a review of United Way's CHNAs from Tarrant County was conducted. The United Way's CHNA, findings are substantively similar to the findings reported in this Community Needs Assessment. In addition to United Way's CHNA data for Tarrant County, a review of JPS Health System's CHNA was also conducted as comparison. The data findings are similar to this Community Needs Assessment. JPS additionally included a section on appointment wait times for new appointments as well as the follow up appointments in different areas within the county. According to JPS's analysis, it takes longer for a new patient to be scheduled at a primary care clinic than OB/GYN or pediatric facilities. On the contrary, follow up appointment times are longer for OB/GYN or pediatrics than primary care. Additionally, new patient appointment wait times differ in Tarrant County based on the geographical location of the provider or the clinic.

D-5: Provider Distribution by County

Ellis County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Baylor Medical Center at Waxahachie	Palmer Medical Clinic	Ennis Care Center	
Ennis Regional Medical Center	HOPE Clinic	Legend Oaks Healthcare and Rehabilitation	
		Red Oak Health and Rehabilitation Center	
		Pleasant Manor health and Rehabilitation Center	
		Refreno Healthcare Center	
		Trinity Mission Health and Rehab of Italy	

Erath County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Texas Health Harris Methodist Hospital Stephenville	Community Health Clinic LLP	Community Nursing and Rehabilitation Center	
	Dublin Family Medicine	Stephenville Nursing and Rehabilitation	
	Cross Timbers Health Clinic Stephenville	Castleview Nursing and Rehab of Stephenville	
		Golden Age Manor Nursing Center	
		Mulberry Manor	
		Senior Care at Stephenville	

Hood County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Lake Granbury Medical Center		Granbury Vila Nursing Center	
		Trinity Mission of Granbury LLC	
		Senior Care of Harbor Lakes	
		Granbury Care Center	

Johnson County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Texas Health Harris Methodist Hospital Cleburne		Alvarado LTC Partners Inc	
		Grandview Nursing Home	
		Heritage Trials Nursing and Rehabilitation Center	
		Ridgeview Rehabilitation and Skilled Nursing	
		Colonial Manor Nursing Center	

Navarro County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Navarro Regional Hospital		Trisun Care Center	
Grace and Mercy Health Clinic		Country Meadows Nursing and Rehabilitation Center	
		Kerens Care Center	

Parker County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Weatherford Regional Medical Center	Campbell Clinic	College Park Rehabilitation and Care Center	Pecan Valley MH/MR, Weatherford Clinic
		Holland Lake Nursing Center	
		Keeneland nursing and Rehabilitation LP	
		Weatherford Health Care Center	
		Crescent Senior Care	
		Santa Fe Health and Rehabilitation Center	

Somervell County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Glen Rose Medical Center		Cherokee Rose Nursing and Rehabilitation	
		Glen Rose Nursing and Rehab Center	

Tarrant County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Baylor All Saints Medical Center at Fort Worth	Northside Community Health Center	Healthsouth City View Rehabilitation Hospital	Millwood Hospital

Baylor Orthopedic and Spine Hospital at Arlington	Southeast Community Health Center	Healthsouth Rehabilitation Hospital	
Baylor Regional Medical Center at Grapevine		Healthsouth Rehabilitation Hospital of Arlington	
Baylor Surgical Hospital at Fort Worth		Ethicus Hospital Grapevine	
Cook Children's Northeast Hospital		Global Rehab Hospital Forth Worth	
Cook Children's Medical Center		Kindred Hospital – Fort Worth	
JPS Health Network		Kindred Hospital– Mansfield	
Medical Center Arlington		Kindred Hospital – Tarrant County	
North Hills Hospital		Kindred Rehabilitation Hospital of Arlington	
Plaza Medical Center of Fort Worth		LifeCare Hospital of Fort Worth	
Methodist Mansfield Medical Center		Regency Hospital – Fort Worth	
Southwest Surgical Hospital		Texas Health Specialty Hospital Fort Worth	
Texas Health Arlington Memorial Hospital		Reliant Rehabilitation Hospital – Mid-Cities	
Texas Health Harris Methodist Hospital Azle			
Texas Health Harris Methodist Hospital Fort Worth			
Texas Health Harris Methodist Hospital Hurst – Euless -Bedford			
Huguley Memorial Medical Center			
Texas Health Harris Methodist Hospital Southlake			
Texas Health Harris Methodist Hospital Southwest Fort Worth			
Texas Health Heart & Vascular Hospital			
USMD Hospital at Arlington			
USMD Hospital at Fort Worth			

Wise County:

Facilities by Type			
Acute Care Hospitals	**Clinics**	**Long-Term Care and Rehab Facilities**	**Mental Health Facilities**
Wise Regional Health System	Alvord Medical Clinic	Senior Care health and Rehabilitation Center – Decantur	
North Texas Community Hospital		Senior Care Health and Rehabilitation Center – Bridgeport	
		Decantur Nursing and Rehabilitation LP	
		The hills Nursing and Rehabilitation	

D-6: Survey of Provider Participation in Federal Initiatives

Region 10 RHP
Survey of Potential DSRIP Project Overlap with Federally Funded Initiatives

Region 10 RHP is required to submit an RHP plan to the Texas Health and Human Services Commission (HHSC) and to the Centers of Medicare and Medicaid (CMS) on behalf of the Region's performing providers that details all proposed Delivery System Reform Incentive Payment (DSRIP) projects. CMS and HHSC guidance indicates that they want performing providers to report their participation in all of the federal initiatives listed below.

Please indicate whether your organization participates in any of the following federal initiatives by indicating "YES," "NO," or "UNKNOWN." If you answer "YES" to an initiative, please also indicate which project(s) potentially overlap by its unique DSRIP Project Identifier number.

Thank you for your continued participation in Region 10 RHP!

Performing Provider Name: _____

Texas Medicaid Provider Identifier (TPI):_____

FEDERAL INITIATIVE	YES	NO	UNKNOWN
Accountable Care Organizations (ACOs)	☐	☐	☐
Advance Payment Model	☐	☐	☐
Pioneer ACO Model Bundled Payments for Care Improvement	☐	☐	☐
Comprehensive Primary Care Initiative	☐	☐	☐
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	☐	☐	☐
Graduate Nurse Education Demonstration	☐	☐	☐
Health Care Innovation Awards	☐	☐	☐
Independence at Home Demonstration	☐	☐	☐

FEDERAL INITIATIVE	YES	NO	UNKNOWN
Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents	☐	☐	☐
Medicaid Emergency Psychiatric Demonstration	☐	☐	☐
Partnership for Patients	☐	☐	☐
State Innovation Models Initiative	☐	☐	☐
Strong Start for Mothers and Newborns	☐	☐	☐
EHR incentive payments	☐	☐	☐
Health Information Exchange Grant	☐	☐	☐
Other HITECH grant or payment(s)	☐	☐	☐
FQHC/RHC/School-based health center grants, including capital grants	☐	☐	☐
Health professions loans and workforce development grants	☐	☐	☐
Ryan White funding	☐	☐	☐
Maternal and child health grants	☐	☐	☐
Community Mental Health Services Block Grant	☐	☐	☐
Substance Abuse Prevention and Treatment Block Grant	☐	☐	☐
Projects for Assistance in Transition from Homelessness (PATH)	☐	☐	☐
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	☐	☐	☐
Other mental health and substance abuse grants: *PLEASE REFER TO THIS PAGE FOR SPECIFIC GRANT DETAILS* http://www.samhsa.gov/Statesummaries/detail/2012/TX.aspx *PLEASE LIST ANY OTHER PERTINENT GRANTS:* _____	☐	☐	☐
Immunization grants	☐	☐	☐
CLASBI/ Hospital acquired infection initiatives	☐	☐	☐
Other CDC grants: *PLEASE REFER TO THIS PAGE FOR SPECIFIC GRANT DETAILS* http://www.cdc.gov/about/business/state_funding.htm	☐	☐	☐

FEDERAL INITIATIVE	YES	NO	UNKNOWN
PLEASE LIST ANY OTHER PERTINENT GRANTS: _____			

D-6.1: List of Provider Participation in Federal Initiatives

Baylor All-Saints Medical Center at Fort Worth
Not participating in any federally funded initiatives

Cook Children's Medical Center
- Ryan White Funds
- Maternal and Child Health Grants

Helen Farabee Centers
Not participating in any federally funded initiatives

Lakes Regional MHMR
Not participating in any federally funded initiatives

Texas Health Fort Worth
Not participating in any federally funded initiatives

Ennis Regional Medical Center
- EHR Incentive Payments

Glen Rose Medical Center
- EHR Incentive Payments

JPS Health Network

- Strong Start for Mothers and Newborns
- EHR Incentive Payments
- FQHC/RHC/School-Based health center grants, including capital grants
- Ryan White funding
- Maternal and Child Health grants
- Community Mental Health Services block grant
- Substance Abuse Prevention and Treatment block grant
- Immunization grants

JPS Physician Group

- EHR Incentive Payment
- Health Information Exchange Grant

HCA - Medical Center of Arlington, North Hills Hospital, and Plaza Medical Center Forth Worth

- Partnership for Patients
- Other HITECH grant or payment
- Health professions loans and workforce development grants

Methodist Mansfield Medical Center

- EHR incentive payments

MHMR of Tarrant County

- EHR incentive payments
- Community Mental Health services block grant
- Substance Abuse Prevention and Treatment Block Grant
- Projects for Assistance in Transition from Homelessness (PATH)
- Other mental health and substance abuse grants

Pecan Valley Centers for Behavioral and Developmental Healthcare

- Community Mental Health services block grant

Tarrant County Public Health

- Ryan White funding
- Immunization grants
- Other CDC grants

Texas Health Forth Worth Methodist Hospital

- Accountable Care Organizations
- EHR incentive payments
- Health Information Exchange Grant

Texas Health HEB

- EHR incentive payments

University of North Texas Health Science Center

- Health Care Innovation Awards
- EHR incentive payments
- Health Information Exchange Grant
- Other CDC grants
- HRSA funds

Wise Clinical Care Associates

- EHR incentive payments

Wise Regional Health System

- EHR incentive payments

D-7: References and Citations

COMMUNITY NEEDS ASSESSMENT RESOURCES
Data Sources

- **American Factfinder** (www.factfinder2.census.gov)
- **Centers for Disease Control – Behavioral Risk Factor Surveillance System** (http://apps.nccd.cdc.gov/brfss-smart/SelMMSAPrevData.asp)
- **Centers for Disease Control – Office of Minority Health and Health Disparities** (www.cdc.gov/omhd/populations/definitionsREMP.htm)
- **Center for Health Statistics** (www.dshs.state.tx.us/chs/datalist.shtm)
- **County Health Rankings** (www.countyhealthrankings.org)
- **Health.Data.Gov** (www.data.gov/health)
- **Health Indicators Warehouse** (www.healthindicators.gov)
- **Health Professional Shortage Areas** (http://hpsafind.hrsa.gov/)
- **Health Resources County Comparison Tool** (http://arf.hrsa.gov/arfwebtool/index.htm)
- **Health Resources Services Administration** (http://bhpr.hrsa.gov/shortage/hpsas/index.html)
- **Kaiser Family Foundation** (www.kff.org)
- **Medically Underserved Areas** (http://muafind.hrsa.gov/index.aspx)
- **State Health Facts** (www.statehealthfacts.org)
- **Texas Department of State Health Services** (www.dshs.state.tx.us/chs/healthcurrents/)
- **Texas Department of State Health Services** (www.dshs.state.tx.us/diabetes/tdcdata.shtm)
- **Thompson Reuters, 2011**
- **United States Census Bureau** (www.census.gov/population/www/projections/projectionsagesex.html)
- **United States Census Bureau** – (http://quickfacts.census.gov/qfd/states/48000.html)
- **United States Department of Health & Human Services – Community Health Status Indicators** (http://www.communityhealth.hhs.gov/homepage.aspx?j=1)

D-7: References and Citations

COMMUNITY NEEDS ASSESSMENT RESOURCES
References

This document defines primary care as family medicine, internal medicine, and pediatric medicine.
[2] NHIS 2001-2005 Overcoming Obstacles to Health
[3] The federal poverty level is $10,890 for an individual, or $22,350 for a family of four, in 2011.
[4] Institute of Medicine, "Hidden Costs, Value Lost," Consequences of Uninsurance Series No. 5, June 2003; and Center for Studying Health System Change, "Triple Jeopardy: Low Income, Chronically Ill and Uninsured in America," Issue Brief No. 49, February 2002.
[5] Region 10 Stakeholder Survey (Appendix D-2.2)
[6] Region 10 RHP County Visioning Sessions

Appendix E:
Additional Stakeholder Engagement Information

E-1: Listing of DSRIP Non-Participating Providers in Region 10

UC-Only Participant Providers in Region 10

Navarro Regional Hospital
Lake Granbury Medical Center
Baylor Medical Center at Waxahachie
Baylor Regional Medical Center at Grapevine
North Texas Community Hospital

Non-DSRIP or UC Participant Providers in Region 10

North Texas Behavioral Health Authority: Ellis, Navarro County
Weatherford Regional: Parker County

E-2: Detailed Description of RHP Committees, Charters, Sample Agendas and List of Committee Members

Steering Committee

Region 10 RHP's steering committee provides leadership and shapes the development of the RHP. Inclusion of leadership from participating Performing Provider was critical to ensure the commitment of the Region's major providers. This committee's responsibilities include educating and informing all stakeholders on the purpose, intent and consequences related to the development and implementation of the RHP plan. Committee members were charged with the following stakeholder engagement duties:

- Define required level of engagement for providers wishing to participate in the RHP;
- Ensure regular communication and updates to and from all RHP committees and stakeholders;
- Identify, recruit and encourage active engagement by all stakeholders in the Region in RHP plan development; and,
- Provide and support representation and communication for the RHP to HHSC.

Meeting dates:

- May 30, 2012
- June 20, 2012
- July 18, 2012
- August 15, 2012
- September 19, 2012
- October 31, 2012

Please see below (Appendix E-2.1) for the charter that was ratified by committee members.
Please see below (Appendix E-2.2) for an example of an agenda used during the meetings.

Elected Officials Committee

Region 10's Elected Officials Committee's roles and responsibilities are to educate and inform constituencies and stakeholders on the purpose, intent and consequences related to the development and implementation of the Waiver, and facilitate coordination and collaboration among Region 10 stakeholders. Responsibilities of the Elected Officials Committee that pertain to stakeholder engagement include:

- Identify county liaison(s) to support and coordinate with Region 10 committees in development of RHP Plan, information gathering and stakeholder involvement and education;
- Discuss and assist with dissemination of new information and developments from HHSC;
- Provide support and guidance to Region 10 Steering committee to ensure performing provider engagement and alignment during the initial Region 10 RHP Plan development and the four year performance period;
- Assist in outreach to stakeholders and encouragement of ongoing stakeholder feedback during the initial RHP Plan development and the four year performance period;

- Provide insight into county needs and relations between various providers and stakeholders; and
- Assist with facilitation of coordination between performing providers, as well as between performing providers and other stakeholders.

Meeting dates:

- May 30, 2012
- June 20, 2012
- July 18, 2012
- August 15, 2012
- September 19, 2012
- October 31, 2012

Please see below (Appendix E-2.1) for the charter that was ratified by committee members.
Please see below (Appendix E-2.2) for an example of an agenda used during the meetings.

Planning Committee

The RHP Planning Committee provides guidance, coordination, and oversight of the development, submission and implementation of the Region 10 RHP Plan. Secondarily, the Planning Committee works to educate RHP participants, particularly IGT entities and performing providers, on Waiver developments, communicate information, develop planning and implementation principles consensus, and to solicit feedback for development of position papers affecting Waiver planning matters. In particular, this committee is responsible for providing technical assistance and support to performing providers during project development. Members of this Committee take lead responsibility for coordination with all other Region 10 committees, and their responsibilities include:

- Identify and engage stakeholders from each county within Region 10;
- Collaborate on timelines, processes, communications and deliverables during the development of the RHP plan;
- Develop by consensus the Regional and local gaps for the Community Health Needs Assessment to be addressed by DSRIP projects in years 3-5;
- Coordinate with Clinical & Quality Committee to support coordinated development of DSRIP projects for participating providers at local and Regional level; and
- Participate in collaboration and implementation of general public engagement and communication process.

The Region 10 RHP planning team conducted a stakeholder survey, a county judge survey, and provided county-level assessment tools and Performing Provider Readiness assessment tools in order to develop an accurate and comprehensive picture of the Region. The team completed the RHP-level CHNA by synthesizing the County-level CHNA and Performing Provider Readiness surveys in mid-July. This information was provided to RHP participants to inform the development of DSRIP projects.

Meeting dates:

- May 24, 2012
- June 14, 2012

- June 28, 2012
- July 12, 2012
- July 26, 2012
- August 9, 2012
- August 23, 2012
- September 27, 2012
- October 11, 2012
- October 25, 2012
- November 15, 2012
- December 3, 2012

Please see below (Appendix E-2.1) for the charter that was ratified by committee members.
Please see below (Appendix E-2.2) for an example of an agenda used during the meetings.

Clinical Quality Committee

The Clinical Quality Committee's primary role and responsibility is to ensure that all DSRIP projects meet quality objective standards, are linked to patient-focused outcomes, and fully comply with Waiver quality requirements. Clinical Quality Committee activities are linked to stakeholder engagement efforts in the following ways:

- Synthesize and disseminate best practices;
- Define which feedback mechanisms to providers will be most helpful and determine the consequences for those providers who do not comply with requirements of a new delivery system;
- Provide leadership for improving care coordination across partners;
- Develop recommendations on how to best utilize and effectively structure specialty care, hospital-based, and ancillary service delivery;
- Identify and strengthen efforts to work with provider advocacy groups/organizations;
- Provide guidance on clinical information systems; and
- RHP Plan content – Provide guidance and content to committees regarding clinical quality matters required for completion of the RHP Plan for Region 10.

Clinical Quality Committee members utilized their individual strengths, expertise, and current roles and coordinated with Region 10 RHP providers on the following tasks:

- Quality improvement;
- Process improvement;
- Creation of clinical quality metrics for DSRIP projects; and
- Evaluations of potential DSRIP projects to ensure that clinical quality outcomes were patient-centered and returned an appropriate clinical value to the community.

Meeting dates:

- May 24, 2012
- June 14, 2012
- June 28, 2012
- July 12, 2012
- July 26, 2012

- August 9, 2012
- August 23, 2012
- September 27, 2012
- October 11, 2012
- October 25, 2012
- November 15, 2012
- December 3, 2012

Please see below (Appendix E-2.1) for the charter that was ratified by committee members.
Please see below (Appendix E-2.2) for an example of an agenda used during the meetings.

Finance Committee

The Finance Committee's roles and responsibilities were to build a detailed, structurally sound and internally consistent budget (for fiscal years 2013 through 2016 of the initial term of the Waiver) that supports the Region 10 RHP Plan. Secondarily, the Committee works to educate members on financial aspects of Waiver development, communicate informational requirements, develop consensus on Regional financial principles, and solicit feedback for development of position papers on Waiver financing. Members of the Finance Committee were committed to the following responsibilities regarding stakeholders:

- Build relationships and enable collaboration among RHP members;
- Provide information as required to complete the RHP Plan; and
- Actively collaborate and provide meaningful participation in determination and completion of the RHP Plan.

Meeting dates:

- May 24, 2012
- June 14, 2012
- June 28, 2012
- July 12, 2012
- July 26, 2012
- August 9, 2012
- August 23, 2012
- September 27, 2012
- October 11, 2012
- October 25, 2012

Please see below (Appendix E-2.1) for the charter that was ratified by committee members.
Please see below (Appendix E-2.2) for an example of an agenda used during the meetings.

Appendix E-2.1. RHP Committee Charters

RHP Steering Committee Charter
Adopted by RHP Steering Committee on June 20, 2012

I. Purpose

The primary goals of the RHP 10 Steering Committee are to (i) ensure all RHP 10 activities support the transformative intent of the Waiver to provide better health care for less money, (ii) educate and inform all stakeholders on the purpose, intent and consequences related to the development and implementation of the Waiver, and (iii) facilitate coordination and collaboration among the RHP 10 stakeholders.

II. Membership

A. All meetings will be open to the public.

B. List of committee members, titles and county affiliation (List of members to be finalized after HHSC makes its final determination of Region 10.)
   1. Robert Earley; CEO, JPS Health Network
   2. David Orcutt; CEO, Lake Granbury Medical Center
   3. Ray Reynolds; CEO, Glen Rose Medical Center
   4. Steve Newton; President, Baylor Health
   5. Scott B. Ransom, DO; President, UNTHSC
   6. Jim Scoggin; President, HCA North Texas Division, HCA
   7. Barclay Berdan; COO, THR
   8. Lou K. Brewer; Director, Tarrant County Public Health
   9. Randall Young; CEO, Parker County Hospital District
   10. Stephen Summers; CEO, Wise Regional
   11. Susan Garnett; Deputy CEO, MHMR Tarrant County
   12. Rick Merrill; President/CEO, Cook Childrens
   13. David Anderson; CEO, Ennis Regional
   14. John Delaney; Executive Director, Lakes Regional MHMR
   15. Xavier Villarreal; CEO, Navarro Regional Hospital
   16. Judge Thompson; County Judge – Erath
   17. Judge Whitley; County Judge – Tarrant

C. Committee Chair – Name, title and organizational affiliation
   1. Robert Earley, CEO, JPS Health Network (Anchor Facility)

D. Voting and decision-making process
   1. Each voting member will be given one vote for matters that require a vote for approval. Decision making will be by majority vote when required.

III. Roles and Responsibilities

The RHP Steering Committee is charged with the following responsibilities for the duration of the rights, interests and obligations contemplated in the Waiver:

- Ensure Performing Provider and IGT Entity engagement and alignment Provide oversight and review recommendations from the RHP committees (Planning, Quality/Clinical and Finance)
- Define required level of engagement for providers wishing to be participants in the RHP
- Ensure regular communication and updates to and from all RHP committees and stakeholders
- Identify, recruit and encourage active engagement in the RHP development by participants and other stakeholders
- Provide and support representation and communication for the RHP to HHSC
- Review interim and final deliverables, ensuring overall alignment with Waiver objectives, guidelines, Regional and local interests
- Support development of unified, coordinated Region 10 RHP proposal
- Act as the intermediary between the Elected Officials committee and the RHP committees
- Discuss and disseminate new developments and updates from HHSC

IV. Meetings

A. Meeting Schedule
   1. 3rd Wednesday of each month
   2. Time: 10:30am-12:00pm
   3. Location: The Riley Center – Southwestern Baptist Theological Seminary, Conference RC - 237

B. Meeting Agenda
   1. Outline of agenda template and content – The attached agenda format will be used.

   2. Process for developing, approving agenda with Chair and timeline for dissemination with committee members – Agenda items for each meeting will be developed in each preceding meeting. Requests for additional agenda items may be made and can be made by a participating member one week prior to a regularly scheduled meeting.

   3. Process for developing, approving and disseminating materials to committee members – Agenda's and materials will be distributed by email on the Friday before each meeting

RHP Elected Officials Committee Charter
Adopted by Region 10 Elected Officials Committee on June 20, 2012

V. Purpose

The primary goals of the Region10 Elected Officials Committee are to (i) ensure all Region 10 Steering Committee activities support the transformative intent of the Waiver to provide better health care for less money, (ii) educate and inform constituencies and stakeholders on the purpose, intent and consequences related to the development and implementation of the Waiver, and (iii) facilitate coordination and collaboration among the Region 10 stakeholders.

VI. Membership

E. Membership Qualification – Each county that participates in the Region 10 Regional Healthcare Partnership (RHP), as memorialized by a Memorandum of Understanding, may nominate its Judge, or a Commissioner in place of its Judge, to participate in the committee meetings. All meetings will be open to the public.

F. List of committee members, titles and county affiliation (List of members to be finalized after HHSC makes its final determination of Region 10)
   1. Judge Glen Whitley, County Judge, Tarrant County
   2. Judge Bill McElhaney, County Judge, Wise County
   3. Judge Darrell Cockerham, County Judge, Hood County
   4. Judge Mark Riley, County Judge, Parker County
   5. Judge Roger Harmon, County Judge, Johnson County
   6. Judge Mike Ford, County Judge, Somervell County
   7. Judge Tab Thompson , County Judge, Erath County
   8. Judge Carol Bush, County Judge, Ellis County
   9. Judge HM Davenport Jr., County Judge, Navarro County

G. Committee Chair:
   1. Judge Carol Bush, County Judge, Ellis County

H. Voting and decision-making process
   1. Each participating county will be required to designate one voting member for matters that require a vote for approval. Decision making will be by majority vote when required.

VII. Roles and Responsibilities

A. The Region 10 Elected Officials Committee is charged with the following responsibilities during the initial Region 10 RHP plan development and the four year performance period:

- Identify county liaison(s) to support and coordinate with Region 10 committees in development of RHP plan, information gathering and stakeholder involvement and education
- Discuss and assist with dissemination of new information and developments from HHSC

- Ensure that their own county's needs are represented within the Region 10, while supporting and informing coordination efforts across counties
- Provide support and guidance to Region 10 Steering committee to ensure performing provider engagement and alignment during the initial Region 10 RHP plan development and the four year performance period
- Assist in outreach to stakeholders and encouragement of ongoing stakeholder feedback during the initial RHP plan development and the four year performance period
- Provide insight into county needs and relations between various providers and stakeholders
- Assist with facilitation of coordination between performing providers, as well as between performing providers and other stakeholders

VIII. Meetings

C. Meeting Schedule
   1. 3rd Wednesday of each month
   2. Time: 9:00am-10:30am
   3. Location: The Riley Center – Southwestern Baptist Theological Seminary, Conference RC - 237

D. Meeting Agenda
   1. Outline of agenda template and content – The attached agenda format will be used.

   2. Process for developing, approving agenda with Chair and timeline for dissemination with committee members – Agenda items for each meeting will be developed in each preceding meeting, with additions recommended to the Chair by Region 10 support staff as new developments arise. Requests for additional agenda items may be made and can be made by a participating member one week prior to a regularly scheduled meeting.

   3. Process for developing, approving and disseminating materials to committee members – Agenda's and materials will be distributed by email on the Friday before each meeting

RHP Planning Committee Charter
Adopted by RHP Planning Committee on June 14, 2012

IX. Overview

The primary goal of the RHP Planning Committee is to provide guidance, coordination, and oversight of the development, submission and implementation of the Region 10 Delivery System Reform Incentive Payment (DSRIP) plan; ensuring the DSRIP projects and plan, and related timelines, objectives, milestones, and metrics, meet all requirements of the Waiver Standard Terms and Conditions and applicable protocols.

The secondary purposes of the committee are to educate members on Waiver developments, communicate information, develop consensus on planning and implementation principles for Region 10 matters when necessary, and to solicit feedback for development of position papers affecting Waiver planning matters. Coordination with all Region 10 committees will be important.

X. Purpose

B. List of objectives and major activities of the committee – The Planning Committee's core focus will be to develop the Region10 plan as required by the terms of the Waiver. This will require focus in, but may not be limited to, the following areas:
   1. Development of Regional Community Health Needs Assessment
   2. Stakeholder Engagement
   3. DSRIP project evaluation – Develop methodologies, guiding principles and protocols for evaluating DSRIP projects to ensure (i) prompt acceptance by HHSC and CMS, (ii) enable reporting and measurement, and (iii) improve access, quality and outcomes to the betterment of the Region. This will require education and coordination with participating members, other Region 10 committees, HHSC and CMS.

C. Overview of deliverables, milestones and deadlines (timeline) – The deliverables for the Planning Committee for Region 10 include:
   1. Completion of Region 10 plan available for public comment: August 17, 2012
   2. Submission of Region 10 plan to HHSC: August 31, 2012
   3. Completion of position papers and other policies necessary for promoting Region 10 requirements and for guiding member participation (as needed)

XI. Membership

I. Membership Qualification – Each provider organization that participates in Region 10, as memorialized by an executed affiliation agreement, may participate in the committee's meetings and agendas. Meetings will be open to the public.

J. List of committee members, titles and organizational affiliation – The committee shall consist of:
   1. List of members to be finalized after HHSC makes final determination of Region 10 counties and map.

K. Chair – Name, title and organizational affiliation – Scott Rule, Vice President – Planning and Analysis of the Anchor organization will chair meetings. The committee shall determine a back-up co-chair.

L. Voting and decision-making process – Each participating organization will be required to designate one voting member for matters that require a vote for approval. Decision-making will be by majority vote when required.

XII. Roles and Responsibilities

A. The RHP Planning Committee is charged with the following responsibilities for the duration of the rights, interests and obligations contemplated in the Waiver.
   4. Identify and engage stakeholders from each county within Region 10
   5. Collaborate on timelines, processes, communications and deliverables during the development of the RHP plan
   6. Develop by consensus the Regional and local gaps for the Community Health Needs Assessment to be addressed by DSRIP projects in years 3-5
   7. Coordinate with Clinical & Quality Committee to support:
      i. Coordinated development of DSRIP projects for participating providers at local and Regional level
      ii. Coordinated development of DSRIP goals, projected outcomes and milestones
   8. Coordinate with Finance and Clinical & Quality Committees in the valuation of DSRIP projects, including development of methodologies and protocols for assigning values to DSRIP projects and education of and coordination with participating providers, HHSC and CMS
   9. Participate in collaboration and implementation of general public engagement and communication process
   10. Collaborate on the development of RHP processes, protocols and standards for data collection, reporting, performance management (post implementation)
   11. Discuss and disseminate new developments and updates from HHSC

XIII. Meetings

A. Meeting Schedule
   1. 2nd and 4th Thursday of each month
   2. Time: 10:30am-12:00pm
   3. Location: The Riley Center – Southwestern Baptist Theological Seminary, Conference RC – 237

B. Meeting Agenda
   1. Outline of agenda template and content – The attached agenda format will be used.

   2. Process for developing, approving agenda with Chair and timeline for dissemination with committee members – Agenda items for each meeting will be developed in each preceding meeting. Requests for additional agenda items may be made and can be made by a participating member one week prior to a regularly scheduled meeting.

   3. Process for developing, approving and disseminating materials to committee members – Agenda's and materials will be distributed by email on the Monday before each meeting.

RHP Clinical & Quality Committee Charter
Adopted by RHP Clinical & Quality Committee on June 14, 2012

XIV. Overview

The primary goal of the Clinical & Quality Committee is to ensure that appropriate clinical and quality metrics and outcomes are considered in (i) the selection of Delivery System Reform Incentive Payment (DSRIP) projects, and (ii) the measurement and reporting for the DSRIP projects consistent with the requirements of the 1115 Waiver Standard Terms and Conditions and the needs of the respective communities of Region 10.

XV. Purpose

D. List of objectives and major activities of the committee – The Clinical & Quality Committee's core focus will be to select and apply appropriate clinical and quality outcomes and metrics related to the Region 10 plan as required by the terms of the Waiver. This will require focus in, but may not be limited to, the following areas:
   1. Input to HHSC on DSRIP project menu
   2. DSRIP project clinical and quality evaluation – Develop methodologies, guiding principles and protocols for evaluating DSRIP projects to (i) ensure prompt acceptance by HHSC and CMS, (ii) enable reporting and measurement, and (iii) improve access, quality and outcomes to the betterment of the Region. This will require education and coordination with participating members, other Region 10 committees, HHSC and CMS.
   3. Analysis of proposed outcomes and metrics associated with proposed DSRIP projects

E. Overview of deliverables, milestones and deadlines (timeline) – The deliverables for the Clinical & Quality Committee for Region 10 include:
   1. Comments to HHSC on DSRIP menu
   2. Coordinate with other RHP committees to complete the Region 10 plan
   3. Completion of position papers and other policies necessary for promoting Region 10 requirements and for guiding member participation (as needed)

XVI. Membership

M. Membership Qualification – Each provider organization that participates in Region 10, as memorialized by an executed affiliation agreement, may participate in the committee's meetings and agendas. Meetings will be open to the public.

N. List of committee members, titles and organizational affiliation – The committee shall consist of:
   1. List of members to be finalized after HHSC makes final determination of Region 10 counties and map.

O. Chair – Name, title and organizational affiliation – Elizabeth Carter, MD, Senior Vice President – Population Health of the Anchor organization will chair meetings. The committee shall determine a back-up co-chair.

P. Voting and decision-making process – Each participating organization will be required to designate one voting member for matters that require a vote for approval. Decision-making will be by majority vote when required.

XVII. Roles and Responsibilities

A. The RHP Clinical & Quality Committee is charged with the following responsibilities during the initial RHP plan development and the four year performance period:

1. Community Health Needs Assessments: Inform development of community and provider readiness assessments.
2. DSRIP projects: Support Planning committee in development and selection of appropriate DSRIP projects that reflect local and Regional provider vision and address health care delivery system gaps; including development of milestones, metrics and clinical outcome measures.
3. DSRIP project valuation – With Planning and Finance committees, develop methodologies and protocols for assigning values to DSRIP projects; including education and coordination with participating providers, HHSC and CMS.
4. Coordinate with Planning Committee to develop RHP processes, protocols and standards for data collection, reporting, performance management (post implementation).
5. Discuss and disseminate new developments and updates from HHSC.

XVIII. Meetings

E. Meeting Schedule
1. 2nd and 4th Thursday of each month
2. Time: 9:00am-10:30am
3. Location: The Riley Center – Southwestern Baptist Theological Seminary, Conference RC - 237

F. Meeting Agenda
1. Outline of agenda template and content – The attached agenda format will be used.

2. Process for developing, approving agenda with Chair and timeline for dissemination with committee members – Agenda items for each meeting will be developed in each preceding meeting. Requests for additional agenda items may be made and can be made by a participating member one week prior to a regularly scheduled meeting.

3. Process for developing, approving and disseminating materials to committee members – Agenda's and materials will be distributed by email on the Monday before each meeting.

Appendix E-2.2. Sample Agendas from RHP Committee Meetings

AGENDA

RHP Combined Committees Meeting
July 12, 2012
10:30 AM - 12:00 PM
Riley Conference Center

Topics
A. Welcome
B. RHP Updates: a. Funding and Mechanics Protocol b. County Visioning Sessions c. Meeting IRS requirements related to Community Health Needs Assessments
C. Updated DSRIP Menu 1. DSRIP Menu Crosswalk between old and new menu 2. Updated DSRIP Metrics and Milestones summary table
D. Performing Provider DSRIP Project Planning 1. Supplemental DSRIP Narrative worksheet 2. Evaluation tool to prioritize projects 3. General FAQs addressed and technical assistance – incorporate q's?/office hours?
E. Next Steps 1. DSRIP project planning worksheets and supplemental narrative tool 2. 2nd draft Performing Provider DSRIP projects – *July 16th* (what is a reasonable date?) 3. Draft multiprovider and Regional DSRIP projects – *July 16th*

AGENDA

RHP Combined Committees Meeting
August 23, 2012
9:00am – 11:00am
Naylor Student Center, SWBTS

Goals:

- Examine trends, gaps and inconsistencies between Region 10 DSRIP projects
- Provide technical assistance/summarize trends in individual DSRIP project development

Topics
F. Welcome
G. HHSC Updates
H. Region 10 RHP Status Check
I. DSRIP Projects: A Deeper Dive **a. Summary of Region 10 projects (Table 1)** **b. Technical Feedback and Project Gap Analysis** **c. Five Year Goal Trends and Alignment** **i. Community Health Needs (Table 2)** **ii. Delivery System Gaps (Table 3)** **iii. Waiver Goals (Table 4)**
J. Region 10 DSRIP Projects: Next Steps **d. Opportunities for collaboration and risks for duplication** **e. Breakout groups**
K. Finance updates
L. Please add to your calendars: <u>September 5th Planning, Clinical & Quality and Finance Meeting</u>
M. Q&A

AGENDA

RHP Elected Officials Committee
June 20, 2012
9:00am – 10:30am
Riley Conference Center

TOPICS
A. Welcome and Introductions
B. Review and approve minutes from May 30th committee meeting
C. Review and ratify committee charter
D. Finance Update: Funding opportunity by county
E. Community Health Needs Assessment Update a. What are your constituents saying? – Stakeholder results by county b. What's requested of your constituents next? i. Performing Provider Readiness Assessment ii. DSRIP Planning
F. County Hosted Visioning Sessions
G. Proposed DSRIP Opportunities by County and for our Region
H. Agenda for next meeting
I. Q&A

AGENDA

RHP Steering Committee Meeting
September 19, 2012
10:30AM
Webinar

Goals:

- Examine trends, gaps and inconsistencies between Region 10 DSRIP projects
- Understand revised RHP timeline/next steps

Topics
N. Welcome
O. HHSC Updates
P. Region 10 RHP Development Timeline
Q. DSRIP Projects: A Deeper Dive **f. Summary of Region 10 projects (Table 1)** **g. Five Year Goal Trends and Alignment** **i. Community Health Needs (Table 2)** **ii. Delivery System Gaps (Table 3)** **iii. Waiver Goals (Table 4)**
R. RHP Plan: Next Steps
S. Finance updates
T. Please add to your calendars: Wednesday, October 17th Meeting
U. Q&A

Appendix E-2.3. RHP Committee Members List

RHP Steering

Name	Title	Organization	County
Robert Earley	CEO	JPS Health Network	Tarrant
David Orcutt	CEO	Lake Granbury Medical Center	Hood
Ray Reynolds	CEO	Glen Rose Medical Center	Somervell
Steve Newton	President	Baylor Health	Tarrant
Scott B. Ransom, DO	President	UNTHSC	Tarrant
Jim Scoggin	President HCA North Texas Division	HCA	Tarrant*
Barclay Berdan	COO	THR	Tarrant*
Lou K. Brewer	Director	Tarrant County Public Health	Tarrant
Randall Young	CEO	Parker County Hospital District	Parker
Stephen Summers	CEO	Wise Regional	Wise
Susan Garnett	Depty CEO	MHMR Tarrant County	Tarrant
Rick Merrill	President/CEO	Cook Childrens	Tarrant
David Anderson	CEO	Ennis Regional	Ellis
John Delaney	Executive Director	Lakes Regional MHMR	Ellis
Xavier Villarreal	CEO	Navarro Regional Hospital	Navarro
Judge Thompson	County Judge – Erath	County Judge – Erath	Erath
Judge Whitley	County Judge – Tarrant	County Judge – Tarrant	Tarrant
Scott Rule	VP, Planning	JPS Health Network	Tarrant
David Salsberry	CFO	JPS Health Network	Tarrant
Roddy Atkins		Helen Farabee Centers	Wise
Coke Beatty		Pecan Valley	Hood, Erath, Parker, Johnson, Somervell
Mark Whitley	Senior VP of Development	Hospital Corporation of America	

RHP Planning

Name	Title	Organization	County
Scott Rule	VP, Planning	JPS Health Network	Tarrant
Noe Gutierrez Jr	CFO	Lake Granbury Medical Center	Hood
Mo Sheldon	COO	Glen Rose Medical Center	Somervell
TBD		Methodist Mansfield	Tarrant
TBD		Baylor Health	Tarrant
Kathleen Sweeney	VP Community Resources HCA North Texas Division	HCA	Tarrant*
Aaron Bujnowski	VP Analytics and Marketing Intelligence	THR	Tarrant*
Kathleen Forbes, MD	EVP Clinical Affairs and Business Dev, President and CEO, UNT Health	UNTHSC	Tarrant
Robert Adams, DO	VP and CMO, UNT Health	UNTHSC	Tarrant
Gianna Harris, LCSW	Associate Executive Director	Helen Farabee Centers	Tarrant
Alecia Morrison	Public Information Officer	Pecan Valley	Tarrant
Doug Fabio	Associate Director Prevention and	Tarrant county Public health	Tarrant

	Planning		
Todd Clawson	HR Director	Parker County Hospital District	Parker
Leon Fuqua	COO- Wise Regional	Wise Regional	Wise
Paul Aslin	COO – Clinical Care Associates	Wise Regional	Wise
Sonja Gaines	Chief of Mental Health Services	MHMR Tarrant County	Tarrant
Larry Tubb	Sr VP System Planning	Cook Childrens	Tarrant
TBD		North Texas Behavioral Health Authority	
John Delaney	Executive Director	Lakes Regional MHMR	Ellis
TBD		Navarro Regional Hospital	Navarro
Wayne Young	VP, Operations and Administrator	JPS Health Network	
Coke Beatty	Director	Pecan Valley	Tarrant
Roddy Atkins	Executive Director	Helen Farabee Centers	Wise
Ruben DeHoyos	Director of Administrative Services	Pecan Valley	Tarrant
Anne Turner		MHMR Tarrant County	Tarrant
John Baumgartner		Meth Health System	Dallas/Tarrant
Fred Savelsbergh		Baylor Health	Tarrant/Ellis/Somervell
Dick Roan	County Commissioner		Hood
Nancy Cooke		Wise Regional	Parker
Donna Martin		MHMR Tarrant County	Tarrant
Dave Anderson		Ennis Regional Medical Center	Ellis
Ron Parent		MHMR Tarrant County	Tarrant
Steve Newton		Baylor Health	Tarrant
Carol Nati, M.D.		MHMR Tarrant County	Tarrant
Lisa McClammy		Glen Rose Medical Center	Somervell

RHP Finance

Name	Title	Organization	County
Noe Gutierrez Jr	CFO	Lake Granbury Medical Center	Hood
David Salsberry	CFO	JPS Health Network	Tarrant
Michael Honea	Controller	Glen Rose Medical Center	Somervell
Mo Sheldon	COO	Glen Rose Medical Center	Somervell
John Baumgartner	SVP Finance, MHS	Methodist Mansfield	Tarrant
Fred Savelsbergh	Chief Financial Officer	Baylor Health	Tarrant
Pam Barnes	VP Reimbursement	Baylor Health	Tarrant
Michael B. Mueller, MBA	VP for Finance, CFO	UNTHSC	Tarrant
John A. Harman, MBA, CPA, CGMA, CMPE	VP and CFO, UNT Health	UNTHSC	Tarrant
Rod Brennan	Chief Financial Officer	Helen Farabee	Tarrant
Jana Simpson	Chief Accountant	Helen Farabee	Tarrant
Ricky Peninger	CFO	Pecan Valley	Tarrant
Tom Corley	CFO HCA North Texas Division	HCA	Tarrant*
Kathleen Sweeney	VP Community Resources HCA North Texas Division	HCA	Tarrant*
Ron Long	CFO	THR	Tarrant*

Marsh Gillespie	Business Manager	Tarrant County Public Health	Tarrant
Judy Harris	Controller	Parker County Hospital District	Parker
Jim Eaton	CFO	Wise Regional	Wise
Donna Martin	CFO	MHMR	Tarrant
Ron Parent	Director of Commercial Contracts	MHMR	Tarrant
Rich Goode	CFO	Cook Childrens	Tarrant
Cory Rhoades	Chief Accounting Officer	Cook Childrens	Tarrant
Jack Wilcox	CFO	Ennis Regional	Ellis
Nancy Cooke	CFO	Weatherford Regional	Parker
Todd Scroggins		Wise Regional	Ellis
TBD		North Texas Behavioral Health Authority	
TBD		Lakes Regional MHMR	Ellis
Marco Rodriguez	CFO	Navarro Regional Hospital	Navarro

RHP Clinical Quality

Name	Title	Organization	County
Lisa Carter, MD	Sr. VP Population Health	JPS Health Network	Tarrant
Joan Tracy	CQO	Lake Granbury Medical Center	Hood
Lisa McClammy	CNO	Glen Rose Medical Center	Somervell
Gale Benoit	Director of Quality	Glen Rose Medical Center	Somervell
Dr. David Ballard	SVP Quality/Chief Quality Officer	Baylor Health	Tarrant
Dr. Lauren Parsons	Medical Director	Helen Farabee	Tarrant
Donna Gilmore	Director of Authority Services	Pecan Valley	Tarrant
Scott Pool	Director of Provider Services	Pecan Valley	Tarrant
Scott Robins, MD	CMO HCA North Texas Division	HCA	Tarrant*
Mark Lester	VP/Chief Quality Officer	THR	Tarrant*
Sandra Parker	Medical Director	Public Health	Tarrant
Cynthia Chamness	DON, Campbell Clinic	Parker County Hospital District	Parker
John Walker, MD	Admin of Clinics	Wise Regional	Wise
Lynn Sherman	VP of QM	Wise Regional	Wise
Carol Nati, MD	Medical Director	MHMR Tarrant	Tarrant
David Stroud	Program Manager, UM/QM – Mental Health Services	MHMR Tarrant	Tarrant
Jim Cunningham	CMO	Cook Childrens	Tarrant
Nancy Cychol	Medical Center, President	Cook Childrens	Tarrant
Edwina Miner	CNO	Ennis Regional	Ellis
Angie Merrell	CNO	Navarro Regional Hospital	Navarro
Wayne Young	VP, Operations and Administrator	JPS Health Network	Tarrant
Gary Floyd	CMO	JPS Health Network	Tarrant
Tyna Noble		Parker County Hospital District	Parker
Todd Clawson		Parker County Hospital District	Parker
Coke Beatty		Pecan Valley	Erath, Somervell, Hood, Parker, Johnson
Lindsey Wallace		JPS Health Network	Tarrant

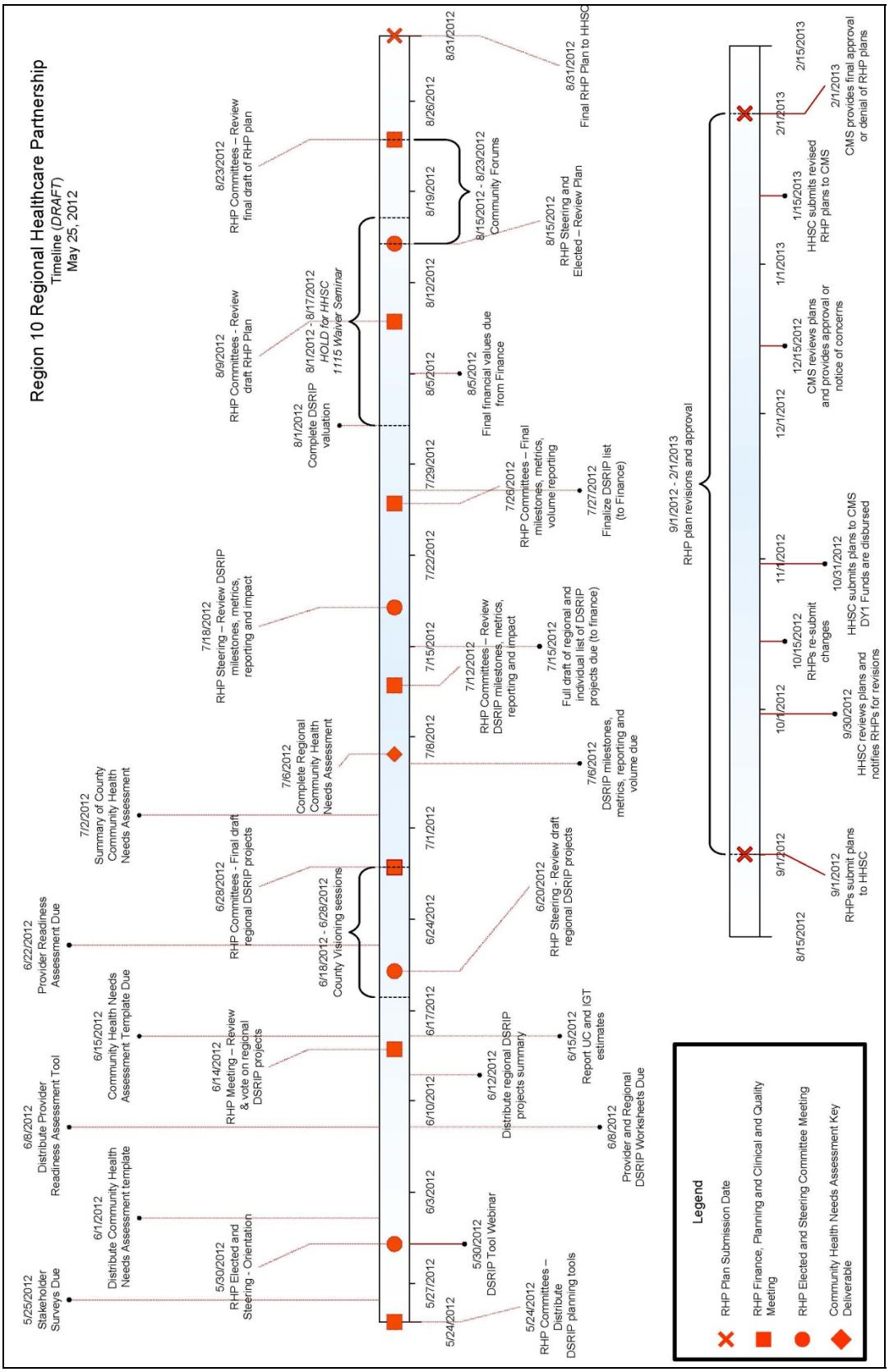
Larry Wayland	Wise Regional	Wise

RHP Elected Leaders

Name	Title	Organization	County
Judge Glen Whitley	County Judge	Tarrant County	Tarrant
Judge Bill McElhaney	County Judge	Wise County	Wise
Judge Darrell Cockerham	County Judge	Hood County	Hood
Judge Mark Riley	County Judge	Parker County	Parker
Judge Roger Harmon	County Judge	Johnson County	Johnson
Judge Mike Ford	County Judge	Somervell County	Somervell
Judge Tab Thompson	County Judge	Erath County	Erath
Judge Carol Bush	County Judge	Ellis County	Ellis
Judge HM Davenport Jr.	County Judge	Navarro County	Navarro

Appendix F:
Additional RHP DSRIP Project Development Information

The following timelines are examples of planning tools used during the RHP development process to communicate deadlines and process. The items in the timelines demonstrate the actions taken the help providers and the Region develop their DSRIP projects.


Region 10 Regional Healthcare Partnership
Timeline (DRAFT)
May 25, 2012
5/25/2012 Stakeholder Surveys Due
6/1/2012 Distribute Community Health Needs Assessment template
6/8/2012 Distribute Provider Readiness Assessment Tool
6/15/2012 Community Health Needs Assessment Template Due
6/22/2012 Provider Readiness Assessment Due
7/2/2012 Summary of County Community Health Needs Assessment
5/30/2012 RHP Elected and Steering - Orientation
6/14/2012 RHP Meeting – Review & vote on regional DSRIP projects
6/28/2012 RHP Committees - Final draft regional DSRIP projects
7/18/2012 RHP Steering – Review DSRIP milestones, metrics, reporting and impact
8/9/2012 RHP Committees - Review draft RHP Plan
8/23/2012 RHP Committees – Review final draft of RHP plan
5/24/2012
5/27/2012
6/3/2012
6/10/2012
6/17/2012
6/24/2012
7/1/2012
7/8/2012
7/15/2012
7/22/2012
7/29/2012
8/5/2012
8/12/2012
8/19/2012
8/26/2012
8/31/2012
5/30/2012 DSRIP Tool Webinar
6/12/2012 Distribute regional DSRIP projects summary
6/18/2012 - 6/28/2012 County Visioning sessions
7/6/2012 Complete Regional Community Health Needs Assessment
7/12/2012 RHP Committees – Review DSRIP milestones, metrics, reporting and impact
8/1/2012 Complete DSRIP valuation
8/1/2012 - 8/17/2012 HOLD for HHSC 1115 Waiver Seminar
8/15/2012 - 8/23/2012 Community Forums
8/15/2012 RHP Steering and Elected – Review Plan
8/31/2012 Final RHP Plan to HHSC
5/24/2012 RHP Committees – Distribute DSRIP planning tools
6/6/2012 Provider and Regional DSRIP Worksheets Due
6/15/2012 Report UC and IGT estimates
6/20/2012 RHP Steering - Review draft regional DSRIP projects
6/6/2012 DSRIP milestones, metrics, reporting and volume due
7/15/2012 Full draft of regional and individual list of DSRIP projects due (to finance)
7/26/2012 RHP Committees – Final milestones, metrics, volume/reporting
7/27/2012 Finalize DSRIP list (to Finance)
8/5/2012 Final financial values due from Finance
8/15/2012
9/1/2012
9/1/2012 RHPs submit plans to HHSC
9/30/2012 HHSC reviews plans and notifies RHPs for revisions
10/1/2012
10/15/2012 RHPs re-submit changes
10/31/2012 HHSC submits plans to CMS DY1 Funds are disbursed
11/1/2012
9/1/2012 - 2/1/2013 RHP plan revisions and approval
12/1/2012
12/15/2012 CMS reviews plans and provides approval or notice of concerns
1/1/2013
1/15/2013 HHSC submits revised RHP plans to CMS
2/1/2013
2/1/2013 CMS provides final approval or denial of RHP plans
2/15/2013
Legend
RHP Plan Submission Date
RHP Finance, Planning and Clinical and Quality Meeting
RHP Elected and Steering Committee Meeting
Community Health Needs Assessment Key Deliverable

Revised RHP Development Timeline
As of: 8/10/2012

Region 10 RHP Timeline

Month		August					September				October					Novermber			
Week of:		30-Jul	6-Aug	13-Aug	20-Aug	27-Aug	3-Sep	10-Sep	17-Sep	24-Sep	1-Oct	8-Oct	15-Oct	22-Oct	29-Oct	5-Nov	12-Nov	19-Nov	26-No
RHP Plan Development and Writing																			
1.01	Write first RHP Plan draft	1-Aug				31-Aug													
1.02	Collect Draft DSRIP plans from performing providers	3-Aug																	
1.03	Research/find data to fulfill CHNA needs		8-Aug		20-Aug														
1.04	Develop master DSRIP projects spreadsheet		8-Aug																
1.05	RHP Summit		8-Aug																
1.06	Review and analyze all DSRIP plans; provide feedback; identify CHNA data needs (rolling basis)		6-Aug	17-Aug															
1.07	RHP Committee Meetings - Review DSRIP plans and state updates		9-Aug																
1.08	RHP Steering and Elected - Review DSRIP plans and state updates			15-Aug															
1.09	Draft CHNA for RHP Plan				20-Aug														
1.10	RHP Committee Meetings - Continue developing DSRIP projects/RHP plan requirements- focus on metrics, evidence base				23-Aug														
1.11	Collecting edits and updates from providers based on feedback				20-Aug	30-Aug													
1.12	Receive final DSRIP Planning Protocols from HHSC (expected)					31-Aug													
1.13	Finalize valuation framework						3-Sep												
1.14	Receive and complete Excel workbooks from Deloitte						7-Sep												
1.15	Providers value their DSRIP projects and submit final DSRIP project revisions						7-Sep												
1.16	Reconciliation of RHP Plan draft with finalized protocols due							10-Sep											
1.17	Second interim RHP Plan draft due							12-Sep											
RHP Plan Review																			
2.01	Internal review of draft RHP plan						1-Sep	12-Sep											
2.02	RHP Committee Meetings - review draft RHP plan							13-Sep											
2.03	RHP Plan posted for public comment							13-Sep	20-Sep										
2.04	RHP Steering and Elected - Review draft RHP plan								19-Sep										
2.05	Synthesis of public comment								20-Sep	25-Sep									
2.06	Final RHP plan written									25-Sep									
2.07	Final review for quality assurance									26-Sep									
2.08	RHP Committee Meetings - final review of RHP plan									27-Sep									
2.09	**Final RHP plan submitted to HHSC***										1-Oct								
2.10	HHSC reviews RHP plans and adds comments/revisions														31-Oct				
2.11	HHSC submits RHP plans to CMS and DY 1 funds disbursed 70 days after														31-Oct				
2.12	CMS reviews RHP plans and adds comments/revisions																		
2.13	HHSC submits revised RHP plans to CMS																		
2.14	CMS gives final approval or denial of RHP plans																		

***The final deadline for all RHP submissions to HHSC is October 31, 2012. The Region 10 RHP intends to submit its RHP plan on October 1, 2012 in order to allow the state time to review the plan before it has to submit all the RHP plans to CMS (HHSC's deadline to submit all plans to CMS is October 31, 2012). HHSC has stated that it will take 30 days to review each RHP plan submitted, and will review plans in the order received.**

Appendix G:

Region 10 Learning Collaborative Plan

Learning Collaborative Proposal for RHP-10 Plan

Region 10's DSRIP plan will transform the region's health system so that low-income residents consistently experience coordinated, quality and timely care in the most appropriate health care setting. The region's providers will achieve this through improvements at multiple levels: (1) at the provider level -- focusing on the provision of right care at the right time and place coordinated with other physical and behavioral health needs; (2) between providers -- integrating health care delivery and information; and (3) at the regional level -- collaborating to share best practices and lessons learned in order to achieve value-added, high-quality, patient-centered and outcomes-driven care.

Many projects in our plan test innovative models of care that move away from episodic treatment toward a more integrated and coordinated approach centered on the patient's whole-person needs and health outcomes. As the region's providers implement improvements, it is important that they learn from each other's successes and challenges, as well as identify best practices that can be widely replicated. In this way, our collective learning can accelerate transformation.

For common areas of focus across multiple providers, the DSRIP program encourages bringing together the hands-on clinical implementation teams to learn from each other and improve more rapidly.

To this end, Region 10's learning collaboratives will focus on:

- Sharing knowledge, experience and expertise;
- Improving patient and caregiver experience;
- Implementing evidence-based guidelines;
- Using data-driven analyses to drive performance improvement; and
- Testing, such as through Plan-Do-Study-Act (PDSA) cycles.

Based on community health needs, we have identified the following regional priority areas as opportunities for shared learning (more detailed information is provided on each below)

1. **Access to and Capacity for Behavioral Health Care, including Integration with Primary Care; and,**

2. **Care Transitions and Patient Navigation.**

These two collaboratives will accelerate the rate of improvement in care for many of our region's most clinically vulnerable residents. Each collaborative will develop quantifiable goals to be reached by the end of the waiver. Goals will be consistent with DSRIP projects, and would utilize common metrics to measure progress toward goals. In order to measure progress, data

would be shared and aggregated. In addition to data, participants would share their qualitative experiences of the interventions being tested.

The Anchor entity may provide necessary assistance and facilitation of additional learning collaboratives to fulfill CQI requirements reflected in the RHP Plan.

Collaborative participants would be able to share information through:

1. A shared **portal** that includes shared data, learning and other resources;
2. A **listserv** for group questions, answers and check-ins;
3. **Regular convenings** and/or site visits.

At each meeting participants will scrutinize and discuss new data and its relevance and encourage discussion around progress toward goals, lessons learned, successes, challenges and identification of best practices.

Both newly formed collaboratives will have a designated project director or coordinator who will be responsible for convening the group, managing data collection and analytics, streamlining communications among group members (listserv, portal, etc.), and functioning as the regional "innovator agent" to observe and spread best practices from site to site, as well as serve as the liaison to the State and other regions and other relevant collaboratives.

Region 10 Learning Collaboratives

1. Expanding BH Access and Integrating Primary and Behavioral Health Care

- **Description:** The collaborative will focus on identifying best practices for primary care-behavioral health integration. Participants may decide to test one model as a group or to test various models and compare results. The collaborative will also provide an opportunity for providers working on behavioral health care access and capacity projects, to participate with those focusing specifically on primary care integration efforts for behavioral health care to reduce the fragmentation between behavioral health providers and those leading integration efforts, and to encourage full continuum thinking about individuals with behavioral health care needs.
- **New or Existing:** New
- **Number of providers with related projects:** 7
- **CHNA:**
    a. CN.4: Lack of access to mental health services. All but one county in Region 10 are recognized as health professions shortage areas for mental health providers.
    b. CN.5: Insufficient integration of mental health care in the primary care medical care system. Community stakeholders cite a need to achieve better integration of primary care and mental health care services in the primary care setting through heightened awareness of medical models for mental health integration.

- **Collaborative goal:** Increase patient access to care that is closely coordinated by a team of health care professionals that includes both primary and behavioral health providers. The collaborative may measure progress toward this goal through these or similar metrics:
    a. Implement integration in XX clinics
    b. Provide X% of Individuals with both physical and behavioral health care
    c. Increase the percentage of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise to XX%
    d. Decrease the "no shows" for behavioral and physical health appointments by XX%
    e. Screen at least X% of patients with one or more chronic diseases for depression
    f. Time from idea to full implementation
- **Meetings:** Teams would participate in bi-weekly check-in calls, quarterly data calls, and semi-annual in-person meetings, which may take place at a medical home that is further along in implementing the model, if appropriate.
- **Structure:** TBD

Region 10 DSRIP Projects with BH components		
Label	Provider	Title
2.19.1	Baylor All Saints Medical Center Fort Worth	Develop Care Management Function that Integrates Primary and Behavioral Health Needs of Individuals
1.12.2	Helen Farabee Centers	substance abuse expansion
1.9.2	Helen Farabee Centers	Improve Access to Specialty Care
2.18.1	Helen Farabee Centers	Implement whole health peer support
1.12.1	John Peter Smith Hospital	Behavioral Health Expanding Hours
1.12.2	John Peter Smith Hospital	PHP
2.15.1	John Peter Smith Hospital	Integrated Behavioral Health Care
2.16.1	John Peter Smith Hospital	Virtual Psychiatric
2.17.1	John Peter Smith Hospital	Discharge Management
1.13.1	Lakes Regional MHMR Center	Crisis Respite - behavioral support wraparound program
1.7.1	Lakes Regional MHMR Center	Introduce, Expand or Enhance Telemedicine/Telehealth
1.12.1	MHMR of Tarrant County	Increase behavioral health clinic hours

2.13.2	MHMR of Tarrant County	Provide an Intervention For a targeted Behavioral Health Population to Prevent Unnecessary Use of Services in a Specific Setting
2.15.1	MHMR of Tarrant County	Integrate Primary and behavioral Health Care Services
2.19.1	MHMR of Tarrant County	RN Care Management
1.9.2	Pecan Valley Centers	Expand Specialty Care Capacity
2.15.1	Pecan Valley Centers	Integrate Primary Care into Behavioral Health Care Clinics
2.13.1	University of North Texas Health Science Center (UNTHSC)	Health Navigation and Incentives for Dual Diagnosis Patients
2.13.2	MHMR	Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system
1.12.2	Lakes Regional	Depression/trauma counseling centers
1.12.2	Pecan Valley	Extend services beyond normal business hours
1.12.2	Childrens Medical Center of Dallas	Enhance community based settings where behavioral health services may be delivered in underserved areas
1.12.4	UNTHSC	Community-based behavioral health care for depressed Medicaid elders and near elders
2.7.6	University of North Texas Health Science Center (UNTHSC)	Promoting Physical and Mental Health Among At-risk, Underserved African American Pre-teen Girls in Tarrant County
2.16.1	Helen Farabee Centers	Virtual psychiatric consultation
2.13.1	Wise Regional Health System	Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population (WRHS NTCH BH/SA Collaboration Project)

2. Care Transitions and Patient Navigation

- **Description:** Many of the region's Performing Providers are undertaking DSRIP projects that will expand access to primary care, transform existing care approaches into a patient centered medical home model, and implement care transitions/patient navigations programs that provide more proactive and tailored prevention-oriented care to patients in the region struggling with chronic diseases, including asthma, diabetes. While specific chronic disease populations vary across the region's DSRIP projects, they are all focused on providing better care coordination across health care settings and ensuring improved chronic care management for specific disease populations. This collaborative will build upon an existing, effective collaborative that focuses on reducing preventable

readmissions using the evidence-based Project RED (Re-Engineered Discharge) framework. In addition, participants from Region 10 will meet separately to share best practices regarding care coordination and transitions improvements that contribute to reduced readmission rates.

- **New or Existing:** Region 10 providers that have proposed care transitions and patient navigation projects in Pass 1 have already initiated the development of a Learning Collaborative focused on the topic.
- **Number of providers with related projects:** 21
- **CHNA:** CN.8. Lack of access to healthcare due to financial barriers (i.e. lack of affordable care). Providers in our stakeholder survey overwhelmingly listed lack of coverage/financial hardship as a major barrier for low income patients.
  CN. 10. Overuse of emergency department (ED) services. Demand for ED visits is on the rise and EDs are becoming overcrowded due to reduced inpatient capacity and impaired patient flow. As a region, there were 1.1 million visits to hospital EDs in 2010, with a rate of 447.5 visits per 1000 persons. The 2007 national ED visit rate was 390.5 per 1000 persons, increasing 23% since 1997, but lower than the ED visit rate of Region 10.
  CN.11: Need for more care coordination. All counties identified it as a system cap and need. Barriers include complexity of coordination, lack of staff, lack of financial integration, fragmented system service, and practicing in silos. Providers did not feel there was strong care coordination between primary care providers, hospitals, and specialists.
- **Collaborative goals:** Improve care coordination for patients across care settings and reduce hospital readmissions occurring within 30 days of discharge. Reduce ED visits due to impaired care coordination for patients. Improve timely and appropriate patient navigation with special emphasis on those with chronic diseases. The collaborative may measure progress toward this goal through these or similar metrics:
  a. Establish targets for care coordination and reduced hospital readmissions.
  b. Provide X% of Individuals with appropriate discharge and post-discharge followup.
  c. Increase the percentage of Individuals with a treatment plan developed and implemented with primary care, specialty care and behavioral health expertise to XX%.
  d. Increase navigation assistance to patients by XX%.

- **Meetings:** Teams would participate in bi-weekly check-in calls, quarterly data calls, and semi-annual in-person meetings, which may take place at a medical home that is further along in implementing the model, if appropriate.
- **Structure:** TBD

Care Transition and Patient Navigation Projects		
Project	Provider	Title

label		
2.9.1	Baylor All Saints Medical Center Fort Worth	Establish/expand a Patient Care Navigation Program
2.12.1	John Peter Smith Hospital	Care transitions
2.9.1	John Peter Smith Hospital	MedStar Patient Navigation
2.12.2	Medical Center of Arlington	Implement/Expand Care Transition Programs
2.9.1	Methodist Mansfield Medical Center	Establish a Patient Care Navigation Program
2.19.1	MHMR of Tarrant County	RN Care Management
2.2.1	Texas Health Harris Methodist Hospital Azle	Health Education and Lifestyles Program and the Chronic Disease Self-Management Program
2.2.1	Texas Health Harris Methodist Hospital Fort Worth	Heart failure clinic
2.2.1	Texas Health Harris Methodist Hospital Fort Worth	Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes
2.9.1	Texas Health Harris Methodist Hospital Fort Worth	Establish/Expand a Patient Care Navigation Program
2.2.1	Texas Health Harris Methodist Hospital Hurst Euless Bedford	Diabetes Management Program
2.2.1	Texas Health Harris Methodist Hospital Hurst Euless Bedford	Expand chronic care management models: redesign the outpatient delivery system to coordinate care for patients with chronic disease (CHF)
2.2.1	Texas Health Harris Methodist Hospital Hurst Euless Bedford	Expand Chronic Care Management Model
2.9.1	Texas Health Harris Methodist Hospital Hurst Euless Bedford	Expand and Develop the ED Care Management Program
2.2.1	Texas Health Harris Methodist Hospital Southwest Fort Worth	Redesign the Outpatient Delivery System to Coordinate Care for Patients with Diabetes
2.9.1	Texas Health Harris Methodist Hospital Southwest Fort Worth	Identify Frequent ED Utilizers and Use Navigators as Part of a Preventable ED Reduction Program
2.2.1	THR - Arlington Memorial Hospital	Improving Management of Heart Failure in Patients and Preventing Readmission
2.2.1	THR - Arlington Memorial Hospital	Redesign the Outpatient Delivery System to Coordinate Care for Patients with Chronic Diseases (Diabetes)

2.9.1	THR - Arlington Memorial Hospital	Establish/Expand a Patient Care Navigation Program
2.13.1	University of North Texas Health Science Center (UNTHSC)	Health Navigation and Incentives for Dual Diagnosis Patients
1.10.3	JPS	Innovation and Transformation Center
1.1.1	Wise Regional	Expand pediatric primary care
1.3.1	Childrens Medical Center of Dallas	Implement and utilize pediatric-specific disease management system functionality
1.7.2	UNTHSC	Managing chronically ill Medicaid patients using interventional telehealth
1.9.2	JPS PG	Expand pain management care services
2.5.1	JPS	Journey to Life prenatal care and healthy babies initiative
2.12.1	JPS	Develop rehab transition process for JPS connection patients
2.12.1	Wise Regional	Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions
2.1.1	Children's Medical Center of Dallas	Enhance medical homes
2.1.1	Wise Clinical Care Associates	Develop implement and evaluate action plans to enhance/eliminate gapes in the development of various aspects of PCMH standards
2.12.2	JPS Health Network	Care Transitions for the homeless
2.12.1	JPS Health Network	Care Transitions Community Connect
2.15.1	Texas Health Harris Methodist Hurst Euless Bedford	Decrease readmissions through the integration of behavioral health into primary care

Appendix H:
Tarrant County Medical Society Letter of Support

November 29, 2012

Lisa Kirsch
Texas Health and Human Services Commission
Healthcare Transformation Waiver Operations
11209 Metric Blvd.
Austin, Texas 78758

Re: Letter of Support for the Region 10 RHP Plan for the Section 1115 Medicaid Waiver

Dear Ms. Kirsch:

I am writing on behalf of the Tarrant County Medical Society to express our organization's strong support of the Region 10 RHP Plan for Texas' Section 1115 Medicaid Waiver and the Delivery System Reform Incentive Payment (DSRIP) projects the plan proposes to implement.

JPS Health Network, the county's public hospital and a critical part of the region's safety net, has acted as Region 10's anchor entity and worked to submit a plan that will truly reform health care delivery in the region's nine counties. The waiver offers significant new opportunities for providers to address the serious access and capacity issues that impede population health and fragment care delivery in Region 10. The projects outlined in the Region 10 RHP plan will have a positive impact on the Medicaid and uninsured patient populations by providing timely and appropriate care with a focus on prevention.

The Tarrant County Medical Society (TCMS) is a professional organization representing more than 3,400 physicians, residents, medical students and Alliance members in Tarrant County. As the local arm of the Texas Medical Association, TCMS serves as the local physician's advocate by linking medicine to the community. The society recognizes outstanding community contributors, coordinates physician access for community events and, most recently, began a "Project Access Tarrant County" project to allow physicians to expand health care access to the area's uninsured and underserved.

The Tarrant County Medical Society welcomes the opportunity to work with Region 10 plan-providers in a coordinated effort to improve care for all residents of Tarrant County.

The society fully supports the efforts being undertaken in the outlined DSRIP projects and the Region 10 RHP vision to transform health care.

Tarrant County Medical Society
555 Hemphill Street Fort Worth, TX 76104 Phone 817-732-2825 Fax 817-732-3033 www.tcms.org

Please feel free to contact me at 817-296-4605 or g.sealy.massingill@unthsc.edu if you have additional questions.

Sincerely,

G. Sealy Massingill, MD
President
Tarrant County Medical Society
555 Hemphill Street
Fort Worth, TX 76104
817-732-2825

[i] This document defines primary care as family medicine, internal medicine, and pediatric medicine.

[ii] NHIS 2001-2005 Overcoming Obstacles to Health

[iii] The federal poverty level is $10,890 for an individual, or $22,350 for a family of four, in 2011.

[iv] Institute of Medicine, "Hidden Costs, Value Lost," Consequences of Uninsurance Series No. 5, June 2003; and Center for Studying Health System Change, "Triple Jeopardy: Low Income, Chronically Ill and Uninsured in America," Issue Brief No. 49, February 2002.

[v] Region 10 Stakeholder Survey (Appendix D-2.2)

[vi]

[vii] Texas Medical Association. (2011). *The Uninsured in Texa*s. Retrieved November 11, 2011, from Texas Medical Association: http://www.texmed.org/template.aspx?id=5517

[viii] Section 1886(q)(3)(c) of the ACA has the floor adjustment factor, is set at 0.99 for FY 2013, 0.98 for FY 2014, and .097 for FY 2015 and subsequent fiscal years

[ix] Dallas-Fort Worth Hospital Council (DFWHC) Foundation on hospital readmission in 2011 for patients 18 years and older, *Key findings: Readmissions in North Texas*

[x] S.F. Jencks, M.V. Williams, and E.A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," New England Journal of Medicine, April 2, 2009 360(14):1418-28

[xi] Keenan PS, Normand ST, Lin Z, Drye EE, Bhat KR, Ross JS, Shuur JD, Stauffer BD, Bernheim SM, Epstein AJ, Wang Y, Herrin J, Chen J, Federer JJ, Mattera JA, Wang Y Krumholz HM. An administration claims measure suitable for profiling hospital performance based on 30-day all-cause readmission rates among patients with heart failure. Circ Cardiovasc Qual Outcomes, 2008, 1:29-37.

[xii] Federal Register, Vol. 76, No. 160 page 51660. Available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-18/pdf/2011-19719.pdf

[xiii] Lappe JM, Muhlestein JB, Lappe DL, et al.: Improvements in 1-year cardiovascular clinical outcomes associated with a hospital-based discharge medication program. Ann Intern Med. 2004; 141(6):446-453

[xiv] Phillips CO, Wright SM, Kern DE, Singa RM, Shepperd S, Rubin HR.: Comprehensive discharge planning with post-discharge support for older patients with congestive heart failure: A meta-analysis [published correction appears in JAMA. 2004;292(9):1022]. JAMA. 2004;291(11):1358-1367.

[xv] Rich MW, Beckham C, Leven CL, Freedland KE, Carney RM.: A multi-disciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. N Engl J Med. 1995;333(18):1190-1195

[xvi] Schneider JK, Hornberger S, Booker J, Davis A, Kralicek R.: A medication discharge planning program: Measuring the effect on readmissions. Clin Nurs Res. 1993;2(1):41-53.

[xvii] Koelling TM, Johnson ML, Cody RJ, Aaronson KD.: Discharge education improves clinical outcomes in patients with chronic heart failure. Curculation. 2005;111(2):179-185.

[xviii] Krumholz HM, Amatruda J, Smith GL, et al.: Randomized trial of an education and support intervention to prevent readmission of patients with heart failure. J Am Coll Cardiol. 2002:391(1):83-89.

[xix] Centers for Disease Control (CDC)

[xx] Institute for Health care Improvement: Sepsis (IHI)

[xxi] Agency for Health care Research & Quality

[xxii] National Hospital Discharge Survey Files (NHDS)

[xxiii] CDC, National Center for Health Statistics, NHDS 2008

[xxiv] National Center for Health Statistics

[xxv] Renders et al, Diabetes Care, 2001; 24:1821 and Bodenheimer, Wagner, Grumbach, *JAMA* 2002; 288:1910.

Peyrot M, Rubin RR, Siminerio L, on behalf of the International DAWN Advisory Panel: Physician and nurse use of
psychosocial strategies in diabetes care: results of the cross-national Diabetes Attitudes, Wishes, and Needs study. Diabetes Care 29:1256 –1262, 2006

[xxvi] MedStar is the public authority emergency medical services agency that provides exclusive 9-1-1 and non-emergency ambulance and mobile healthcare services in Ft. Worth and 14 other cities in North Central Texas.
[xxvii] 5,400 enrollees in the 9-1-1 Nurse Triage Program, 450 enrollees in the Observational Admission Avoidance program; 450 enrollees in the HUG program and 225 enrollees in the CHF program.
[xxviii] http://www.innovations.ahrq.gov/content.aspx?id=3343
[xxix] http://www.iom.edu/Reports/2006/Emergency-Medical-Services-At-the-Crossroads.aspx

[xxx] Texas Medical Association. (2011). *The Uninsured in Texa*s. Retrieved November 11, 2011, from Texas Medical Association: http://www.texmed.org/template.aspx?id=5517
[xxxi]Region 10 RHP County Visioning Sessions