Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

March 2013

RHP 11

RHP Lead Contact: *Harris Brooks*
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Palo Pinto General Hospital
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Mineral Wells, TX 76067
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Instructions

Supporting Documents: RHPs shall refer to Attachment I (RHP Planning Protocol), Attachment J (RHP Program Funding and Mechanics Protocol), the Anchor Checklist, and the Companion Document as guides to complete the sections that follow. This plan must comport with the two protocols and fulfill the requirements of the checklist.

Timeline:

HHSC Receipt Deadline	What to submit	How to submit
10:00 am Central Time, October 31, 2012	Sections I, II, & III of the RHP Plan & Community Needs Supplemental Information	Submit electronically to HHSC Waiver Mailbox
5:00 pm Central Time, November 16, 2012	Pass 1 DSRIP (including applicable RHP Plan sections, Pass 1 Workbook, & Checklist)	Mail to address below
5:00 pm Central Time, December 31, 2012	Complete RHP Plan (including RHP Plan, Workbooks, & Checklist)	Mail to address below

All submissions will be date and time stamped when received. It is the RHP's responsibiility to appropriately mark and deliver the RHP Plan to HHSC by the specified date and time.

Submission Requirements: All sections are required unless indicated as optional.

The Plan Template, Financial Workbook, and Anchor Checklist must be submitted as electronic Word/Excel files compatible with Microsoft Office 2003. RHP Plan Certifications and Addendums must be submitted as PDF files that allow for OCR text recognition. Please place Addendums in a zipped folder.

You must adhere to the page limits specified in each section using a minimum 12 point font for narrative and a minimum 10 point font for tables, or the RHP Plan will be immediately returned.

Mailed Submissions: RHP Packets should include one CD with all required electronic files and two hardbound copies of the RHP Plan (do not include hardbound copies of the finanical workbook).

Please mail RHP Plan packets to:

Laela Estus, MC-H425
Texas Health and Human Services Commission
Healthcare Transformation Waiver Operations

11209 Metric Blvd.
Austin, Texas 78758

Communication: HHSC will contact the RHP Lead Contact listed on the cover page with any questions or concerns. IGT Entities and Performing Providers will also be contacted in reference to their specific Delivery System Reform Incentive Payment (DSRIP) projects.

Section I. RHP Organization

Please list the participants in your RHP by type of participant: Anchor, IGT Entity, Performing Provider, Uncompensated Care (UC)-only hospital, and other stakeholder, including the name of the organization, lead representative, and the contact information for the lead representative (address, email, phone number). The lead representative is HHSC's single point of contact regarding the entity's participation in the plan. Providers that will not be receiving direct DSRIP payments do not need to be listed under "Performing Providers" and may instead be listed under "Other Stakeholders". Please provide accurate information, particularly TPI, TIN, and ownership type, otherwise there may be delays in your payments. Refer to the Companion Document for definitions of ownership type. Add additional rows as needed.

Note: HHSC does not request a description of the RHP governance structure as part of this section.

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Anchoring Entity						
Public Hospital	138950412	1751256948 8 000	Non-State-owned public entity	Palo Pinto General Hospital	Harris Brooks	Palo Pinto General Hospital 400 SW 25th Avenue Mineral Wells, TX 76067 PH# (940) 328-6400 Fax# (940) 325-7903 E-mail: harris@ppgh.com
IGT Entities						
Public Hospital	094104901	1756003659 6 000	Non-State-owned public entity	City of Anson, d/b/a Anson General Hospital	Pam Gonzalez	101 Avenue J, Anson, TX, 79501, pgonzales@ansongh.com, 325 823-1151
Public Hospital	121784603	1751566827 9 000	Non-State-owned public entity	Comanche County Consolidated Hospital District	Barbara Williams	10201 Highway 16 North, Comanche, TX, 76442, 254-879-4970,

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
						Email: N/A
Public Hospital	137074409	1752313255 7 002	Non-State-owned public entity	Eastland Memorial Hospital District	Ted Matthews	304 South Daugherty, Eastland, TX, 76448, ted.matthews@emhd.org, 254-631-5342
Public Hospital	112692202	1751433495 6 012	Non-State-owned public entity	Fisher County Hospital District	Steve LeFevre	774 State Highway 70 North, Rotan, TX, 79546, slefevre@fishercountyhospital.com, 325-735-2256 x246
Public Hospital	094131202	1751453952 1 501	Non-State-owned public entity	Hamlin Memorial Hospital	Brian Roland	632 N W Second Street, Hamlin, TX, 79520, hmhbrianr@gmail.com, 325-576-3646
Public Hospital	112702904	1756001753 9 000	Non-State-owned public entity	Haskell County Hospital District	Fran McCown	1 North Avenue N, Haskell, TX, 79521, fmccown@windstream.net, 940-864-2621

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Public Hospital	121053602	1750808798 2 001	Non-State-owned public entity	Knox County Hosptial	Stephen A Kuehler	701 South 5th Street, Knox City, TX, , knoxhospital@srcaccess.net, (940) 657-3535
Public Hospital	136325111	1751246488 8 501	Non-State-owned public entity	Mitchell County Hospital District	Robbie Dewberry	997 West I-20, Colorado City, TX, 79512, rdewberry@mitchellcountyhospital.com, 325-728-3431
Public Hospital	138950412	1751256948 8 000	Non-State-owned public entity	Palo Pinto General Hospital District	Harris Brooks	400 SW 25th Avenue, Mineral Wells, TX, 76067, harris@ppgh.com, 940-325-7891
Public Hospital	133244705	1756003896 4 000	Non-State-owned public entity	Rolling Plains Memorial Hospital District	Donna Boatright	200 E Arizona, Sweetwater, TX, 79556, , 325-235-1701 x220, donab@rpmh.net
Public Hospital	126842705	1751315205 2 004	Non-State-owned public entity	Stamford Memorial Hospital	Rick DeFoore	1601 Columbia Street, Stamford, TX, 79553, rdefoore@stamfordhosp.com, 325-773-2725 x1108

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Public Hospital	119875604	1756003328 8 001	Non-State-owned public entity	Stephens County dba Stephens Memorial Hospital	Shane Kernell	200 South Geneva, Breckenridge, TX, 76424, skernell@smhtx.com, 254-559-2241
Public Hospital	020992601	1751212666 9 007	Non-State-owned public entity	Stonewall Memorial Hospital District	Debbie Roberson	821 N. Broadway St., Aspermont, TX, 79502, andy.kolb@smhdhealth.org, 940-989-3551
CMHC	133338707	1 7513776587 001	Non-State-owned public entity	Betty Hardwick Center d/b/a Abilene Regional MHMR Center	Jenny Goode	2616 S Clack St, Abilene, TX 79606, jgoode@bhcmhmr.org, 325-690-5100
CMHC	133339505	1-75-1294432-7000	Non-State-owned public entity	Central Texas MHMR Center dba Center for Life Resources	Dion White	408 Mulberry, Brownwood, TX 76801, dion@cflr.us, 325-643-9574

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CMHC	127373205	1-751241976-7000	Non-State-owned public entity	Helen Farabee Centers	Roddy Atkins	P.O. Box 8266, Wichita Falls, TX 76307-8266, Atkinsr@helenfarabee.org, (940)397-3101
CMHC	130724106	1-751532100-2000	Non-State-owned public entity	Pecan Valley Centers for Behavioral & Developmental HealthCare	Coke Beatty	P.O. Box 729-2101 W. Pearl, Granbury, TX 76048, coke@pecanvalley.org, 817-579-4400
CMHC	130725806	17526061696 003	Non-State-owned public entity	West Texas Centers	Shelley Smith	319 Runnels St, Big Spring, TX 79720, shelley.smith@wtcmhmr.org, 432-263-0007
Performing Providers						

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Hospital	281406301	1273993262 7 000	Private	Comanche County Medical Center Company	Kevin Storey	10201 Highway 16 North, Comanche, TX, 76442, Kstorey@comanchecmc.com, 254-879-4900
Hospital	138644310	1750827446 5 324	Private	Hendrick Medical Center	Stephen Kimmel	1900 Pine Street, Abilene, TX, 79601, skimmel@hendrickhealth.org, 325-670-4522
Public Hospital	0094131202	1756003659 6 000	Non-State-owned public entity	City of Anson, d/b/a Anson General Hosptial	Pam Gonzalez	101 Avenue J, Anson, TX, 79501, pgonzales@ansongh.com, 325 823-1151
Public Hospital	137074409	1752313255 7 002	Non-State-owned public entity	Eastland Memorial Hospital District	Ted Matthews	304 South Daugherty, Eastland, TX, 76448, ted.matthews@emhd.org, 254-631-5342
Public Hospital	112692202	1751433495 6 012	Non-State-owned public entity	Fisher County Hospital District	Steve LeFevre	774 State Highway 70 North, Rotan, TX, 79546, slefevre@fishercountyhospital.com, 325-735-2256 x246

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Public Hospital	136325111	1751246488 8 501	Non-State-owned public entity	Mitchell County Hospital District	Robbie Dewberry	997 West I-20, Colorado City, TX, 79512, rdewberry@mitchellcountyhospital.com, 325-728-3431
Public Hospital	138950412	1751256948 8 000	Non-State-owned public entity	Palo Pinto General Hospital District	Harris Brooks	400 SW 25th Avenue, Mineral Wells, TX, 76067, harris@ppgh.com, 940-328-6400
Public Hospital	133244705	1756003896 4 000	Non-State-owned public entity	Rolling Plains Memorial	Donna Boatright	200 E Arizona, Sweetwater, TX, 79556, , 325-235-1701 x220

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				Hospital District		donab@rpmh.net
Public Hospital	126842705	1751315205 2 004	Non-State-owned public entity	Stamford Memorial Hospital	Rick DeFoore	1601 Columbia Street, Stamford, TX, 79553, rdefoore@stamfordhosp.com, 325-773-2725 x1108
Public Hospital	119875604	1756003328 8 001	Non-State-owned public entity	Stephens County dba Stephens Memorial Hospital	Shane Kernell	200 South Geneva, Breckenridge, TX, 76424, skernell@smhtx.com, 254-559-2241
Public Hospital	020992601	1751212666 9 007	Non-State-owned public entity	Stonewall Memorial Hospital District	Debbie Roberson	821 N. Broadway St., Aspermont, TX, 79502, andy.kolb@smhdhealth.org, 940-989-3551
CMHC	133338707	1 7513776587 001	Non-State-owned public entity	Betty Hardwick Center d/b/a Abilene Regional MHMR Center	Jenny Goode	2616 S Clack St, Abilene, TX 79606, jgoode@bhcmhmr.org, 325-690-5100

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CMHC	127373205	1-751241976-7000	Non-State-owned public entity	Helen Farabee Centers	Roddy Atkins	P.O. Box 8266, Wichita Falls, TX 76307-8266, Atkinsr@helenfarabee.org, (940)397-3101
CMHC	130724106	1-751532100-2000	Non-State-owned public entity	Pecan Valley Centers for Behavioral & Developmental HealthCare	Coke Beatty	P.O. Box 729-2101 W. Pearl, Granbury, TX 76048, coke@pecanvalley.org, 817-579-4400
CMHC	130725806	17526061696 003	Non-State-owned public entity	West Texas Centers	Shelley Smith	319 Runnels St, Big Spring, TX 79720, shelley.smith@wtcmhmr.org, 432-263-0007
UC-only Hospitals						

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
(list hospitals that will only be participating in UC)						
Hospital	112705203	1 460496933 8	Private Hospital	Abilene Regional Medical Center	Jeremy Riney	6250 US HWY 83/84 Abilene, TX 79606 (325) 428-1000 Jeremy.Riney@armc.net
Hospital	020930601	16217625215 000	Private Hospital	Brownwood dba Regional Medical Center	Jack Montois	1501 Burnet Dr, Brownwood, TX 76801 jack_montois@brmc-cares.com 325-649-3305
Hospital	150260101	N/A	Private Hospital	Acadia Abilene LLC	Shana Hisaw	shisaw@acadiahealthcare.com
Other Stakeholders						
Regional Public Health Directors	018967201, 018967202, 091779102, 025446801, 148090701	75-6000440	Municipality	Abilene-Taylor County Public Health	Barry Camarillo	850 N. 6th, Abilene, Tx 79601, Healthde@abilenetx.com, 325-692-5600

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
				District		
County Officials	N/A	N/A	non-state public	Brown County IHC	Amy Hamrick	comishassist@browncountytx.org, 325-643-1985
County Officials	N/A	N/A	non-state public	Comanche County Consolidated Hospital District	Barbara Williams	barbara.williams@retiree.tarleton.edu, 325-356-3324
County Medical Associations	N/A	N/A	non-state public	Medical Care Mission	Scott Golding	scott@medicalcaremission.org, 325-669-6334
County Officials	N/A	N/A	non-state public	Taylor County	Downing Bolls	bollsd@taylorcountytexas.org, 325-674-1235
County Officials	N/A	N/A	non-state public	Taylor County	Stan Egger	eggers@taylorcountytexas.org, 325-669-4476
County Officials	N/A	N/A	non-state public	Taylor County	Chuck Statler	statlerc@taylorcountytexas.org, 325-691-1600
County Medical Associations/Societies	N/A	N/A	non-state public	Taylor Jones Medical Society	Ralph McClesky	rmccleskey@hendrickhealth.org, 325-668-2992
County Medical	N/A	N/A	non-state	Taylor	Pat Evans	medsociety@abilene.co

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)*	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Associations/Societies			public	Jones Medical Society		m, 325-673-5861
Regional Consultants	N/A	N/A	Private	WCT-COG	Kelly Cheek	kcheek@bcahec.org, 325-672-0495
Regional Consultants	N/A	N/A	Private	WCT-COG	Tom Smith	tsmith@wctog.org, 325-733-3163
Regional Public Health Directors	N/A	N/A	non-state public	MCHD	Joe Wright	N/A

Section II. Executive Overview of RHP Plan

RHP 11, including 15 Counties: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall and Taylor, encompasses the Abilene area. Five counties are Frontier Counties, and all of the counties have a Medically Underserved Area (MUA) designation as noted by Health Resources and Services Administration (HRSA) and some type of Health Professional Shortage Area (HPSA) designation, including Primary Care and Mental Health Care Professionals. The RHP 11 plan establishes a provider system of support that enables the development of more advanced care models, such as patient-centered medical homes, chronic disease management models, co-location of acute and behavioral health care, and palliative care programs. RHP 11 seeks to increase primary and specialty care capacity, increase appropriate care in appropriate settings, better engage patients with diabetes in disease management and ongoing preventive and primary care treatments, and expand services and care for persons with Severe and Persistent Mental Illness (SPMI) through the Healthcare Transformation Waiver. With so many providers focusing on increasing access to primary and preventive care and reducing non-emergent utilization of the Emergency Department, Palo Pinto General Hospital (PPGH) as the anchor has included an optional learning collaborative component in their primary care project. This quality initiative is focused on bringing primary care providers from across the region together to discuss what models work best and to empower them to best implement projects which seek to serve patients in the most low-cost setting.

With various statistical data uncovering quantifiable limitations on patient access to appropriate care professionals and settings, RHP 11 has developed a regional approach to DSRIP projects to efficiently and effectively address local healthcare needs for Medicaid and the uninsured. Providers are committed to working together to address total population health outcomes across county lines. RHP 11 goals are to

- Transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time; and
- Focus on increasing the capacity of primary care, increasing strategies related to disease prevention, and expanding behavioral health services.

We anticipate that all the projects will reduce the burden on Emergency Departments and improve health outcomes across the region. The selected DSRIP projects will begin to build the infrastructure needed in our primary care system to be the backbone for improved care coordination, chronic disease management and care transitions.

Abilene, Texas, in Taylor County is the urban hub in RHP 11. Hendrick Medical Center and Abilene Regional Medical Center are both hospitals local to this community. HHSC has identified Hendrick Medical Center as the Major Safety Net Hospital in RHP 11. As the Major Safety Net Hospital, Hendrick Medical Center's projects make up 54% of the total DSRIP allocation. The system of care within RHP 11 utilizes smaller Critical Access Hospitals to provide the first tier of quality institutional care and then utilizes partnerships with the tertiary hospitals to ensure patients receive quality institutional specialty care. As a region, we have discussed

regional projects which would establish innovative models of care when patients from rural parts of RHP 11 discharge from Abilene hospitals back home. This is contemplated under the Care Transitions project in Category 2. We believe that removing the barriers to home care will increase patient satisfaction and patient outcomes while reducing unnecessary costs.

Over recent years, RHP 11 communities have experienced health crises. It is essential to address the needs for transformation to ensure persons with diabetes, for example, who have treatment needs can access dialysis in their home communities or with a small commute. Some communities without dialysis facilities may have a 60 mile one-way trip to the nearest facility for routine care up to 5 times a week in certain cases. Additionally, RHP 11 has five CMHCs which also face tough choices and barriers when addressing the mental health needs in frontier and rural communities. Advancements in telemedicine, specifically telepsychiatry, will provide needed access to care for persons with ongoing, chronic behavioral health needs. Various projects address barriers to access when chronic disease patients live in frontier and rural counties. Additionally, the regional meetings to discuss learns learned which is part of the anchor's primary care project will also support regional transformation in reducing non-emergent use of the ED and increase access to primary care in cities and towns where access is very limited.

RHP 11 wants to pursue transformation to impact total population health as well as increase the Triple Aim to potentially include a fourth aim: Right Cost. Economic factors of healthcare are growing exponentially as the public payers have the need to find cost savings and better and more efficient models to deliver quality health care. Across our region, hospitals are faced with patients seeking non-emergent care in the Emergency Department. Many factors contribute to Medicaid and uninsured patients seeking primary, preventive, and mental health care in the ED, but as the backbone of healthcare in rural Texas, we are committed to progressing transformation of care delivery. Since the Hill-Burton Act, our communities has rested on the assurances that come with having a public hospital district. RHP 11 has 13 public hospitals supported by local tax bases. Through consolidated, regional transformation, we aim to help patients and residents, primarily Medicaid and the uninsured, find the most appropriate care settings. Our communities have only had the hospital and the CMHC as sole sources for all their healthcare needs for years. Through educational pushes and increases in the capacity of mental health and primary care services, we expect to measure more appropriate ED utilization in our region. Increasing appropriate ED utilization will also better ensure the appropriate care teams are available when real emergencies and/or traumas hit the ED.

As a Tier 4 region, various collaborations were developed across providers in order to enable more robust projects to alleviate the ever growing burden where sole providers face burnout and fatigue. Initially potential performing providers with artificially low allocations were disadvantaged and not able to consider robust projects. Had collaborations not been developed, the level of innovative projects in RHP 11 would have been negligent. However, the encumbered DSRIP funds associated with provider projects will ignite a regional effort to address health disparities and improve patient centered and evidence based approaches.

Other transformational outcomes for Category 1 and 2 projects include patient satisfaction. As providers begin to measure patient satisfaction, it becomes increasingly clear there is room for improvement. As the economic trends in healthcare seek to enable patients to own and to engage with providers regarding treatment options and healthy lifestyles, training for providers and staff in the hospital and clinics is essential. Patients want to be able to email the clinic to find out if they need to come in for a blood pressure check. When they go to the wellness center for their therapy or exercise session, they want to be able to ask questions about other preventive efforts they can be engaged in. Creating comprehensive care models and training staff on how to best enable the patient to manage their condition will further advance initiatives related to value-based purchasing. Value-based purchasing and payment variances which award providers who reduce potentially preventable events, further improves clinical outcomes for patients who might otherwise have an avoidable complication when admitted on an avoidable hospitalization. Bending the cost curve in healthcare isn't happening fast, but strategic efforts to continue Pay-for-Outcome type initiatives set forth in S.B. 7 (Legislative Session, 82-1 by Senator Nelson) will further impact the slope of the curve for Medicaid and the uninsured, which will spill over to the private and commercial markets as well.

RHP 11 seeks increase healthy competition in the healthcare arena and to increase patients' ability to self-manage and participate in healthy lifestyles over the course of their lives. Specific initiatives include increased access to primary and specialty care capacity; increased appropriate care in appropriate settings; improved patient centered treatment plans for patients with diabetes, heart disease, and at end of life; and expanded services and care for persons with Severe and Persistent Mental Illness (SPMI) through the Healthcare Transformation Waiver.

Summary of Categories 1-2 Projects

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Category 1: Infrastructure Development			
0094104901.1.1, 1.1 Expand Primary Care Capacity Anson General Hospital/0094104901	1.1 Expand Primary Care Capacity	0094104901.3.1 OD-1 Primary Care and Chronic Disease Management IT-1.7 Controlling High Blood Pressure	$266,000
1333387-07.1.1, 1.9 Expand Specialty Care Capacity Betty Hardwick Center d/b/a Abilene Regional MHMR Center /1333387-07	1.9 Expand Specialty Care Capacity	1333387-07.3.1 OD-1 Primary Care and Chronic Disease Management IT-1.18, Follow Up After Hospitalization for Mental Illness	$6,168,017
Pass 3B NEW: 1333387-07.1.3 OLD: 1333387-07.1.2, 1.13 - Development of behavioral health crisis stabilization services as alternatives to hospitalization. Betty Hardwick Center d/b/a Abilene Regional MHMR	1.13 - Development of behavioral health crisis stabilization services as alternatives to hospitalization.	NEW: 1333387-07.3.3 OLD: 1333387-07.3.2 OD - 9 Decrease in MH admissions/readmissions to criminal justice settings IT-6-2 Other Outcome Improvement Target	$1,715,238

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Center /1333387-07			
133339505.1.1, 1.11 Implement Technology Assisted Services	1.11 - Implement technology-assisted services	133339505.3.1 OD-9 Right Care, Right Setting	$426,344
Central Texas MHMR Center dba Center for Life Resources/133339505		IT-9.2 ED appropriate utilization	
133339505.1.2, 1.11 Implement Technology Assisted Services Central Texas MHMR Center dba Center for Life Resources/133339505	1.11 - Implement technology-assisted services	133339505.3.2 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$1,853,205
Pass 3B NEW: 281406301.1.2 OLD: 281406301.1.1, 1.1 - Expand Primary Care Capacity Comanche County Medical Center/281406301	1.1 - Expand Primary Care Capacity	NEW: 281406301.3.3 OLD: 281406301.3.2 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$749,415
PASS 3B NEW: 137074409.1.4 OLD: 137074409.1.1, 1.9 Expand Specialty Care Capacity	1.9.2 – Improve access to specialty care – Outpatient Dialysis Center	NEW: 137074409.3.4 OLD: 137074409.3.1 OD-2 Potentially Preventable Admissions	$1,707,492

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Eastland Memorial Hospital 137074409		IT-2.2 End-Stage Renal Disease (ESRD) Admissions Rate	
Pass 3B NEW: 137074409.1.5 OLD: 137074409.1.2, 1.9 Expand Specialty Care Capacity Eastland Memorial Hospital 137074409	1.9.2 – Improve access to specialty care – Expand Surgical Services	NEW: 137074409.3.5 OLD: 137074409.3.2 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$1,177,614
Pass 2 137074409.1.3, 1.1 - Expand Primary Care Capacity	1.1 - Expand Primary Care Capacity	137074409.3.3 OD-9 Right Care, Right Setting	$727,156
Eastland Memorial Hospital 137074409		IT-9.2 ED appropriate utilization	
Pass 2 112692202.1.1, 1.1 Expand Primary Care Capacity Fisher County Hospital District/112692202	1.1 Expand Primary Care Capacity	112692202.3.2 112692202.3.3 112692202.3.4 OD-1 Primary Care and Chronic Disease Management IT-1.12 Diabetes care: Retinal eye exam235—NQF 0055 IT-1.13 Diabetes care Foot exam- NQF 0056 IT-1.14 Diabetes care: Microalbumin/Nephropathy-	$316,615

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
		NQF 0062	
Pass 3B NEW: 094131202.1.3 OLD: 094131202.1.1, 1.1 Expand Primary Care Capacity Hamlin Memorial Hospital 0094131202	1.1 Expand Primary Care Capacity	NEW: 094131202.3.4 OLD: 0094131202.3.1 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$558,712
Pass 2 094131202.1.2, 1.10 - Enhance Performance Improvement and Reporting Capacity Hamlin Memorial Hospital 0094131202	1.10 - Enhance Performance Improvement and Reporting Capacity	09413202.3.3 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$140,812
Pass 3B NEW: 112702904.1.2 OLD: 112702904.1.1, 1.1 Expand Primary Care Capacity	1.1 Expand Primary Care Capacity	NEW: 112702904.3.3 OLD: 112702904.3.1 OD-6 Patient Satisfaction	$944,880

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Haskell Memorial Hosptial-112702904		IT-6.1 Percent improvement over baseline of patient satisfaction scores.	
127373205.1.1, 1.12 Expand BH Services Helen Farabee Center/127373205	1.12 Expand BH Services	127373205.3.1 OD-10 Quality of Life IT-10.1 Quality of Life	$356,411
127373205.1.2, 1.9 - Expand Specialty Care Capacity Helen Farabee Center/127373205	1.9 Expand Specialty Care Capacity	127373205.3.2 OD-10 Quality of Life IT-10.1 Quality of Life	$60,298
138644310.1.1, 1.1 Expand Primary Care Capacity Hendrick Medical Center/138644310	1.1 Expand Primary Care Capacity	138644310.3.1 138644310.3.2 138644310.3.3 OD-12 Primary Care and Primary Prevention IT-12.1 Breast Cancer Screening IT-12.2 Cervical Cancer Screening IT-12.4 Pneumonia vaccination status for older adults	$10,602,527
Pass 2 138644310.1.2, 1.9.2 - Improve access to specialty care	1.9.2 - Improve access to specialty care	138644310.3.8 OD-9 Right Care, Right Setting	$7,702,706

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Hendrick Medical Center/138644310		IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.	
Pass 3B: NEW: 136325111.1.2 OLD: 136325111.1.1, 1.1 Expand Primary Care Capacity Mitchell County Hospital District – 136325111	1.1 Expand Primary Care Capacity	NEW: 136325111.3.3 OLD: 136325111.3.1 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$1,464,334
Pass 3B: New: 138950412.1.3 OLD: 138950412.1.1, 1.1. Expand Primary Care Capacity Palo Pinto General Hospital – TPI # - 138950412	1.1 Expand Primary Care Capacity	New: 138950412.3.4 OLD: 138950412.3.1 OD-1 Primary Care and Chronic Disease Management IT-1.7 Controlling high blood pressure	$7,807,685
Pass 2 138950412.1.2, 1.9 - Expand Specialty Care Capacity	1.9 - Expand Specialty Care Capacity	138950412.3.3 OD-9 Right Care, Right Setting	$2,150,666
Palo Pinto General Hospital – TPI # - 138950412		IT-9.2 ED appropriate utilization	
130724106.1.1, 1.9 Expand Specialty Care Capacity	1.9 Expand Specialty Care Capacity	130724106.3.1 OD-9 Right Care, Right Setting	$1,029,118

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Pecan Valley Centers for Behavioral and Developmental Healthcare/130724106		IT-9.2 ED appropriate utilization	
133244705.1.1, 1.9 Expand Specialty Care Capacity Rolling Plains Memorial Hospital/133244705	1.9 Expand Specialty Care Capacity	133244705.3.1 OD-8 Perinatal Outcomes IT-8.2 Percentage of Low Birth-weight births	$2,061,753
Pass 3B: NEW: 126842705.1.3 OLD: 126842705.1.1, 1.1 Expand Primary Care Capacity Stamford Memorial Hospital, TPI 126842705	1.1.2 Expand existing primary care capacity	NEW: 126842705.3.3 OLD: 126842705.3.1 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$1,576,722
Pass 3B: NEW: 126842705.1.4 OLD: 126842705.1.2, 1.6 - Expand Access to Urgent Care and Enhance Urgent Medical Advice Stamford Memorial Hospital, TPI 126842705	1.6 - Expand Access to Urgent Care and Enhance Urgent Medical Advice	NEW: 126842705.3.4 OLD: 126842705.3.2 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$777,741
119875604.1.1, 1.1. Expand Primary Care Capacity	1.1 Expand Primary Care Capacity	119875604.3.1 OD-6 Patient Satisfaction	$548,993
Stephens Memorial Hospital–TPI # - 119875604		IT-6.1 Percent improvement over baseline of patient	

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
		satisfaction scores.	
Pass 2 020992601.1.1, 1.1 Expand Primary Care Capacity Stonewall Memorial Hospital/020992601	1.1 Expand Primary Care Capacity	020992601.3.1 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$1,280,441
130725806.1.1, 1.11 Implement technology assisted services West Texas Centers: 130725806	1.11 Implement technology assisted services	130725806.3.1 OD-6 Patient Satisfaction with improvement measure IT-6-2 Other Outcome Improvement Target	$1,006,134
Pass 3B: NEW: 130725806.1.3 OLD: 130725806.1.2, 1.13 - Development of behavioral health crisis stabilization services as alternatives to hospitalization. West Texas Centers: 130725806	1.13 - Development of behavioral health crisis stabilization services as alternatives to hospitalization.	NEW: 130725806.3.3 OLD: 130725806.3.2 OD-6 Patient Satisfaction with improvement measure IT-6-1 Percent Improvement over baseline of patient satisfaction scores	$359,922

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Category 2: Program Innovation and Redesign			
Pass 3B: NEW: 281406301.2.2 OLD: 281406301.2.1, Implement Evidence-based Disease Prevention Programs Comanche County Medical Center/281406301	2.7 Implement Evidence-based Disease Prevention Programs	NEW: 281406301.3.4 OLD: 281406301.3.1 OD-2 Potentially Preventable Admissions IT-2.10 Flu and Pneumonia Admission Rate	$1,464,333
Pass 3B NEW: 112692202.2.2 OLD: 112692202.2.1, 2.2 Expand Chronic Care Management Models Fisher County Hospital District/112692202	2.2 Expand Chronic Care Management Models	NEW: 112692202.3.5 OLD: 112692202.3.1 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$1,012,710
Pass 3B: NEW: 112702904.2.2 OLD: 112702904.2.1, 2.5 Redesign for Cost Containment Haskell Memorial Hosptial-112702904	2.5 - Redesign for Cost Containment	New: 112702904.3.4 OLD: 112702904.3.2 OD-5 COST OF CARE IT-5.1 IMPROVED COST SAVINGS: DEMONSTRATE COST SAVINGS IN CARE DELIVERY	$592,562

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
138644310.2.1, Enhance/Expand Medical Homes, Hendrick Medical Center/138644310	2.1 Medical Home	138644310.3.4 OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization	$3,710,885
138644310.2.2, Expand Chronic Care Management Models – Cellulitis Treatment, Hendrick Medical Center/138644310	2.2 Expand Chronic Care Management Models	138644310.3.5 OD-2: Potentially Preventable Admissions IT-2.13: Other Admissions Rate - Cellulitis	$3,710,885
138644310.2.3, Use of Palliative Care Programs, Hendrick Medical Center/138644310	2.10 Palliative Care Programs,	138644310.3.6 OD-13: Palliative Care IT-13.4 Proportion admitted to the ICU in the last 30 days of life	$11,132,653
138644310.2.4, Implement Evidence-based Health Promotion Programs – Diabetes Health Promotion, Hendrick Medical Center/138644310	2.6 - Implement Evidence-based Health Promotion Programs Diabetes Health Promotion	138644310.3.7 OD-2: Potentially Preventable Admissions IT-2.7: Diabetes Short Term Complication Rate	$6,891,642
Pass 2 138644310.2.5, 2.6 - Implement Evidence-based Health Promotion Programs	2.6 - Implement Evidence-based Health Promotion Programs	138644310.3.9 OD-3 Potentially Preventable Re-Admissions - 30 day	$4,621,619

Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Hendrick Medical Center/138644310		IT-3.5 Acute Myocardial Infarction (AMI) 30 day readmission rate	
121053602.2.1, 2.4 - Redesign to Improve Patient Experience	2.4 - Redesign to Improve Patient Experience	121053602.3.1 OD-6 Patient Satisfaction with improvement measure	$388,855
Knox County Hospital District/121053602		IT-6-2 Other Outcome Improvement Target	
Pass 2 121053602.2.2, 2.3 - Redesign Primary Care Knox County Hospital District/121053602	2.3 - Redesign Primary Care	121053602.3.2 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$117,756
Pass 2 136325111.2.1, 2.2 - Expand Chronic Care Management Models Mitchell County Hospital District – 136325111	2.2 - Expand Chronic Care Management Models	136325111.3.2 OD-6 Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$414,155
Pass 3B: NEW: 138950412.2.2 OLD: 138950412.2.1, 2.9 Patient Navigator	2.9 - Establish/Expand a Patient Care Navigation Program	NEW: 138950412.3.5 OLD: 138950412.3.2 OD-8 Perinatal Outcomes	$725,417

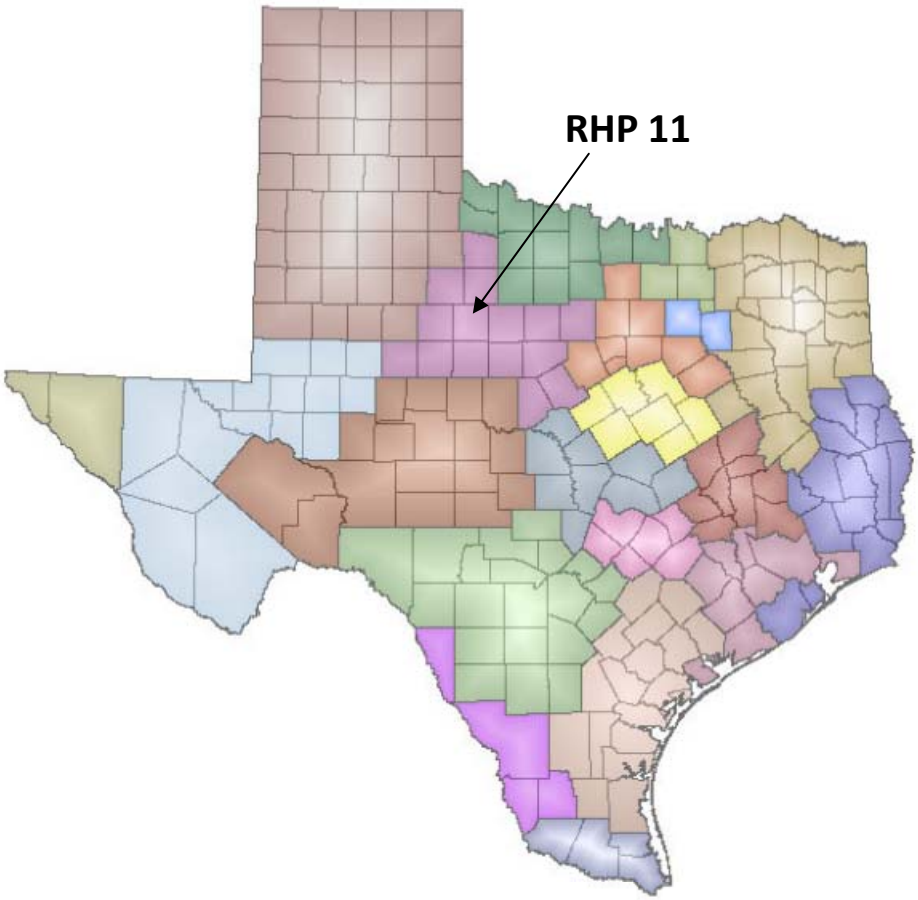
Project Title (include unique RHP project ID number for each project. Do not restart numbering for different Performing Providers)	**Brief Project Description**	**Related Category 3 Outcome Measure(s)** (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	**Estimated Incentive Amount (DSRIP) for DYs 2-5**
Palo Pinto General Hospital – TPI # - 138950412		IT-8.2 Percentage of Low Birth-weight Births	
133244705.2.1, Implement Evidence-based Disease Prevention Programs Rolling Plains Memorial Hospital/133244705	2.7 Implement Evidence-based Disease Prevention Programs	133244705.3.2 OD-2 Potentially Preventable Admissions IT-2.10 Flu and Pneumonia Admission Rate	$2,199,204
Pass 2 133244705.2.2, 2.5 - Redesign for Cost Containment Rolling Plains Memorial Hospital/133244705	2.5 - Redesign for Cost Containment	133244705.3.3 OD-5 COST OF CARE IT-5.1 INPROVED COST SAVINGS: DEMONSTRATE COST SAVINGS IN CARE DELIVERY	$1,073,896

Section III. Community Needs Assessment

Regional Healthcare Partnership 11

Community Needs Assessment

October 2012



Summary of Community Needs, RHP 11		
	Description	Data Sources
CN.1	High rates of chronic disease, including cancer, heart disease, cardiovascular disease, respiratory diseases, and obesity.	•County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation •Texas Department of Health and Human Services
CN.2	High costs associated with preventable hospitalization admissions and readmissions.	•Texas Department of State Health Services, Center for Health Statistics
CN.3	Shortages of health care professionals, including mental health care providers.	•Texas Center for Public Policy Priorities •Texas Department of State Health Services, Center for Health Statistics •Texas Medical Board •US Department of Health and Human Services, Health Resources and Services Administration
CN.4	Low utilization of preventative care services, including sigmoidoscopy, colonoscopy, and immunizations.	•Texas Behavioral Risk Factors Surveillance System
CN.5	Need to overcome patient access to care barriers.	•Texas Behavioral Risk Factors Surveillance System •US Census Bureau
CN.6	Need for improvement in fertility and natality care.	•County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation •Texas Department of Health and Human Services
CN.7	Shortages in dental care.	•US Department of Health and Human Services, Health Resources and Services Administration
CN.8	High rate of teen pregnancy.	•Texas Department of State Health Services, Center for Health Statistics

INTRODUCTION

A community needs assessment often focuses on barriers to accessing care. It can also describe the primary service area of a hospital, a hospital's patients and its services, other healthcare providers in the area, and demand for services. Community needs assessments also aid in planning and improving access to and quality of care. This assessment concerns Regional Healthcare Partnership (RHP) 11 in Texas, which includes the following 15 counties: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, and Taylor. The assessment's purpose is to assist RHP 11 as it plans its proposal for the HHSC 1115 Waiver. The Delivery System Reform Incentive Pool (DSRIP) section of the waiver includes the following four categories:

Category 1: Infrastructure Development
Category 2: Program Innovation and Redesign
Category 3: Quality Improvements
Category 4: Population-focused Improvements

This assessment contributes supporting data for Categories 1 and 2. In addition, providers in the respective region should contribute specific data to support the need for additional infrastructure, including clinic, emergency department, and inpatient hospital volume and cost data by payer and by condition. If infrastructure is determined to be required for particular disease areas (e.g., diabetes clinics), then provider-specific volume data should be provided as well. Categories 3 and 4 require data supporting high burden areas in particular, some of which are provided with this document, but again, should be strengthened with data from providers in the region. This assessment includes several supporting data tables and figures, most of which can be found in the Supporting Data Appendix; Appendix data are ordered by letter and are noted in parentheses beside section subtitles. Data provided in this document are numbered. However, in compilation of multiple documents some pictures are not viewable in the plan. Please see the addendum for all charts and figures.

DATA SUPPORTING INFRASTRUCTURE AND ACCESS DEVELOPMENT

Population growth, age distribution, and race/ethnicity have a significant impact on community need for healthcare services. Overall population growth and growth by age cohort impact the total demand for healthcare services and demand for specific services, while certain racial/ethnic backgrounds increase the likelihood of some diseases and disorders.

Population and Counties (Table A in the appendix supplements information discussed below)
The total population of RHP 11 grew by 1.5% from 2000 to 2010. (See Table 1 below.) All but three counties (Callahan, Jones, Taylor) in RHP 11 are considered rural by the U.S. Census. Population density per square mile for the region is 23.2. Five counties (Fisher, Haskell, Knox, Shackelford,

Stonewall) in RHP 11 are considered Frontier Counties because they have less than seven people per square mile.

Ninety percent of RHP 11 residents identify as white, while 22% of all people, regardless of race, identify as Hispanic. Eighty-six percent speak English only. The region's percentage of the population 65 and older (16%) is greater than Texas' percentage (10%).

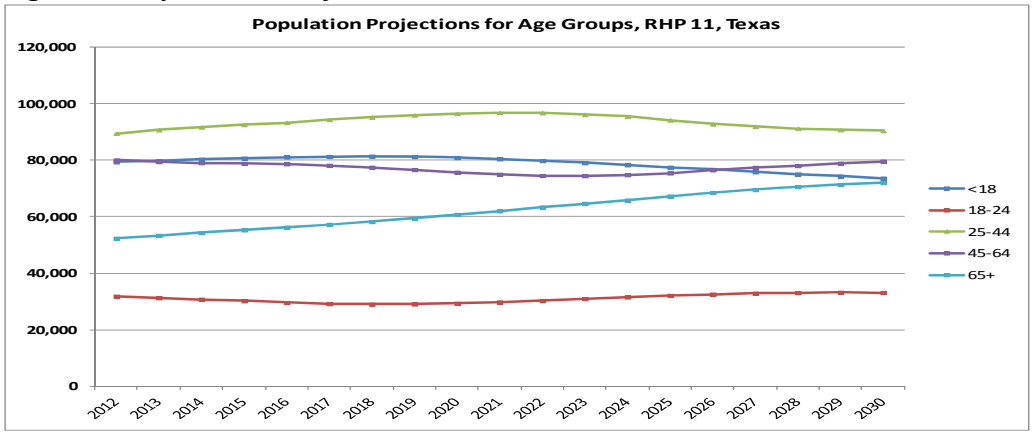
Population Projections

Population growth in RHP 11 is expected to increase 5% from 2012 to 2030, growing from 332,899 to 348,706. People aged 65 and older will continue to account for a larger percentage of the population. (See Figure 1 below.)

Table 1. Population Density

Population and Size, RHP 11, Texas	
Population	
2000	312,127
2010	316,735
2011	317,935
Population of RHP's counties (2011)	
Brown	38,186
Callahan	13,515
Comanche	13,891
Eastland	18,633
Fisher	3,914
Haskell	5,989
Jones	20,146
Knox	3,758
Mitchell	9,426
Nolan	15,269
Palo Pinto	28,115
Shackelford	3,318
Stephens	9,548
Stonewall	1,472
Taylor	132,755
Size in square miles	
Land area	13,707.1
Water area	127.4
Total area	13,834.6
Population density per square mile (2011)	23.2

Figure 1. Population Projections



Socioeconomic Profile of Residents (Tables B-D)

Twenty percent of adults 25 years or older in RHP 11 do not graduate from high school. About 24% have some kind of college degree. Almost 20% of all people in the RHP fall below the poverty line. The percentage of children living in poverty is close to 30%.

The percentages of high school dropouts and poor people are expected to increase in Texas. According to demographer Dr. Steve Murdock, "The state's public schools have more and more low-income kids and persistently high dropout rates, and unless that changes, the future of Texas will contain more long-term unemployment and poverty, and more folks depending on food stamps, Medicaid and CHIP."[1]

Median household income and per capita income in the RHP are 35% and 20% lower than Texas estimates, respectively; and 41% and 24% lower than national estimates, respectively. The average wage per job has increased slightly since 2006. However, the unemployment rate has also increased over the last five years. (Table D in the appendix displays the major employers in RHP 11.)

[1]Scharrer, Gary. "Poverty, dropout rates threaten Texas' future," Austin Bureau. Available: http://www.chron.com/news/houston-texas/article/Report-Poverty-dropout-rates-threaten-Texas-1698327.php. June 2012.

Rural Healthy People 2010, a companion document to *Healthy People 2010*, examined top rural health priorities and presented promising models to address *Healthy People 2010* objectives. Both public and private health organizations identified access to quality health services (primary care, emergency medical services, insurance, and long-term care) as the leading focus area.

RHP 11 has five hospitals in the Metropolitan Statistical Area (MSA) of Abilene and 14 hospitals outside the MSA. Eleven of the hospitals are public, five are for-profit, and one is private/non-profit. In 2009, there were 1,530 acute beds and 60 psychiatric beds among all of the region's hospitals. As of 2011, none of the hospitals in RHP 11 had Teaching Facilities or offered Burn Care, Intermediate Nursing Care, or Other Long Term Care.

Health Professional Shortage Areas

Texas ranks 42nd in the nation for the ratio of physicians to population, and 47th for the ratio of nurses to population. There is a shortage of every kind of health professional in Texas except Licensed Vocational Nurses. Physicians, registered nurses, physical therapists, clinical laboratory

scientists, occupational therapists, pharmacists, dentists, audiologists, and other healthcare professionals all number less (per 100,000 population) than the national averages.[2]

The 2012-2013 Texas legislative budget allows for some growth in support for health-related institutions of higher education, but many programs sustained significant cuts. State support for Graduate Medical Education has been reduced by almost a third, from $79 million to $54 million. Funds for the Professional Nursing Shortage Reduction Program have been cut by 40%, and about three-fourths of funding for both the Family Practice Residency Program and the Physician Education Loan Repayment Program has been eliminated. Other primary care training programs have also been completely eliminated, including the Children's Medicaid Loan Repayment Program.

It is important for Texas to build its healthcare workforce in order to (1) reduce current shortages and (2) prepare for large increases in demand when more Texans become insured in 2014 through the Affordable Care Act. Over $250 million in new federal medical education training funds have been allocated since the Affordable Care Act passed in 2010. The Texas legislature did not build on this investment in 2011, but instead made cuts to key healthcare professional training.[3]

Health Professional Shortage Areas (HPSAs) are designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) as areas with shortages of primary medical care, dental, or mental health providers and may be geographic (a county or service area), demographic (low-income population) or institutional (comprehensive health center, federally qualified health center or other public facility). As of 2011, every county in RHP 11 is considered a Mental Health Professional Shortage Area and four counties are considered Primary Care Health Professional Shortage Areas. (See Table 2 below.) Seven counties in the region have special populations with unmet needs (i.e., limited access) for primary care health professionals. Special populations include: Medicaid eligibles, low-income populations, migrant and seasonal farm workers, homeless, American Indians, Alaska Natives, and other populations isolated by linguistic or cultural barriers. The majority of counties in the region are also shortage areas for dental health professionals.

Medically Underserved Areas

Medically Underserved Areas designated by HRSA are those with too few primary care providers, high infant mortality, high poverty, or high elderly population. Twelve counties in the region are designated as Medically Underserved Areas; the other three counties have areas within them that are designated as a Medically Underserved Areas.

Supply of Physicians and Specialists (Tables H-M)

Medicaid funding has a large impact on the supply of physicians. For health professionals, Texas Medicaid fees fall well below commercial insurance or Medicare, and sometimes do not even

[2] Dunkelberg, Anne. 2011. Texas *Health Care 2011: What Has Happened and the Work that Remains*, Center for Public Policy Priorities. 2011. Available: http://www.cppp.org/files/2011_11_TexasHealthCare.pdf. June 2012.
[3] Ibid.

cover the costs of services. The failure of Texas Medicaid rates to keep up with inflation—even before the recent rate cuts made by the legislature—discourages providers from agreeing to take Medicaid patients. For example, the Texas Medical Association's biennial poll of doctors shows the percentage of doctors taking on new Medicaid patients has dropped steeply over the last decade.[4]

Rate cuts during the 82nd Legislature were the largest healthcare budget cuts the Texas Legislature made since 2003—even larger than the CHIP cuts. Before the last rate increase in 2007, accumulated Texas Medicaid rate cutbacks had reduced physicians' fees to 1993 levels for most services. Due to these cuts, we expect the supply of physicians in the region to decrease relative to the population in the next five years.

[4] Ibid.

Table 2. HPSAs and MUAs in RHP 11

X" Denotes "Entire County" as Health Professional Shortage Area or Medically Underserved Area, RHP 11, Texas, September 2011				
	Primary Care	Mental	Dental	Medically Underserved Area
Brown		X		X
Callahan		X		X
Comanche	Facility	X	X	X
Eastland	X	X	X	X
Fisher	X	X		X
Haskell	X	X	X	X
Jones	X	X	X	X
Knox	Low-income, facility	X	X	Partial county
Mitchell	Low-income	X	X	X
Nolan	Low-income, facility	X	Facility	X
Palo Pinto	Low-income	X		Partial county
Shackelford	Low-income, facility	X	X	X
Stephens		X	X	X
Stonewall	Low-income	X	X	X
Taylor		X		Partial county

* In 2012 Eastland became an HPSA

"Direct Patient Care" (DPC) physicians are those who work directly with patients and do not include researchers, administrators, or teachers. For the region as a whole, the rate of DPCs per 100,000 population ranged from 136.3 in 2007 to 142.3 in 2011. Rates of DPCs in the state of Texas are higher than those of RHP 11. Taylor County has the highest rate of Direct Patient Care physicians, while Callahan County has the lowest.

"Primary Care" (PC) physicians are those who indicate that they have a primary specialty of General Practice, Family Practice/Medicine, Internal Medicine, Pediatrics, Obstetrics and/or

Gynecology, or Geriatrics, and are a sub-set of DPC physicians. For the region as a whole, the rate of PC physicians per 100,000 people varied from 68.8 to 72.6 between 2007 and 2011. Rates of PC physicians in the state of Texas are similar to those in RHP 11. Stonewall County has the highest rate of PC physicians per 100,000 people, while Callahan County has the lowest.

Over the last five years, family practitioners have accounted for approximately 40% of all primary care specialists. Percentages of each specialization have remained stable since 2007. The percentage of family practitioners in RHP 11 (42%) is higher than that of Texas (29%).

Healthcare Coverage (Tables N-P)

About half the people living in RHP 11 have commercial insurance. Twenty-one percent are uninsured, and the remainder relies on Medicare, Medicaid, or CHIP.

People without healthcare coverage are less likely to have a usual source of care, to use preventive or specialty services, to obtain needed prescription medications, or to receive high-quality services. As a result, they are at increased risk of poor health outcomes and death. Screenings and the utilization of other preventative services are other measures of access to healthcare.

The latest data from the U.S. Census Bureau show that in 2010, Texas remained the state with the highest uninsured rate in the nation at 24.6%. The total number of uninsured Texans is 6.2 million—roughly 250,000 fewer than in 2009. Working-age adults saw a small increase in coverage through job-based insurance, which was a slight reverse in the long-term trend in loss of job-based coverage, made even worse by the recession. Despite the modest up-tick, Texas' working-age adults are still nearly twice as likely as children to be uninsured. Compared to Texas as a whole, RHP 11 has similar percentages of people who lack healthcare coverage. Compared to the U.S., the region and Texas have higher percentages of uninsured adults.

Medicaid is the foundation of Texas' healthcare safety net, providing healthcare benefits for over 3.3 million low-income Texans in September 2011. Children make up the greatest number of enrollees, but adults with disabilities, low-income seniors, pregnant women, and a small number of parents in poverty also rely on the program for critical medical care and community services and supports. About seven in 10 Texas nursing home residents rely on Medicaid for their care. Approximately 14% of RHP 11 residents are enrolled in Medicaid.

Disparities in Accessing Healthcare (Tables Q-S)

In recent decades, the U.S. has made much progress in improving health among its residents and in reducing health disparities. However, health disparities by race/ethnicity, income, education, and other characteristics still exist. Public Health Administrative Region 2/3, which includes RHP 11, and the state of Texas have similar percentages of adults who could not access healthcare due to cost. RHP 11 and Texas have slightly higher percentages than the U.S.

In the region, the following groups were more likely than their counterparts to report that they could not access healthcare due to cost in the past 12 months: women, blacks and Hispanics, younger adults, those with no high school diploma, and people with low incomes. According to

the Texas Behavioral Risk Factor Surveillance System (BRFSS), these groups were more likely than their counterparts to report that they were uninsured: blacks and Hispanics, younger adults, and those with lower education and income levels.

Screenings and the utilization of other preventative services are other access to care measures. RHP 11, Texas, and the U.S. have similar percentages of adults who did not access these specific aspects of preventative care. In the region, women aged 50 and older are less likely than their male counterparts to have had a sigmoidoscopy, colonoscopy, or a flu vaccination. Hispanics are less likely than whites and blacks to receive preventative services. Older blacks are less likely than older whites to get a flu vaccine. Those with lower levels of education and income are less likely than adults with higher education and income levels to receive preventative services.

DATA SUPPORTING FOCUS ON HIGH BURDEN CONDITIONS: HEALTH FACTORS AND BEHAVIORS

Like every state, Texas funds family planning through both federal block grants and Medicaid coverage. These programs provide not only birth control, but also preventive care and basic check-ups to low-income and largely uninsured women (one-third of Texas' working age adults are uninsured). The 82nd Texas Legislature passed deep cuts in block-grant-funded family planning care that will reduce the total number of Texas women served with birth control by at least 70% in 2012-2013.

The appropriations act for 2012-13 says that the Department of State Health Services (DSHS) Family Planning programs will serve 61,135 Texas women in each year of the budget; this is down from the actual 211,980 served in 2010—a 71% reduction (150,845 less) in clients served by DSHS programs.

The Texas Legislative Budget Board estimated the 2010-2011 DSHS Family Planning spending at over $111 million, compared to appropriations for 2012-2013 of $37.9 million for the biennium. This results in a 66% reduction ($73.2 million) from 2010-2011—a two-thirds cut.[5]

Access is critical to reducing several Texas challenges: high and growing rates of pre-term births, births too close together causing medical risks for the newborn, and births to unmarried teen mothers. More than half of all Texas births are reportedly unplanned, and maintaining access to family planning services is essential to reducing unplanned pregnancies. The fertility and natality-related rates are similar for the region and Texas.

[5] DSHS, Behavioral Health Data Book, FY 2012 Qtr 1, Jan 9, 2012. BHIPS and CMBHS.

The Texas pregnancy rate per 1000 female teenagers between 13 and 17 years was 21.4 in 2010.[6] The rate in RHP 11 was slightly higher (22.1/1000) than the Texas rate. Table 3 below displays the pregnancy rate among this population by county. Nine of the 15 counties in RHP 11 have higher pregnancy rates among 13 to 17 year olds than Texas' overall rate. Fisher County had the highest rate, while Shackelford County had the lowest.

In 2010, 4.3% of births in Texas were to mothers less than 18 years of age.[7] The rate in RHP 11 was higher than in Texas – 5.2% overall. Table 4 below shows the percent of births to these young mothers by county. Eleven of the 15 counties in RHP 11 have higher birth rates to young mothers than Texas' overall rate. In Fisher and Haskell Counties, 15.2% of all births were to mothers less than 18 years of age. According to an official at Palo Pinto General Hospital in Palo Pinto County, 21.9% of births in that hospital since 2009 have been to teen mothers.

The birth rate to white, black, and Hispanic teen mothers in Texas was 1.8%, 5.0%, and 6.2%, respectively, in 2010.[8] The majority of counties in RHP 11 showed higher rates in white mothers less than 18 years of age than overall Texas rates.

Table 3. Pregnancy Rates, Ages 13 - 17

Reported Pregnancy Rate Per 1000 Women Age 13-17 by County, RHP 11, 2010	
	Rate per 1000
Brown	14.2
Callahan	8.1
Comanche	31.6
Eastland	24.4
Fisher	53.3
Haskell	38.7
Jones	16.7
Knox	33.9
Mitchell	31.0
Nolan	28.9

[6] http://www.dshs.state.tx.us/chs/vstat/vs10/t14b.shtm
[7] http://www.dshs.state.tx.us/chs/vstat/vs10/t11.shtm
[8] Ibid.

Palo Pinto	24.2
Shackelford	7.2
Stephens	18.8
Stonewall	20.0
Taylor	22.2

Table 4. Births to Mothers Less than 18 Years of Age

Births to Mothers ≤ 17 Years by County and Ethnicity, RHP 11, 2010				
	Total %	White %	Black %	Hispanic %
Brown	4.1%	4.2%	0.0%	4.5%
Callahan	3.3%	3.5%	0.0%	0.0%
Comanche	7.1%	4.2%	0.0%	10.7%
Eastland	6.8%	6.6%	n/a	2.8%
Fisher	15.2%	11.5%	0.0%	n/a
Haskell	15.2%	11.5%	0.0%	n/a
Jones	4.7%	4.5%	0.0%	6.0%
Knox	8.3%	8.3%	n/a	4.8%
Mitchell	7.0%	7.3%	0.0%	6.8%
Nolan	7.5%	7.8%	n/a	7.2%
Palo Pinto	5.5%	4.7%	0.0%	7.9%
Shackelford	3.7%	4.5%	0.0%	0.0%
Stephens	5.4%	2.7%	0.0%	11.1%
Stonewall	n/a	n/a	0.0%	0.0%
Taylor	4.4%	3.0%	8.6%	6.5%

Mental Health and Substance Abuse

In Texas, between 2001 and 2010, the number of psychiatric hospitals in Texas increased by 5% and the number of beds increased by 8%. Admissions for mental conditions increased by 22% across the state, indicating that the growth in services may not meet the growth in need.[9] In addition, the number of youth admitted to substance abuse treatment programs and have interacted with the criminal justice system increased in Texas from 4,305 in 2008 to 4,803 in 2011.[10]

Funding for community mental health services in the Texas Department of State Health Services budget escaped deep cuts in 2010-2011. However, no funding was provided to allow for inflation or population growth, so service levels per person will likely be reduced in some programs. For example,

- The number of children receiving community mental health services in 2012-2013 is projected to be the same as in 2011, though lower than in 2010. The 2012-2013 number represents a 6% gain over children served in 2003, though not enough to keep up with population growth.
- The number of adults receiving community mental health services has been flat since 2009 and remains at essentially the same number served in 2003. However, the population in Texas has grown by 3.3 million (15%), and the number of uninsured Texans has grown by nearly 1 million.

[9] Texas Hospitals: Utilization and Financial Trends. 2001-2010 http://www.dshs.state.tx.us/chs/hosp/hosp5. Accessed July 5, 2012

[10] DSHS, Behavioral Health Data Book, FY 2012 Qtr 1, Jan 9, 2012. BHIPS and CMBHS.

- The Legislature expressed an intent to maintain state and community mental health hospital bed capacity, contingent on DSHS implementing $15 million in cost-containment policy changes in the state facilities.
- The number of adults and youth receiving substance abuse treatment is held at the 2010 level.[11]

RHP 11 has higher "all-cause" death rates than Texas. Its rates for all-cancer, heart disease, cardiovascular disease, and chronic lower respiratory disease are also higher than the rates for Texas.

[11] Ibid.

The Varicella rate is much higher in RHP 11 than in Texas, while the rate for pertussis is lower in the region. The region has a slightly higher rate of AIDS than Texas as a whole.

Health Factors (Table W)

There are many different variables that measure health behaviors and other factors related to health. We have chosen obesity, excessive drinking, motor vehicle crash death rate, Chlamydia rate, and teen birth rate for illustrative comparison. Obesity is a risk factor for adult-onset diabetes, coronary heart disease, and several other serious medical conditions that can lead to poor health and premature death. Chlamydia is the most common bacterial sexually transmitted infection (STI) in North America and is one of the major causes of tubal infertility, ectopic

pregnancy, pelvic inflammatory disease, and chronic pelvic pain. STIs in general are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, involuntary infertility, and premature death. RHP 11 has a much lower excessive drinking rate than Texas and a motor vehicle crash death higher rate than Texas.

Health Outcomes (Table X)

Among the many health outcomes, we include mother/baby issues of low birth weight, and birth defects, and the chronic disease diabetes. In 2006, the leading causes of death in Texas were 1) cardiac conditions, 2) cancer, 3) cerebrovascular diseases, 4) accidents, 5) chronic respiratory disease, and 6) diabetes. These rankings vary by race and ethnicity. However, as care for cardiac, cerebrovascular, and chronic respiratory conditions is largely covered by Medicare, we focus here on diabetes as a leading driver of costs in the Medicaid population. Other health conditions are worth exploring in future drill-down analyses with provider-specific data recommended in the introduction section of this assessment.

Low birth weight represents two factors: maternal exposure to health risks and an infant's current and future morbidity and premature mortality risk. Diabetes is one of the major causes of premature death in the U.S. and disproportionately affects some racial and ethnic populations. Among the Type I diabetic population in Texas, almost 19% of primary payment for hospitalizations in 2006 was provided by Medicaid, compared to 15% by Medicare. Among Type II diabetics, Medicaid was the primary payment source for 10% of discharges in 2008, compared to 43% by Medicare.

The percentages of low birth weight babies and diabetes among adults are similar for the region and Texas. The region has a higher rate of premature death than Texas.

Counties in RHP 11 Ranked

The Population Health Institute at the University of Wisconsin produces *County Health Rankings* for almost all counties in the U.S. The *Rankings* are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work, and play. The Population Health Institute examined data for 223 Texas counties. Each received a rank from 1 to 223.

Our Community Needs Assessment examined data for the counties in RHP 11. Using the percentile rank for each county, we determined the quartile in which the counties fell. Comparing the counties in RHP 11 to 223 Texas counties, the lower quartile (up to 24%) represents the *highest, or relatively better,* scores for health factors and outcomes. The upper quartile (75% to 100%) represents the *lowest, or relatively worse,* scores for factors and outcomes.

Looking at the rankings for health factors, 65% of RHP 11 counties ranked relatively well in health behaviors; 35% ranked relatively poorly. (See Figures 2 and 3.) There is great opportunity for improvement in health behaviors, clinical care, and the physical environment, where about a third of the counties were relatively worse off than other Texas counties. Forty-three percent of RHP 11's counties ranked relatively well in health outcomes. Looking at the rankings for health

outcomes, no county in RHP 11 scored in the best quartile for mortality rates. Fifty-four percent scored relatively poorly compared to other Texas counties for mortality and morbidity.

Figure 2. Percentage of RHP 11 Rankings for Health Factors

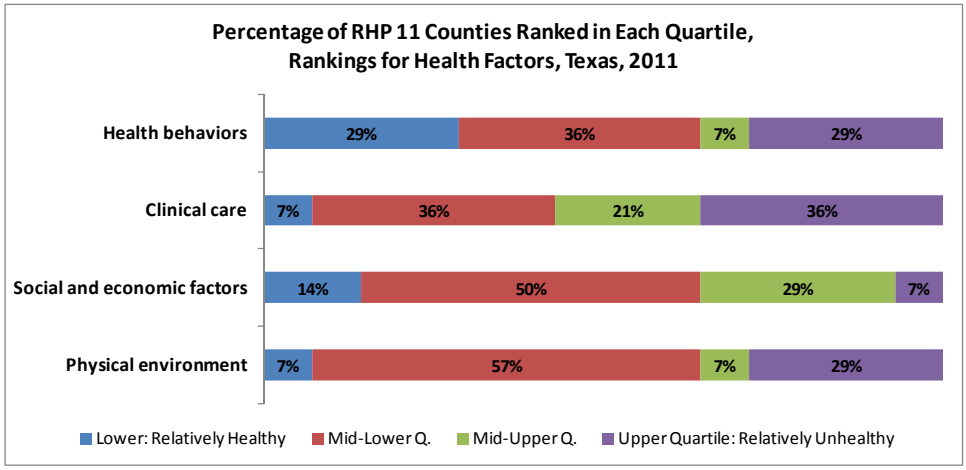
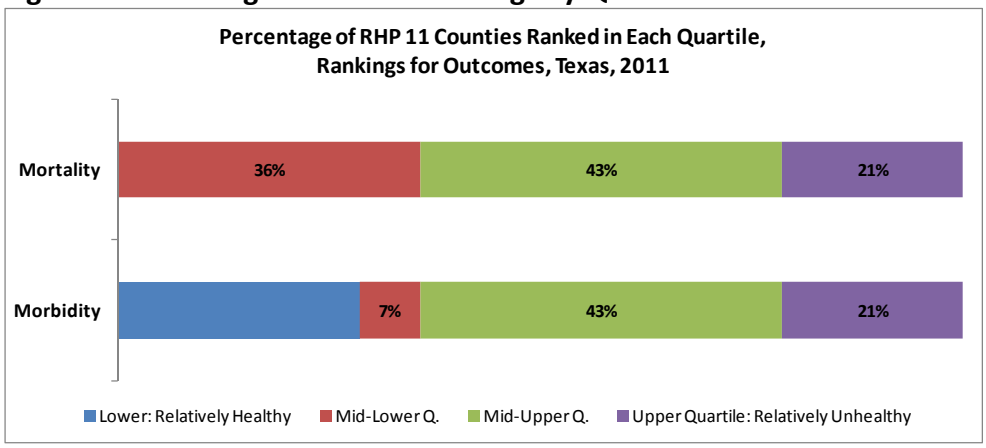


Figure 3. Percentage of RHP 11 Rankings by Quartile



Preventable Hospitalizations *(Table Y)*

Hospital admissions increased across Texas by 7.8% between 2001 and 2010, and inpatient days increased by 6.9%. Also across Texas, emergency room visits increased by 28.6%, and inpatient surgical operations increased by 11%. RHP 11, which is roughly Public Health Region 2, had higher hospital utilization than the state average of 546 inpatient days per 1,000 population, with 571 inpatient days per 1,000. In Public Health Region 2, roughly including RHP 11, bad debt charges totaled $9.6 million and charity charges totaled $1.7 million, for total uncompensated care charges

of $11.2 million. As a percent of gross patient revenue, uncompensated care was 9.6% in PHR 2 in 2010, while the state average was 14%.[12]

According to a recent analysis of THCIC data, RHP 11 received $413,525,403 between 2005 and 2009 for hospitalizations that may have been preventable. The two most costly hospitalizations per county resident were pneumonia ($476 per adult resident) and CHF ($430 per adult resident). These conditions in particular may be focus areas for quality improvement. Provider-specific data regarding volume and other burden to the current healthcare infrastructure may be supplemented here to drive initiatives in these two high-burden conditions.

SUMMARY: DEMAND AND NEED FOR SERVICES

Regional Healthcare Partnership 11, compared to Texas as a whole, has a greater percentage of whites and people 65 years or older. This older population means that expansion of services for chronic conditions related to coronary and cerebrovascular disease may be as cost-beneficial (perhaps more so) as those related to pre-natal and infant care, diabetes, and acute illnesses. Conditions of focus to reduce potentially avoidable hospitalizations, with both inpatient and outpatient efforts, may be bacterial pneumonia and congestive heart failure. These two conditions have the highest rate of reimbursement per county resident from 2005 to 2009.

The median household income and per capita income of RHP 11 residents are lower than those of Texas. Thirty percent of the region's adults are uninsured, and 17% of its children are uninsured. An analysis of ED overutilization may reveal an opportunity to shift ED visits among the poor to community based care. Additionally, with market reforms underway and expanded coverage in 2014 under the Affordable Care Act, the percentage of uninsured persons is expected to decrease. The population of the region is inadequate to support full-time specialty physicians, so the community must rely on satellite clinics, telemedicine, and travel to secure specialty care. As of 2011, all counties in the region are considered Medically Underserved Areas. Medically Underserved Areas are areas designated by HRSA as having too few primary care providers, high infant mortality, high poverty, or a high elderly population. All of the RHP 11 counties are also designated as Mental Health Professional Shortage Areas. Most counties are considered shortage areas for primary care health professionals and dental health providers. These shortages are expected to worsen in the short-term future.

Texas' health challenges have also been made more severe by a deep revenue shortfall from the global recession and the 82nd Texas Legislature's Budget for 2012-2013, which made deep cuts in healthcare investment. Cost-effective healthcare is a priority for RHP 11.

[12] Texas Hospitals: Utilization and Financial Trends. 2001-2010. http://www.dshs.state.tx.us/chs/hosp/hosp5. Accessed July 5, 2012

DATA SOURCES

This report presents the current data available from national, state, public, and private databases. Data are based on estimates, projections, or self-reported information from different time periods. Data such as population and socioeconomic characteristics are not comparable among different sources. Please refer to the specific data source for complete description of methodologies:

- Abilene Industrial Foundation
- Behavioral Risk Factor Surveillance System
- U.S. Department of Commerce, Bureau of Economic Analysis
- Bureau of Economic Analysis, U.S. Department of Commerce
- Center for Health Statistics, Texas Department of State Health Services
- County Health Rankings, University of Wisconsin and Robert Wood Johnson Foundation
- Environmental Protection Agency
- Kids Count Data Center, Annie E. Casey Foundation
- County Information Project, Texas Association of Counties
- National Center for Health Statistics
- Texas Department of Health and Human Services
- Texas Department of State Health Services, Center for Health Statistics, Health Professions Resource Center
- Texas Department of State Health Services, Texas Health Care Information Collection, Center for Health Statistics
- Texas Department of State Health Services, Texas Hospital List
- Texas Health and Human Services Commission
- Texas Medical Board
- Texas Population Estimates Program and Texas Population Projections Program, Texas State Data Center and Office of the State Demographer
- Texas Workforce Commission
- U.S. Census Bureau 2005-2009, 2009, 2010, 2011
- U.S. Department of Health and Human Services, Health Resources and Services Administration

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Section IV. Stakeholder Engagement

RHP Participants Engagement

In May 2012, the Texas Health and Human Service Commission finalized the Regional Healthcare Partnership 11 region with 15 counties that serve as the gateway to the West. Palo Pinto General Hospital was designated as the RHP 11 anchor and began engaging stakeholders. Stakeholder forums were hosted in the central, suburban center of Abilene, Texas throughout the summer and into the fall. Hospitals, Community Mental Health Centers, elected officials and health departments all participated in meetings. Once Pass 1 allocations were released by HHSC, performing providers were more clearly delineated and took leadership roles in researching and publishing projects to meet the needs for access to care and delivery reform in RHP 11. Participating providers have engaged one-on-one within RHP 11 in order to finalize plans, workbooks and projects.

In addition to face-to-face meetings, RHP 11 utilized webinars, conference calls and email distribution to quickly and effectively communicate with providers across the region. We expect to continue all forms of communication in order to ensure all providers have the appropriate information regarding their participation in the RHP 11 plan. Additionally, there is a plan for a regional project, Primary Care, which will be coordinated by the anchor, Palo Pinto. Through this regional project, all providers will be engaged to participate in learning forums where best practices can be discussed and status reports can encourage and enable all providers to meet their Category 3 outcomes in reducing non-emergent utilization of the Emergency Department. We believe this regional support will enable true transformation across the region which is the best way to impact total population health.

Public Engagement

In May 2012, the Health and Human Service Commission finalized the region with 15 counties included in Regional Healthcare Partnership 11. Palo Pinto General Hospital was designated as the RHP 11 anchor and began engaging stakeholders. Stakeholder forums were hosted in the central, urban center of Abilene, Texas throughout the summer and fall.

RHP 11 Meetings

In addition to general stakeholder and provider meetings, several different committees were formed in order to hone in on the needs in RHP 11. Two different committees for the different provider types were formed, the Acute DSRIP Committee and the Mental Health DSRIP Committee. The Executive Committee was also formed to provide guidance throughout the process.

All of these committees were formed to evenly delegate meetings and information equally across the region. The Executive Committee meets every Wednesday from 10:30 a.m. to 11:30

a.m. They then disperse the proper information to stakeholders in the other groups and across our region. This system proved to be efficient and effective because time and resources were managed appropriately. Minutes are taken during all of the committee meetings and posted in a central location where all of the stakeholders have access to them. Hendrick Medical Center has also hosted four different face to face workshops for all of the stakeholders in our region. On August 7 – 8, 2012 a group of stakeholders from our region went to Austin for the Waiver Summit hosted by HHSC. On August 21, 2012 the region hosted a conference call informing people of the information obtained at the waiver summit.

Acute DSRIP Committee Conference Call Dates and Times:
May 24, 2012 from 2:00p.m. – 2:30p.m.
June 13, 2012 from 4:00p.m. – 5:00p.m.
June 20, 2012 from 4:00p.m. – 5:00p.m.
July 11, 2012 from 4:00p.m. – 5:00p.m.

Mental Health DSRIP Committee Conference Call Dates and Times:
May 24, 2012 from 9:00a.m. – 9:30a.m.
June 14, 2012 from 2:30p.m. – 3:00p.m.
June 21, 2012 from 2:00p.m. – 2:30p.m.
July 6, 2012 from 11:00a.m. – 12:00p.m.
July 12, 2012 from 2:00p.m. – 2:30p.m.
July 19, 2012 from 2:00p.m. – 2:30p.m.

Executive Committee Conference Call Dates and Times:
May 8, 2012 from 10:30a.m. – 11:30a.m.
May 21, 2012 from 10:30a.m. – 11:30a.m.
June 4, 2012 from 10:30a.m. – 11:30a.m.
June 13, 2012 from 10:30a.m. – 11:30a.m.
June 20, 2012 from 10:30a.m. – 11:30a.m.
June 27, 2012 from 10:30a.m. – 11:30a.m.
July 18, 2012 from 10:30a.m. – 11:30a.m.
August 1, 2012 from 10:30a.m. – 11:30a.m.
August 15, 2012 from 10:30a.m. – 11:30a.m.
August 29, 2012 from 10:30a.m. – 11:30a.m.
September 5, 2012 from 10:30a.m. – 11:30a.m.
September 12, 2012 from 10:30a.m. – 11:30a.m.
September 19, 2012 from 10:30a.m. – 11:30a.m.
October 31, 2012 from 10:30a.m. – 11:30a.m.
November 7, 2012 from 10:30a.m. – 11:30a.m.

Stakeholder Workshops Face-to-Face Meetings:
July 2, 2012 from 11:30a.m. – 4:00p.m.
July 24, 2012 from 11:30a.m. – 4:00p.m.

September 10, 2012 from 11:30a.m. – 4:00p.m.
October 15, 2012 from 11:30a.m. – 4:00p.m.

Medical providers and patients were also engaged as stakeholders across the region. Medical societies were invited to participate and provided information along the way. Representatives were included in the distribution list of stakeholder information and regularly attend meetings.

RHP 11 distributed a newsletter to providers and stakeholders shortly after the HHSC Waiver Summit in August 2012. We also held a webinar for providers and stakeholders to provide step by step instructions on how to fill out the workbook and complete the plan template. Throughout the process the anchor has updated providers via email and the website to keep providers up to speed. At each new juncture, RHP 11 provided communication using tools that would best communicate important information to participants.

Throughout the stakeholder process and plan development phase, the 13 public hospitals and five Community Mental Health Providers have had public board meetings where discussions of the waiver, IGT and financing were discussed. The public hospitals are located in 10 of the 12 counties in RHP 11.

On November 5, 2012, the RHP 11 Pass 1 projects were posted to the RHP 11 website, www.texasrhp11.com, for public comment. The plan was officially up for 5 business days; however a copy remained on the website until the December 2012. A public comment form was imbedded in the website for stakeholders to easily provide feedback on the projects identified under Pass 1 allocations.

On December 3, 2012, the RHP 11 Final Draft Plan was posted to the RHP 11 website for public comment. A public comment form was imbedded in the website for stakeholders to easily provide feedback on the projects. The plan was officially posted for 5 days, but a copy remained on the website longer in order to allow for public comment. There were no comments submitted through the online form.

Ongoing RHP activities will include the weekly executive committee conference call on Wednesday mornings until the plan is finally submitted and approved. This meeting is needed to direct full stakeholder conference calls and meetings when necessary. There have been ongoing conference calls in order to respond to feedback and further changes directed to participate in DSRIP and UC. Once the projects get underway, regional and executive committee meetings will be scheduled based on need and further coordination on UC and DSRIP projects by the region. The regional project by Palo Pinto General Hospital to coordinate providers doing primary care projects will get underway and have meetings related to that specific project.

Section V. DSRIP Projects

RHP Plan Development

RHP 11 is a Tier 4 region, meeting the required 4 projects from Categories 1 and 2, with at least 2 of the 4 projects selected from Category 2.

Through the stakeholder engagement forums, participating providers in Pass 1, Pass 2 and Pass 3B submitted strategic projects to address the critical access to care hindrances and needed transformation in the delivery system. Projects were selected based on the individual needs for each provider. RHP 11 providers shared goals related to increasing access to Primary Care in order to reduce non-emergence ED utilization, as this has been an issue in RHP 11. After individual selections were made for projects, providers submitted their proposals to the anchor who compiled the draft plan. Face-to-face meetings provided time for providers to discuss project selection and to provide any concerns and/or disapproval for projects submitted by other providers. For the most part, there was no negative feedback on provider project selection. Providers with similar projects typically rallied around one table and then shared ideas for project development.

While projects submitted were not rejected, there were projects that were not submitted due to lack of funding. These are listed in the following section.

Projects not included in the RHP Plan:

1. Betty Hardwick Center d/b/a Abilene Regional MHMR Center- Behavioral Supports Services for individuals with co-occurring Intellectual and Developmental Disabilities and Mental Health Needs
2. Central Texas MHMR Center dba Center for Life Resources-1.13 Development of behavioral health crisis stabilization services as alternatives to hospitalization
3. Eastland Memorial Hospital District- Medical Home Project to help ER patients
1. Hendrick Medical Center-Sepsis
2. Hendrick Medical Center-Tele-Screenings
3. Hendrick Medical Center-Neonatal Training,
4. Hendrick Medical Center-39 Week Gestational Education
5. Hendrick Medical Center-Breast Cancer Clinic
6. Rolling Plains Memorial Hospital-Diabetic Outreach Program
7. Stamford Memorial Hospital-ER Expansion
8. Stamford Memorial Hospital-Diabetes Chronic Care Management Plan with a Wellness Club
9. Stamford Memorial Hospital-Mobile Clinic
10. West Texas Centers- Crisis Respite Facility in Nolan County

Based on the Community Needs Assessment, RHP 11 established goals to further the Triple Aim: right care, right setting and right time as well as progress transformational delivery

system reform such as right cost and patient centered healthcare. In order to address these goals, RHP 11 providers concentrated on the number one issue facing local communities, access to primary care. In order to impact the cost curve, providers see the need for taking care outside the hospital and back into the clinic and the home community for patients. Barriers such as transportation cause delays in care and for persons with chronic conditions, delays in maintenance type services can cause more intense acute episodes which can be costly. RHP 11 projects show this commitment and lead our communities back to this delivery model. Community Mental Health Centers will expand their reach for individuals in need of specialty care for behavioral health services which enhances care model transformation on the front lines in the less costly settings of care. Transformational projects, such as patient experience, have also been deployed to build on the primary care infrastructure of access. These projects engage patients to take ownership of their own health and hold providers accountable.

Providers Exempt from Category 4:

Reporting Status	Provider Name	Hospital County	RHP
Exempt	Anson General Hospital	Jones	11
Exempt	Stonewall Memorial Hospital	Stonewall	11
Exempt	Stephens Memorial Hospital	Stephens	11
Exempt	Eastland Memorial Hospital	Eastland	11
Exempt	Hamlin Memorial Hospital	Jones	11
Exempt	Haskell Memorial Hospital	Haskell	11
Exempt	Knox County Hospital	Knox	11
Exempt	Fisher County Hospital District	Fisher	11
Exempt	Stamford Memorial Hospital	Jones	11
Exempt	Rolling Plains Memorial Hospital	Nolan	11

Project Valuation

After HHSC released the Pass 1 allocations, RHP 11 reflected on the artificially low allocations to providers who had been working toward robust projects that would not be supported by their low allocations. In order to achieve transformation, collaborations were initially formed across RHP 11 in order to support robust projects in communities where local taxpayers already support the healthcare delivery systems. With the January 2013 guidance, certain collaborations were removed from the RHP 11 Plan. However, the remaining collaborations support benefits to regional transformation and thereby remain identified as a collaboration.

General provider valuation methodology considered the patient impact, project size and scope, the community need and potential for regional transformation. Additionally, the goals of the region were established and supported these projects which will build up the needed primary care infrastructures. While slight variances remain with regard to like projects, providers used industry standards to estimate patient impact for new services and reported that variances exist around recruitment of physicians which is one of the largest costs and could take longer than expected to achieve. Loan repayment programs and coverage requirements for the Emergency Department, OB and other emergency services can also create added challenges for providers seeking to recruit additional providers to their community. Thereby increasing the difficulty for transformation in regions where access to primary care is vital to change patient behaviors and engage them in their health choices and outcomes.

Pass 3B

Per HHSC guidance issued January 2013, certain collaboration projects were removed from Pass 1 or Pass 2. Once the projects were removed, Pass 3B funds, totaling $28,963,518, were rebid to providers in RHP 11. The email announcing the rebid of the funds in Pass 3B is included in the appendix. Providers wanting to participate in Pass 3B were required to submit project ideas and request sum certain valuations for their projects under the new Pass 3B. Once compiled by the anchor Pass 3B DSRIP allocations were made to providers requesting it.

Pass 3B workbooks and narratives have been included in the RHP 11 Plan, submitted in response to HHSC's Formal Feedback.

Category 1

Anson General Hospital
DSRIP Project Pass 1
Expand Primary Care Capacity-1.1

Identifying Project and Provider Information

1.1 Expand primary care capacity

ID# 0094104901.1.1

Anson General Hospital-0094104901

Project Descriptions:

Anson General Hospital serves a rural area of uninsured, Medicaid and Medicare households. Based on the Community Needs Assessment done by the Texas Tech University Health Science Center Jones County has a population of 20,202 63.1% of the population is 18-64. The Per capita income is very low compared to the State average with a large numbers of TANF and SNAP recipients and a high unemployment rate. Therefore 23.9% of the population lives below the Federal Poverty Level, 15% of the county population is 65 or older. The county has an uninsured rate of 16.8% among those < 18 years of age and an uninsured rate of 22.8% among those <65%. Anson General Hospital is also located in a within a Health Professional Shortage Area. Based on these factors, we will transform, enhance and improve access to primary and preventive care by enhancing access points and increasing capacity for the growing need for the right care at the right time in the right setting. We will add a physician and support staff to access care in the clinic. This will also improve access for the uninsured. The county has an overall primary care shortage so this will enhance and improve access to care within the county and surrounding region. Patient care and patient outcomes will improve with more readily available access to care by DY5 through recruitment of an additional physician for primary care. . This project achieves the goals of RHP 11 to transform healthcare and impact total population health outcomes by establishing a backbone of primary and preventive care in the system.

Starting Point/Baseline

As of December 2011, the primary care clinic was seeing 2,383 clinic visits per year with a need remaining as not all patients can be seen. This has resulted in patients using the ER for minor illnesses and non-emergent care. We are planning to start the recruiting process and get a primary care physician established within DY2 and use DY3 as the baseline for encounters for the physician. We anticipate a 2% increase in DY3 to DY 4 and a 3% increase from DY 4 to DY 5.

Rationale:

Anson General Hospital has identified project option

1.1.2 Expand existing primary care capacity

Required core project components:

a) Expand primary care clinic space

b) Expand primary care clinic hours

c) Expand primary care clinic staffing

As of September 2012 Anson General Hospital has two full time physician providing primary and preventative care in a clinical setting. One provider has been practicing in the clinic in Anson for over 35 years and the other has only practiced for the last 2 years. One practitioner that has been here for over 35 years is nearing retirement age and experiencing health issues and burnout it is therefore critical that we start the recruiting process as soon as possible for a primary care physician to alleviate the burden placed on these physicians and increase the care provided to the population of Jones County and the need identified by the RHP 11 Community Needs Assessment. Our physicians also provide ER coverage in the hospital. Recruiting now would help to expand and prepare for the eminent retirement of one physician and the eminent departure of the other physician who is relocating to another area. This project falls under the RHP 11 Community needs identification number of CN.3 Shortages of Health Care Professionals.

By providing additional primary care capacity, patients and families will receive better access to care which will result in the patients and families receiving the right care at the right time in the right setting. Also there could be a reduction in the number of non-emergent patients seen and treated in the Emergency Department.

Related Category 3 Outcome Measure:

OD-1 Primary Care and Chronic Disease Management

IT-1.7 Controlling High Blood Pressure

Rationale/Evidence:

Approximately 76.4 million (33.5%) of the population of the United States has high blood pressure. In Jones County the death rate due to stroke is 94.6 per 100,000 populations compared to 47.0 per 100,000 populations for the USA as stated in the Community Needs Assessment. Clinical trials have shown that aggressive treatment of high blood pressure reduces mortality from heart disease, stroke and renal failure results were particularly striking in elderly which makes up 13.7% of the population of Jones County. A 5mm to 6mm HG reduction in diastolic blood pressure was associated with a 42% reduction in stroke mortality and a 12% to 20% reduction in mortality rate from coronary heart disease.(CHD) Literature from the 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 USPSTF and the Joint National Committee.

The Community Health Assessment for Jones County done by Texas Tech University Health Science Center states that Jones County has 94.6 deaths per 100,000 population as compared to the United State average of 47.0 deaths per 100,000 populations they cited their source as the communityhealth.hhs.gov. The study also stated that when asked about chronic disease in the households 66% stated someone in the household as having had a stroke or high blood pressure.

By adding another Primary Care Physician to our community we believe this will increase the availability to primary care and allow patients of the county the Right care in the right setting at the right time. Better quality care will be achieved including those with low incomes who may not seek attention due to cost in the inpatient or ED setting. Will allow patients continuation of care with a primary care physician instead of seeking care in ED, where they may see a different physician with each visit.

Relationship to other Projects:

Others in the RHP 11 Region are striving to provide Primary Care to the communities and the population of the RHP 11 Region. We are all working towards the same goals to provide the patients and communities within the regions access to care that meets the growing need of the communities for the right care at the right time in the right setting. And by adding an additional Primary Care physician and expanding our clinic hours and staff we will be able to increase access to care.

Relationship to other performing providers' projects in the RHP:

The goal of the RHP is to provide care to the population within each region and to insure that the population has access to the right care, right place and at right time. RHP focus is on increasing the capacity of primary care services, increasing strategies in disease prevention. The foal would be that all the projects will reduce the burden on physicians in HRSA areas, reduce the burden in over crowded

Project Valuation:

We have chosen to do only one pass one project 1 project due to the limited amount of allocated funds to our facility. We have decided to put all of our value in the project to recruit a primary care physician. This is the number one goal we have at our facility. This recruit will enable us to better serve our county populations of 20,202 including the low income, Medicaid, Medicare and uninsured population. We also anticipate it will decrease the number of non-emergent visits to the ED for non-emergent care. Allow our physicians to not be overwhelmed and burned out due to the number of hours spent additionally in the ED for non-emergent care.

0094104901.1.1	*1.1.2.*	1.1.2 Expand existing primary care capacity *A,B,C*	1.1 Expand Primary Care Capacity	
Anson General Hospital				0094104901
OD-1	0094104901.3.1	IT-1.7	**Controlling high blood pressure *(Standalone measure)***	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 Train/hire additional primary care providers and staff and increase primary care providers P-5.1 Metric: Documentation of increased number of providers and staff at clinical site Rationale/Evidence: Additional staff and increased number of providers is necessary to increase the capacity to deliver and provide access to care	**Milestone 2** Increase volume of visits and evidence of improved access for patients seeking primary care in the clinic I-12.1. Metric: Documentation of the increased number of visits over the prior reporting year. Rationale Evidence: The measure of increased visits is a method to assess that the primary care provider is able to increase capacity for care. Baseline/Goal: Establish a baseline for visits using the first	**Milestone 3** Milestone: Increase the volume of visits and evidence of improved access for those patients seeking primary care in clinic . I-12-1Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Total number of visits fo the reporting period Rationale/Evidence: This measures the increase improvement in visits and a assessment tool for the performing providers ability to provide care. Baseline/Goal 2% increase in	**Milestone 4** I-12 Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period Rationale/Evidence: This will measure the increased volume of visits and the ability of the performing provider to provide care Baseline/Goal 3% increase in

0094104901.1.1	*1.1.2.*	1.1.2 Expand existing primary care capacity *A,B,C*	1.1 Expand Primary Care Capacity	
Anson General Hospital				0094104901
OD-1	0094104901.3.1	IT-1.7	**Controlling high blood pressure *(Standalone measure)***	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Baseline/Goal: Recruit primary care physician and staff for the clinic Data Source: New primary care schedule or other Performing Provider document. Policies and contracts Milestone 1 Estimated Incentive Payment *($66,000)* *Milestone 1 Estimated Incentive Payment (maximum amount):* *$66,000*		full year for documentation Data Source: Registry, claims and logs Milestone 2 Estimated Incentive Payment: ($100,000) *Milestone 2 Estimated Incentive Payment (maximum amount)* *$100,000*	clinic visits Data Source: Registry, EHR, claims or other Performing Provider source Milestone 3 Estimated Incentive Payment: ($72,000) *Milestone 3 Estimated Incentive Payment (maximum amount)* *$72,000*	clinic visits Data Source: Registry, EHR, claims or other Performing Provider source Milestone 4 Estimated Incentive Payment: ($28,000) *Milestone 4 Estimated Incentive Payment (maximum amount)* *$28,000*
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $66,000		Year 3 Estimated Milestone Bundle Amount: $100,000	Year 4 Estimated Milestone Bundle Amount: $72,000	Year 5 Estimated Milestone Bundle Amount: $28,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $266,000				

Summary Information (RHP 11):
RHP Project ID Number: 1333387-07.1.1
Project: 1.9.3 Expand Specialty Care

Provider: Abilene Regional MHMR Center d/b/a Betty Hardwick Center is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, and serves as the designated local authority for mental health and intellectual and developmental disabilities for the established service area. The Center began operations in 1971 and continues to serve as the designated local authority for mental health and intellectual and developmental disabilities through a contractual relationship with the Texas Department of State Health Services, Texas Department of Aging & Disability Services, and Texas Department of Assistive & Rehabilitative Services. Betty Hardwick Center provides mental health services in five counties in the RHP 11 area.

Intervention: This project will enable Betty Hardwick Center to expand psychiatry access by the equivalent of one full time Board Certified Adult and Child psychiatrist either through employment or purchase of tele-psychiatry services. This project will be an expansion of Betty Hardwick Center's current psychiatry service.

Need for the Project: Currently, the Center has access to a Child Psychiatrist only 3 days of each month, resulting in lengthy wait times for initial and follow up appointments. Additionally, the Center has implemented an Open Access schedule for Mental Health services for both adults and children, in order to provide more rapid access to outpatient services. This results in a need for more capacity for adult services as well, as initial and follow up appointment times were already difficult to schedule with only 1.13 ftes of Psychiatry for the caseload. Delays in obtaining psychiatric appointments often result in consumers experiencing preventable crisis situations, which frequently require costly hospitalizations. All counties within the project are designated Federal health professional shortage areas.

Target Population: The project is expected, by DY 5, to increase available clinic visits by no fewer than 1400 over the baseline year. Our estimate is that approximately 44% of the adults will have Medicaid and 70% of the child and adolescents will have Medicaid, with the remainder being indigent or having no pay source.

Category 1 expected patient benefits: This project will increase access to behavioral health care services in these locations, enabling at least 1400 visits over the baseline by the end of demonstration year 5. Average first psychiatric appointment wait times should decrease to fewer than 10 days.

Category 3 outcomes: Betty Hardwick Center has selected outcome measure OD-1 Primary Care And Chronic Disease Management, and IT-1.18 Follow up After Hospitalization for Mental Illness, which is a standalone measure. Outcome measures for this project are to be determined**.** It is expected that increased specialty care capacity will enhance our ability to

improve follow up after patients have inpatient treatment. During DY2 we will use internal reports to establish baseline rates.

Category 1: Infrastructure and Development
Project Title: Expand Specialty Care (Psychiatry)
Project Option: 1.9, 1.9.3 "Other" - Expand Specialty Care Capacity

RHP Project ID Number: 1333387-07.1.1

RHP Performing Provider: Abilene Regional MHMR Center d/b/a Betty Hardwick Center-1333387

Project Description:

Currently, residents in the Betty Hardwick Center service area have limited access to Psychiatry services. The goal for this project is to increase the capacity to provide specialty care services, specifically psychiatry, and the availability of psychiatry providers to better accommodate the high demand for psychiatry care so that patients have increased access. With regard to specialty areas of greatest need, the recent report of the Committee on Physician Distribution and Health Care Access cites psychiatry, general/preventive medicine, and child/adolescent psychiatry where the ratios per 100,000 population are 56.7%, 60.2%, and 67% of the US ratios, respectively. The ratio for psychiatry is 1 per 17,000. Our service area is about 13 short. The project goal will be add capacity either through hiring or telemedicine service contracting for the equivalent of one Psychiatrist Board Certified for both adults and children in order to address access and capacity issues. In keeping with the RHP 11 goals to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time., this project specifically addresses the Triple Aim by enhancing the ability for adults and children and adolescents with serious mental illness or emotional disturbance to have adequate access to outpatient psychiatric care. The expected outcome will be more timely access to outpatient psychiatry for individuals at the front door, following inpatient care and in crisis.

Other providers in RHP 11 have similar projects to expand psychiatry access. They do not overlap because the LMHA projects serve different counties in the region; thereby access is being increased but is targeted to the counties served by each LMHA. Hendrick Medical Center also has a project to expand Psychiatry, but our projects are not duplicative for two reasons – a) there is such a serious shortage of Psychiatrists in our area that there is abundant need for both of our entities to have independent capacity; and b) the goals of the projects are different in that our project addresses outpatient care capacity and the hospital needs to provide psychiatry for admitted patients or those who do receive ER services.

Starting Point/Baseline:

The Center provides outpatient psychiatric services to a population of adults with severe and persistent mental illness in the public mental health system. Additionally, we serve child and adolescent patients with emotional disturbance. We presently have 1.13 ftes of Psychiatry for the caseload. More specifically, a Board Certified Child and Adolescent Psychiatrist is only available 3 days per month, seriously limiting all appointment times, extending time periods between follow up visits and often resulting in long waits for initial evaluations. The limited capacity increases wait time for initial and time between appointments.

Rationale:

The project option 1.9.3 "Other", Expand Specialty Care Capacity (Psychiatry) was selected to address a need found in our community. The Community Needs Assessment indicates CN.3, shortage of health care professionals, including mental health care providers is a significant need in our area. Inadequate access to Psychiatry care has contributed to the limited scope and size of safety net health systems. In order to ensure adequate and timely access to this level of care for clients in the outpatient setting, both capacity and timely access must be improved, so this project is a significant enhancement to current capability. The current caseload does not permit timely access to physician services, adequate access for patients who are experiencing crisis or following up from inpatient admissions and may lead to higher cost inpatient care or readmissions. We believe HPSA and claims data support the need to expand psychiatric care in our community.

Related Category 3 Outcome Measure:

The Category 3 Quality Improvement measure associated with this project is OD-1 Primary Care And Chronic Disease Management, IT-1.18, Follow Up After Hospitalization for Mental Illness, which is a standalone measure. This measure is relevant and a priority because timely access to psychiatric care following inpatient stay is important in reducing readmissions. Increased capacity will positively impact the ability to see patients in a timely manner following inpatient stays.

Relationship to Other Projects:

Betty Hardwick Center believes that this project will directly impact our Category 3 project, 1333387-07.3.1, in that we will have increased capacity to provide timely and important outpatient follow up services delivered by a psychiatrist for individuals shortly following their discharge from inpatient hospitalization for mental illness.

Relationship to Other Performing Providers' Projects in the RHP:

Other local mental health authorities in this region also have plans to expand specialty care services including psychiatry, substance abuse. Some are to be delivered using telemedicine and other types of care in expanded clinic locations. All of these projects have the goal of transforming behavioral health services in the outpatient settings. Hendrick Medical Center is working to increase capacity for psychiatric care for patients in the hospital, which may result in referrals to the outpatient LMHA system of care and prevent future use of the emergency room.

Project Valuation:

We valued the project at $6,168,140 based upon the following:

A. Project Size – This project will cover outpatient mental health services in 5 of the 15 counties in RHP 11.
B. Project Scope – The services to be provided in this project will consist of outpatient psychiatric services that include diagnosis and treatment services. Most typically, those services will be psychiatric evaluations and medication management services
C. Population Served – The population to be served will include adults and child or adolescent patients of the local mental health authority who reside in Taylor, Jones, Callahan, Shackelford and Stephens counties. The local mental health authority serves patients who meet DSHS established priority population including adults with serious and persistent mental illness and children or adolescents with serious emotional,

behavioral or mental disorders. Clients served may be involved in ongoing outpatient care or brief crisis intervention care.

D. Community Benefit – Access to appropriate levels of psychiatric care in an outpatient setting is a benefit to our community and the individuals in need of care. Betty Hardwick Center used data and reports provided by the UT Austin Center for Social Work Research in determining some aspects of valuation. The valuation is aligned with the Demonstration program goals to develop programs that enhance access to healthcare, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In developing this plan, the primary valuation method uses cost-utility analysis (a type of cost effectiveness research) and additional information is reported on potential future costs saved and quality adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. This threshold has been a standard way of valuing life years in terms of whether the cost of the intervention exceeds this standard. The number of life years added is based on a review of the scientific literature. There are a variety of studies about the cost effectiveness of medication therapy for persons with severe and persistent mental illness, about the cost savings of providing timely outpatient care versus hospitalization emergency or inpatient costs. Further, the lack of psychiatry available in this part of Texas, recruiting and retaining a Board certified child and adult psychiatrist, and the improvement that yields to our community's health factored into valuation determinations.

E. Cost Avoidance – Appropriate levels of outpatient medication care can reduce cost of psychiatric care over the long term (Martin and Leslie, 2003). The populations to be served include adolescents, adults with mental illness, jail patients, dually diagnosed clients with Intellectual or Developmental Disabilities or Co-Occurring Substance Abuse.

F. Priority Community Need – The community needs assessment completed for RHP 11's planning purposes identified CN.3, shortage of healthcare professionals, including mental health care providers as a significant need in the region.

G. Estimated Local Funding – Betty Hardwick Center has identified appropriate funds to cover the intergovernmental transfer for the project proposed. There is not federal funding involved in this project.

1333387-07.1.1	***PROJECT 1.9 EXPAND SPECIALTY CARE CAPACITY***	***PROJECT COMPONENT 1.9.3***	***EXPAND SPECIALTY CARE CAPACITY***	
Abilene Regional MHMR Center d/b/a Betty Hardwick Center				RHP 11 - 1333387-07
OD-1	*1333387-07.3.1*	*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-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: Numerator: Sum, for all referrals, of the number of days between when request for referral is received from referring provider and the referral appointment during the reporting period. Denominator: Total number of	**Milestone 2** [P-X]: Hire/Contract additional Psychiatry service time Metric 1 [P-X.1]: Evidence increase in psychiatry staffing by equivalent of 1 fte Baseline/Goal: Increase psychiatry capacity by one provider over DY1by either contract or employment Data Source: HR documents or Contract Milestone 2 Estimated Incentive Payment: $759,246 **Milestone 3** [P-11]: Launch/expand a specialty care clinic Metric 1 [P-11.1]: Establish/expand specialty care		**Milestone 4** [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 available clinic visits by 600 over the baseline over the report year. Data Source: Internal Service Reports Milestone 4 Estimated Incentive Payment: $1,624,435	**Milestone 5** [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 available clinic visits by 1400 over the baseline over the report year. Data Source: Internal service reports Milestone 5 Estimated Incentive Payment: $1,569,502

1333387-07.1.1	***PROJECT 1.9 EXPAND SPECIALTY CARE CAPACITY***	***PROJECT COMPONENT 1.9.3***	***EXPAND SPECIALTY CARE CAPACITY***	
Abilene Regional MHMR Center d/b/a Betty Hardwick Center				RHP 11 - 1333387-07
OD-1	*1333387-07.3.1*	*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)**
referrals during the reporting period. Data Source: Administrative records Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,455,847	clinics Baseline/Goal: 10% increase in monthly number of patients served by specialty care clinic over the baseline of December 2011 Data Source: Documentation of new/expanded specialty care clinic Milestone 3 Estimated Incentive Payment: $759,247			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,455,847	Year 3 Estimated Milestone Bundle Amount: $1,518,493		Year 4 Estimated Milestone Bundle Amount: $1,624,435	Year 5 Estimated Milestone Bundle Amount: $1,569,502
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $6,168,017				

Pass 3b

Summary Information (RHP 11):
New RHP Project Number: 133387-07.1.3
Old RHP Project Number: 1333387-07.1.2

Project: 1.13.1 Mobile Crisis Outreach Team Expansion

Provider: Abilene Regional MHMR Center d/b/a Betty Hardwick Center is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, and serves as the designated local authority for mental health and intellectual and developmental disabilities for the established service area. The Center began operations in 1971 and continues to serve as the designated local authority for mental health and intellectual and developmental disabilities through a contractual relationship with the Texas Department of State Health Services, Texas Department of Aging & Disability Services, and Texas Department of Assistive & Rehabilitative Services. Betty Hardwick Center provides mental health services in five counties in the RHP 11 area.

Intervention: This project will enable Betty Hardwick Center to enhance its Mobile Crisis Outreach Team services to serve 5 counties in RHP 11. The Center will complete a gap analysis and engage stakeholders in gathering feedback about the best approach to implement the expansion, which is planned to add a minimum of three dedicated Mobile Crisis Staff.

Need for the Project: Currently, the Center has two dedicated Mobile Crisis staff covering a population of 178,260 and 4,594 square miles. The workload demands additional staff dedicated to mobile crisis in order to provide timely assessment and intervention, and additionally, follow up after crisis events. In 2012, Betty Hardwick Center received over 4800 calls for the RHP 11 counties we serve with over 1700 being legitimate "go mobile" crisis calls. During 2012, we diverted approximately 209 individuals from Jail using both pre and post booking efforts. We also facilitated inpatient hospital stays for about 474 individuals. Our ability to respond to these calls in a timely manner with well qualified crisis staff enhances our ability to deter emergency room admissions, jail diversion and appropriate referrals to treatment.

Target Population: The project serves five counties in RHP 11. The crisis services are available to the entire county population in those counties.

Category 1 expected patient benefits: By DY5, we expect to see a 15% increase in utilization of appropriate crisis alternatives. The quantifiable results will be measured by an increase in the overall number of mobile crisis screenings indicating that persons are receiving the right care, at the right time in the right setting.

Category 3 outcomes: Betty Hardwick Center has selected outcome measure- 0D-9 Right Care, Right Setting and IT-9.1 Decrease in MH admissions/readmissions to criminal justice settings. It is expected that increased Mobile Crisis Team Services availability will serve as an intervention which can prevent individuals from cycling through the criminal justice setting, can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning.

Pass 3b
Category 1: Infrastructure Development

Project Title: Abilene Regional MHMR Center d/b/a Betty Hardwick Center Mobile Crisis Outreach Team Expansion

Project Option: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system

New RHP Project Number: 133387-07.1.3
Old RHP Project Number: 1333387-07.1.2

RHP Performing Provider: Abilene Regional MHMR Center d/b/a Betty Hardwick Center- 1333387-07

Project Description:

This project will expand the capacity of Betty Hardwick Center's behavioral health services to better meet the needs of the patient population and the community. Specifically, the Center's Mobile Crisis Outreach Team (MCOT) services will be significantly enhanced. Crisis response services must be provided 7 days a week, 24 hours a day, 365 days a year by highly trained mental health staff. The program serves a five county area of West Central Texas in RHP 11. The population of the targeted service area is 178,260 and covers 4,594 square miles. Betty Hardwick Center will perform a gap analysis of its current crisis response system for the counties the Center serves in RHP 11. This analysis will identify barriers, potential cost savings, community needs and overall crisis response processes which may need refinement or expansion. Additionally community needs will be further met through stakeholder meetings and feedback to help identify crisis response system needs. Betty Hardwick Center will expand its current Mobile Crisis Outreach Team staff by a minimum of three additional qualified mental health providers. These additional staff will effectively double the current capacity of the Center's crisis response system in these counties.

Project Goals:

Goals will include increasing access to Betty Hardwick Center's Mobile Crisis Outreach team by emergency room and law enforcement personnel as well as individuals in the communities Betty Hardwick Center serves in RHP 11. Additionally, a goal of the

project will be to enhance BHC Crisis Services through aggressive crisis follow up procedures. Individuals who access crisis services will receive follow up contacts to assess current level of functioning and facilitation of referrals to other services that may assist in reducing further crisis. Crisis resolution may involve use of other community resources such as counseling, substance abuse services, or other social service needs. Along with crisis assessment intervention skills staff are trained in engagement strategies and motivational interviewing techniques to facilitate individuals staying motivated and engaged until problem resolution.

This service will result in fewer ER visits for Mental Health Problems; Fewer individuals in jails with mental health problems; and fewer individuals being hospitalized for mental health issues. In FY 2012 Betty Hardwick Center received over 4800 crisis calls for the RHP 11 counties we serve with over 1700 being legitimate "go mobile" response situations. During 2012, we diverted approximately 209 individuals from Jail using both pre and post booking efforts. We also facilitated inpatient hospital stays for about 474 individuals. The current Mobile Crisis Outreach team is responding to calls throughout more populated Taylor County and lesser populated rural Jones, Shackelford, Stephens and Callahan counties in RHP 11. Additional assessment of Betty Hardwick Center's crisis response system to identify crisis call patterns, including geographic considerations and increasing the staffing component of the Mobile Crisis Outreach team is expected to significantly increase consumer diversion from the emergency rooms, jails, and inpatient facilities. This will result in more appropriate right care, right setting, and right time treatment for our behavioral health consumers. Betty Hardwick Center currently provides these crisis services with only two dedicated Mobile Crisis Outreach staff members in the RHP 11 service area. This leaves many shifts outside of normal business hours covered by a rotation of on call staff. With additional Mobile Crisis Outreach staff it is expected that we would be able to reduce our crisis response time and intervene in behavioral health crisis prior to the consumer being booked into the jail, admitted to the ER or taken to a psychiatric hospital for admission.

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) as well as any citizen experiencing a behavioral health crisis. This project would serve 5 counties in RHP 11, including Taylor, Jones, Callahan, Shackelford and Stephens. 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.

Project Challenges

Challenges may involve difficulty in recruitment of experienced professionals as some of our service area is considered underserved. The addition of Mobile Outreach Crisis staff members will improve the ratio of crisis calls to staff member which in turn will improve recruitment and retention of staff in these high stress, high travel, critical decision making positions. Additional challenges will include administrative support cost associated with patient satisfaction survey instruments and assessment activities to determine current and future crisis system design needs. Betty Hardwick Center plans to utilize highly qualified administrative personnel to design survey instruments and conduct the assessment activities in order to obtain the best most reliable information possible. Research of available crisis systems among other state and national providers will be done to identify progressive, innovative crisis management approaches which may be applied to Betty Hardwick Center's current crisis process. Also the Center will utilize professional software packages as needed to obtain the consumer data necessary for a complete crisis system gap analysis and assessment.

Five Year Expected Outcome:

Betty Hardwick Center anticipates meeting all core component requirements as identified in Project Option 1.13.1; a-e, and achieving all milestones and metrics within the project by completion of demonstration year 5. It is expected this project will increase Betty Hardwick Center's capacity to provide cost effective and appropriate behavioral health intervention and triage for individuals experiencing a psychiatric crisis. This project will also increase BHC's ability to provide appropriate treatment alternatives to incarceration for individuals with low level charges and serious psychiatric impairment, reduce emergency department utilization and wait times for individuals experiencing a psychiatric crisis, ensure appropriate triage and maximization of psychiatric inpatient resources and maximize law enforcement time and resources by providing behavioral health crisis intervention services and assessment "real time" in the community. By DY5, we expect to see a 15% increase in utilization of appropriate crisis alternatives. The quantifiable results will be measured by an increase in the overall number of mobile crisis screenings indicating that persons are receiving the right care, at the right time in the right setting.

Relationship to Regional Goals:

This project will work to 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 the existing behavioral health care system; and infrastructure, is responsive to patient needs throughout the region and improves health care outcomes and patient satisfaction. This project relates to RHP 11 goals of

transforming health care in the total population of the region and to further advance the goals of the Triple Aim: to provide right care, at the right place, and at the right time.

Starting Point/Baseline:

Baseline data will from BHC fiscal year 2012 records reflects that with two dedicated MCOT staff and after hour on call staff, the center initiated mobile crisis response times more than 1700 times. We will continue to analyze data relevant to this project and will continue to refine baseline data during DY 2.

Rationale:

RHP 11 Rural Community Needs Assessment numbers CN.2, High costs associated with preventable hospitalization admissions and readmissions and CN.3, Shortages of health care professionals, including mental health care providers, will be addressed through this project. Both of these needs were identified as significant in the rural needs assessment done by the RHP. This project is an enhancement to the current crisis service network Betty Hardwick Center currently operates in these counties.

Betty Hardwick Center's limited dedicated Mobile Crisis Outreach staff covering the five counties in RHP 11 is not adequate. With over 1700 FY 2012 "go mobile" crisis calls, the ongoing ability to provide timely intervention and assistance to consumers and community stakeholders is tenuous. Ongoing assessment of our crisis delivery system is necessary to insure the most up to date and cost effective processes are in place. Additional staffing increases will increase diversions from emergency rooms and law enforcement incarceration while providing faster more real time assistance to the consumer. Required components of this project are: a) convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps; b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service; c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g. a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings; d) Explore potential crisis alternative service models and determine accept and determine feasible models for implementation; e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and

identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. Through the project descriptions, goals and rationale described in this document, Betty Hardwick Center anticipates all required core components described above will be fulfilled during the 5 year demonstration project. Process milestones for this project are those identified for project option 1.13.1

Related Category 3 Outcome Measure(s):

Betty Hardwick Center has selected outcome measure. 0D-9 Right Care, Right Setting and IT-9.1 Decrease in MH admissions/readmissions to criminal justice settings.

Relationship to other Projects:

This project will closely be related Betty Hardwick Center's RHP 11 Expand Specialty Care Services Psychiatry project number 1333387-07.1.1. This project and the Psychiatry expansion project are closely related in that they will work together to meet both the day to day access needs as well as the crisis needs of the consumer and the community.

Relationship to Other Performing Providers' Projects in the RHP:

Other Local Mental Health Authorities in the RHP also have MCOT staff and some are enhancing their programs in DSRIP projects. All of these projects are working to transform behavioral health services in outpatient settings. We will gather feedback routinely from stakeholders in our area about the MCOT enhancement and ongoing analysis of gaps and service needs. We will also learn from our neighboring LMHAs with related projects.

Project Valuation:

We valued this project at $1,672,407 based upon the following –

A. Project Size – The project will cover a five county area of West Central Texas in RHP 11. The population of the targeted service area is 178,260 and covers 4,594 square miles.

B. Project Scope – The services to be provided in this project will be available to everyone in the community with a behavioral health crisis and will work closely with individual citizens, hospital emergency rooms, law enforcement, jails and many other community agencies.

C. Community Benefit - This project will decrease the cost of care through increased diversion of consumers from jails (there are 5 in the area) and emergency rooms as well as decrease the cost of inpatient care through inappropriate admissions to psychiatric facilities. The project will meet the waiver goals additionally through more right care, right setting and right time treatment provision. The project will increase access to crisis response services through additional Mobile Crisis Outreach team members. It will decrease response times for these staff to assist emergency rooms and law enforcement agencies with mental health crisis situations.

D. Cost Avoidance - According to txpricepoint.org, the average cost for just one possible preventable admission, such as severe psychological disorders including Schizophrenia, among all Taylor County hospitals for Federal Year 2011 was $10,519.00 average charge per average length of stay for this diagnosis (excludes physician cost). Further research shows the average cost to transport an individual to a local hospital by local EMS services is $535.00. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, where an officer is on hand, can range from 1 to 3 hours, sometimes substantially more. A law enforcement officer's average pay can range from $12.50 to $18 per hour, so in an average situation this would be an additional $30-$45 cost per event. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services. Additionally, the small rural police or sheriff's department, often employing due to lack of resources, a low ratio of officers to citizens, is left significantly understaffed while an officer is on duty at the emergency department or transporting clients to distant inpatient sites. Even though these financial costs are significant, the human cost which is much harder to measure can be even more significant. Additionally, the cost of an average stay in the Taylor County Jail runs $50 per day, but that does not include the cost of additional supervision and psychiatric medication for a person who is suffering from untreated or undertreated mental illness.

E. Priority Community Need - RHP 11 Rural Community Needs Assessment numbers CN.2, High costs associated with preventable hospitalization admissions and readmissions and CN.3, Shortages of health care professionals, including mental health care providers, will be addressed through this project.

F. Estimated Local Funding - Betty Hardwick Center has identified appropriate funds to cover the Interlocal governmental transfer for the project proposed. There is not federal funding involved in this project.

New: 133387-07.1.3 Old: 1333387-07.1.2	1.13.1 : Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system,	Betty Hardwick Center Mobile Crisis Outreach Team Expansion	
Abilene Regional MHMR Center d/b/a Betty Hardwick Center			133338707
Related Category 3 Outcome Measure(s): OD-9	New: 1333387-07.3.3 Old: 1333387-07.3.2	OD-9: Right Care, Right Setting IT-9.1 Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
<u>P-1 Milestone 1</u> Milestone: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers. P-1.1. Metric: Number of meetings and participants. Data Source: Attendance lists Baseline: N/A Goal: Will conduct a minimum of 2 stake holder meetings.	<u>P-4 Milestone 3</u> Milestone: Hire and train staff to implement identified crisis stabilization services. P-4.1. Metric: Number of staff hired and trained. a. Staff rosters and training records b. Data Source: Training Curricula Baseline: N/A Goal: Will hire and train MCOT staff as determined by DY1 stakeholder meetings and gap analysis, projected to be no more than 3 staff. Milestone 2 Estimated Incentive	<u>I-12 Milestone 4</u> Milestone: Utilization of appropriate crisis alternatives I-12.1. Metric: 10% increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured at specified time intervals throughout the	<u>I-12 Milestone 5</u> Milestone: Utilization of appropriate crisis alternatives I-12.1. Metric: 15% increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would

New: 133387-07.1.3 Old: 1333387-07.1.2	1.13.1 : Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system,	Betty Hardwick Center Mobile Crisis Outreach Team Expansion	
Abilene Regional MHMR Center d/b/a Betty Hardwick Center			133338707
Related Category 3 Outcome Measure(s): OD-9	New: 1333387-07.3.3 Old: 1333387-07.3.2	OD-9: Right Care, Right Setting IT-9.1 Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings	

Year 2 (10/1/2012 – 9/30/2013)	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 $214,163 <u>P-2 Milestone 2</u> Milestone: Conduct mapping and gap analysis of current crisis system. P-2.1. Metric: Produce a written analysis of community needs for crisis services. Data Source: Written plan Baseline: N/A Goal: Will conduct a mapping and	Payment: $447,369	project to determine if there was an increase. Data source: Claims, encounter, and clinical record data. d. Rationale: see project goals. Baseline: Betty Hardwick Center FY 2012 encounter data for MCOT services, crisis hotline call data and other relevant data sources Milestone 4 Estimated	be measured at specified time intervals throughout the project to determine if there was an increase. Data source: Claims, encounter, and clinical record data. d. Rationale: see project goals. Baseline: Betty Hardwick Center FY 2012 encounter data for MCOT services, crisis hotline call data and other relevant data sources

New: 133387-07.1.3 Old: 1333387-07.1.2	1.13.1 : Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system,	Betty Hardwick Center Mobile Crisis Outreach Team Expansion	
Abilene Regional MHMR Center d/b/a Betty Hardwick Center			133338707
Related Category 3 Outcome Measure(s): OD-9	New: 1333387-07.3.3 Old: 1333387-07.3.2	OD-9: Right Care, Right Setting IT-9.1 Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
gap analysis of current crisis system to determine baseline and identify improvement strategies. Milestone 2 Estimated Incentive Payment: $214,163		Incentive Payment: $454,346	Milestone 5 Estimated Incentive Payment: $385,196
Year 2 Estimated Milestone Bundle Amount: $428,327	Year 3 Estimated Milestone Bundle Amount: $447,369	Year 4 Estimated Milestone Bundle Amount: $454,346	Year 5 Estimated Milestone Bundle Amount: $385,196
Total Estimated DSRIP Funding for 4 Years :$1,715,238			

Category 1 Project Narrative
Central Texas MHMR Center dba Center for Life Resources – 133339505.1.1

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

Performing Provider Name: Central Texas MHMR Center dba Center for Life Resources
Performing Provider TPI #: 133339505

Project Summary

- **Provider Description:** Central Texas MHMR Center dba Center for Life Resources (CFLR) is a local mental health authority (LMHA) serving: Brown, Coleman, McCulloch, San Saba, Mills, Comanche, and Eastland Counties. CFLR serves a variable number of clients based on Department of State Health Services (DSHS)/Department of Aging and Disabled Services (DADS) contractual agreements. Currently, (FY 13) we are serving approximately 1,250 clients in a 7,074 square mile area with a population of approximately 102,497.

- **Intervention:** Through the implementation of a telemedicine model we will provide clinically appropriate treatment as indicated by a psychiatrist or other qualified provider throughout this expansive area. Thus reducing unnecessary emergency department (ED) and service use and improve consumer satisfaction/access were previously limited or unavailable.

- **Project Status:** This is a new project for this region (RHP 11 County of Comanche). We will determine a baseline in DY2 that will serve as a foundation for future progress and monitoring. We expect to see a progressive increase in those served through DY5.

- **Project Need:** There currently is very limited to no access to psychiatric or other mental health care providers in this region (CN2.6). This fact has led to the federal distinction of mental health professional shortage area. http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm. This limited availability often lends itself to utilization of unnecessary or inappropriate ED use. Further, as highlighted through the mental health professional shortage area map; there are inadequate numbers of providers willing to relocate to rural and frontier regions. We believe innovative solutions, such as telemedicine, must be considered and attempted to address the stated community need (CN 2.6).

- **Target Population:** The to be determined target populations we intend to serve are individuals residing in Comanche County suffering from serious mental illness. These primarily include but are not limited to individuals who either are Medicaid eligible or are indigent. Our estimation based on current calculations and past billing is that no less than 50% of our clients currently meet this distinction. This would imply that at least half of

those we serve in this new capacity through telemedicine would be Medicaid eligible or indigent.

- ***Category 1 or 2 Expected Project Benefit for Patients:*** The project seeks to provide 72 telemedicine services in DY4 and 84 in DY5. Through the implementation and subsequent provision of telemedicine services this project seeks to provide a satisfying, individually tailored service that also works to reduce unnecessary emergency department usage. Customer satisfaction will be measured using evidenced based satisfaction tools in DY4 and DY5. These two years will be compared and steps to ensure continued satisfaction will be based on the subsequent data. Frequency of unnecessary emergency department usage will be accounted for through internal tracking in our electronic health records.

- ***Category 3 outcom*es:** IT-9.2 ED appropriate Utilization (Standalone measure). Our goal is to reduce ED visits for the target conditions of behavioral health/substance abuse with baseline to be determined in DY2.

Category 1- Infrastructure Development

Project Title: Telemedicine in Comanche County

Project Option: 1.11.1 **Procure and build the infrastructure needed to pilot or bring to scale a successful pilot of the selected forms of service in underserved areas of the state**

RHP Project Identification Number: 133339505.1.1

Performing Provider Name: Central Texas MHMR Center dba Center for Life Resources-133339505

Project Description:

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

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

Central Texas MHMR Center dba Center for Life Resources proposes that we can better address the psychiatric need in these rural community settings through the implementation of a telemedicine system.

Core Components:

A. *Identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in rural, frontier, and other underserved areas of the state;*
   Central Texas MHMR Center dba Center for Life Resources or agent thereof, will identify existing infrastructure for high speed broadband communications technology (such as T-3

lines, T-1 lines) in (Comanche) County as defined as a mental health professional shortage area.

B. *Assess the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology.* This will be accomplished by assessing the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology.

C. *Assess applicable models for deployment of telemedicine, telehealth, and telemonitoring equipment.* Further, we will assess the applicable models of deployment of telemedicine, telehealth, and telemonitoring equipment. This will be accomplished as we evaluate previously successful models also adopted in rural settings that might be successful in ours. This process will be done to determine feasibility and likely highlight the offsetting of costs associated with unnecessary emergency department services. Simply, we propose the use of a telemedicine system that will give greater access of care to citizens and reduce any unnecessary costs.

Due to our agency placing high priority on the right care, in the right place, at the right time, our regional project focuses on RHP Milestone I-15: Satisfaction with telemental services. We believe that satisfaction is an integral milestone when focusing on the right care, in the right place, and right setting. As telemedicine systems have not been indicated currently in this region other outside resources must be examined for efficacy. It is commonly accepted in private sector management that customer satisfaction is an important factor in determining utilization. It is believed that data will begin to demonstrate this belief after implementation in DY 3. Our intention in the implementing of this project will be to show an increase in the number of those who would not normally be able to receive these services having greater access and greater satisfaction as a result.

Goals and Relationship to Regional Goals

Project Goals:

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

This project meets the following Regional Goals:

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

Challenges:

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

5- Year Expected Outcome for Provider and Patients:

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

Starting Point/Baseline:

Baseline will be determined over the course of DY 2 and implemented in DY3. This will be found through data collection sources such as local hospitals, law enforcement, and other sources as indicated.

Rationale

Community Need Addressed:

Community Need Area: CN.2 - Limited access to mental health/behavioral health services
Specific Community Need: CN.2.6 – Limited access to behavioral health services for rural populations in Comanche and Eastland Counties.

Central Texas MHMR Center dba Center for Life Resources or agent thereof, will identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in (Comanche) County as defined as a mental health professional shortage area. This will be accomplished by assessing the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology. Further, we will assess the applicable models of deployment of telemedicine, telehealth, and telemonitoring equipment. This process will be done to determine first feasibility and then determine if the project would be capable of offsetting the costs associated with unnecessary emergency department services. Some of the possible cost deferments are listed below although are not limited to these specific examples.

According to txpricepoint.org, the average cost accounted for just one possibly preventable condition such as psychosis at Brownwood Regional Medical Center (BRMC) is $6,030 a day with a median charge of $14,472. Another example of a possibly preventable condition is an acute adjustment & psychosocial dysfunction. BRMC has an average charge per day of $7,699 with a median charge of $16,939. Further research shows the average cost to transport an individual to a local hospital by local EMS services is $655. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, where an officer is on hand, can range from 1 to 3 hours. A law enforcement deputy's average pay can range from $12.50 to $25+ per hour, so in an average situation this would be an additional $30-$75 cost. When multiplied by the average number of preventable situations per year, 24, the total costs for EMS transport and law enforcement time is around $17,000 per year. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services. The given $17,000 is solely an average and our best estimation based on prior experience prior to extensive data being collected.

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

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

Continuous Quality Improvement: CFLR is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as "lessons learned" and identifying project impacts. In addition, we are participating in a regional learning collaborative which shares information such as challenges, lessons learned and considerations for safety net populations.

We do not currently receive any U.S. Department of Health and Human Services funding that will be directly used for the implementation of telemedicine services. Given the need for the right care at the right time in the right place and addressing local needs, telemedicine provides great promise.

Related Category 3 Outcome Measure(s):

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

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

Relationship to other Projects:

We are proposing to implement/enhance telemedicine services in seven counties covering RHP 8 (Project #133339505.1.1), RHP 11(Project #13339505.1.1 & #13339505.1.2), and RHP13 (Project #133339505.1.1). Each of these projects will work ~~to~~ in tandem with the intended purpose of greatly increasing the likelihood of right care, at the right time, in the right setting. Projects #13339505.1.1 & #13339505.1.2 are both dealing with telemedicine services but deal with different levels of implementation. Project #13339505.1.1 is putting telemedicine in a new area where not previously available. Project #13339505.1.2 affords that some telemedicine services are being provided but the type of provision will be enhanced. Clearly stated, we intend to build a new system in Comanche and provide new services in Brown and Eastland Counties.

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

Central Counties Services is also proposing a telemedicine project (Project # 081771001.1.2) but it will cover Bell, Lampasas and Milam Counties. Collaboration is greatly encouraged and will be a part of our overall implementation and success. Further, as part of DY2 or DY3 as appropriate, CFLR will contact other similar providers to discuss the planning necessary for a learning collaborative and implementation.

Project Valuation:

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

Given the data provided above from txpricepoint.org and independent local research found in the rationale section, costs were determined to be roughly $17,000.00 per event. The stated

per event cost multiplied by the number of individuals we plan to serve is significant and offers tremendous value through telemedicine. For instance, providing the same 72 encounters we intend to provide in DY4 in the current system would cost over 1.2 million dollars (72 *17,000 =1,224,000). When adding in the additional services in DY5 the costs of provision for just those two years in the current system would be over 2.6 million dollars (84* 17,000 = 1,428,000 + 1,224,000= 2,652,000). Given the total four-year incentive payment of $426,344 the cost savings and value of providing right care in the right setting is a fraction of the cost (16%). It is our belief that our commitment to right care, at the right time, in the right setting offers an alternative option that would greatly improve patient and community care through local access at a comparatively lower cost. We do not believe that the value is limited to just cost savings.

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

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

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

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Identify Texas Counties having availability of high speed broadband communication lines. **Metric 1** [P-1.1]: Documentation of assessment of counties that identifies areas of state that have or lack capacity for high speed broadband connections capable of supporting telemedicine, telehealth, telemonitoring **Baseline/Goal:** Baseline - Results of the assessment rationale/evidence; Goal - Implement telemedicine in underserved area to	**Milestone 2** [P-7]: Hiring of tele-presenters, as needed, for remote site equipment operation. **Metric 1** [P-7.1]: Number of staff hired and trained. **Baseline/Goal:** Hire appropriate number of staff. **Data Source:** Interviews with staff, review of hiring or payroll records, appropriate licensure records. **Milestone 2 Estimated Incentive Payment: $84,879**	**Milestone 3** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service. **Metric 1** [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles. a. Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project	**Milestone ~~4~~-5** [I-15[: Satisfaction with telemental services. **Metric 1** [1.15.1]: XX #% of consumer, peer and provider surveys indicates satisfaction with telemental services. a. Numerator: 63 of patients, peers and providers reporting satisfaction b. Denominator: 84 of patients, peers and providers surveyed **Baseline/Goals:** We set as our goal for 63 of the 84 (75%) encounters we plan to provide to be classified as satisfying to the individual by the end of DY5. Depending on the actual encounter

improve access and provide right care, right setting service. **Data Source:** Filed record of research. **Milestone 1 Estimated Incentive Payment: $140,050**		continuously uses data such as weekly run charts or monthly dashboards to drive improvement). Project reports also include output measures which describe the number and type of telemental transactions which occur. **Baseline/Goal:** After implementation we will use real-time data analysis of our Anasazi database system. Specifically, telemedicine will have its own tracking code through which we can run real-time monitoring. **Data Source:** Standards will be set and routinely monitored through Anasazi our electronic health record. **Milestone 3 Estimated Incentive Payment:** $**50,269.50** **Milestone 4** [I-X]:	numbers, should they vary, we maintain a goal that 75% of encounters will be classified as satisfying to the individual. **Data Source:** Use of evidenced based satisfaction tools used in appropriate format. **Milestone ~~4~~ 5 Estimated Incentive Payment: $~~125,618~~ $50,438** **Milestone 6** [I-X]: Provide telemedicine services. **<u>Metric 1</u>** [I-X.1]: Provide documentation of telemedicine encounters. **Baseline/Goal:** Provide 84 telemedicine encounters. **Data Source:** Standards will be set and routinely monitored through Anasazi our electronic health record system. **Milestone 6 Estimated Incentive Payment: $50,438**

		Provide telemedicine services. **<u>Metric 1</u>** [I-X.1]: Provide documentation of telemedicine encounters. **Baseline/Goal:** Provide 72 telemedicine encounters over baseline. **Data Source:** Standards will be set and routinely monitored through Anasazi our electronic health record system **Milestone 4 Estimated Incentive $50,269.50**	
Year 2 Milestone Bundle Amount: $140,050	**Year 3 Estimated Milestone Bundle Amount: $84,879**	**Year 4 Estimated Milestone Bundle Amount: $100,539**	**Year 5 Estimated Milestone Bundle Amount: $100,876**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $ 426,344			

Project 13333905.1.2 – Telemedicine

Category 1 Project Narrative
Central Texas MHMR Center dba Center for Life Resources – 133339505.1.2

Project Area, Option and Title: 1.11.2 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers.

RHP Project Identification Number: 133339505.1.2

Performing Provider Name: Central Texas MHMR Center dba Center for Life Resources
Performing Provider TPI #: 133339505

Project Summary

- **Provider Description:** Central Texas MHMR Center dba Center for Life Resources (CFLR) is a local mental health authority (LMHA) serving: Brown, Coleman, McCulloch, San Saba, Mills, Comanche, and Eastland Counties. CFLR serves a variable number of clients based on Department of State Health Services (DSHS)/Department of Aging and Disabled Services (DADS) contractual agreements. Currently, (FY 13) we are serving approximately 1,250 clients in a 7,074 square mile area with a population of approximately 102,497.

- **Intervention:** Through the implementation of a telemedicine model we will provide clinically appropriate treatment as indicated by a psychiatrist or other qualified provider throughout this expansive area. Thus reducing unnecessary emergency department (ED) and service use and improve consumer satisfaction/access were previously limited or unavailable.

- **Project Status:** This is a new implementation of an ongoing project for this region (RHP 11 Counties of Brown and Eastland). We will determine a baseline in DY2 that will serve as a foundation for future progress and monitoring. We expect to see a progressive increase in those served through DY5.

- **Project Need:** There currently is very limited to no access to psychiatric or other mental health care providers in this region (CN2.6). This fact has led to the federal distinction of mental health professional shortage area. http://www.dshs.state.tx.us/chs/hprc/hpsa.shtm. This limited availability often lends itself to utilization of unnecessary or inappropriate ED use. Further, as highlighted through the mental health professional shortage area map; there are inadequate numbers of providers willing to relocate to rural and frontier regions. We believe innovative solutions, such as telemedicine, must be considered and attempted to address the stated community need (CN 2.6).

- **Target Population:** The to be determined target populations we intend to serve are individuals residing in Brown and Eastland Counties suffering from serious mental illness. These primarily include but are not limited to individuals who either are Medicaid eligible or are indigent. Our estimation based on current calculations and past billing is that no less than 50% of our clients currently meet this distinction. This would imply that at least half of those we serve in this new capacity through telemedicine would be Medicaid eligible or indigent.

- ***Category 1 or 2 Expected Project Benefit for Patients:*** The project seeks to provide 108 telemedicine services in DY4 and 120 in DY5. Through the implementation and subsequent provision of telemedicine services this project seeks to provide a satisfying, individually tailored service that also works to reduce unnecessary emergency department usage. Customer satisfaction will be measured using evidenced based satisfaction tools in DY4 and DY5. These two years will be compared and steps to ensure continued satisfaction will be based on the subsequent data. Frequency of unnecessary emergency department usage will be accounted for through internal tracking in our electronic health records.

- ***Category 3 outcom*es:** IT-9.2 ED appropriate Utilization (Standalone measure). Our goal is to reduce ED visits for the target conditions of behavioral health/substance abuse with baseline to be determined in DY2.

Category 1

Project Area, Option and Title: 1.11.2 Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers.

RHP Project Identification Number: 133339505.1.2

Performing Provider Name: Central Texas MHMR Center dba Center for Life Resources

Performing Provider TPI #: 133339505

Project Description:
Implement Technology-Assisted Behavioral Health Services

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

Due to the difficult nature of obtaining and keeping psychiatric services in rural areas it is necessary to develop and implement other strategies to provide the needed services. Our project will address the issue of Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers which will be combined with the following plan of action.

Central Texas MHMR Center dba Center for Life Resources proposes that we can better address the psychiatric need in these rural community settings through the implementation of a telemedicine system.

Core Components:

D. Develop or adapt administrative and clinical protocols that will serve as a manual of technology-assisted operations. We will accomplished this by utilizing best practices and previously indicated successful project manuals along with specific community needs as defined through community input.

E. Determine if a pilot of the telehealth, telemonitoring, telementoring, or telemedicine operations is needed. Engage in rapid cycle improvement to evaluate the processes and procedures and make any necessary modifications. We will continue to monitor community need and make adjustments as indicated.

F. Identify and train qualified behavioral health providers and peers that will connect to provide telemedicine, telehealth, telementoring or telemonitoring to primary care providers, specialty health providers (e.g., cardiologists, endocrinologists, etc.), peers or behavioral health providers. Connections could be provider to provider, provider to patient, or peer to peer. We will utilize the best practices as seen through research TBD as well as collaboration were possible from other providers to hire, train and maintain the best possible applicants. This will be done with the intent of assuring the project's success.

G. Identify modifiers needed to track encounters performed via telehealth technology. This will be done utilizing Anasazi (EHR), law enforcement, and EMS. Other sources will be considered given the need and usefulness of application.

H. Develop and implement data collection and reporting standards for electronically delivered services. We will again utilize resources of our electronic health record and in such a way that is considered best practices for a rural setting.

I. Review the intervention(s) impact on access to specialty 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. CFLR will work diligently to provide the best possible care giving consideration as indicated to safety-net populations as well as look for ways to use the information we have learned to improve quality of care.

J. Scale up the program, if needed, to serve a larger patient population, consolidating the lessons learned from the pilot into a fully-functional telehealth, telemonitoring, telementoring, or telemedicine program. Continue to engage in rapid cycle improvement to guide continuous quality improvement of the administrative and clinical processes and procedures as well as actual operations. We will continually strive to improve access and engage community support to provide the best care possible. Ultimately, we want to serve as many individuals as we can in the best clinical setting possible. We strive to make Brownwood the central coordinating office for all our 1115 projects thereby linking individuals to services they previously could not enjoy.

K. Assess impact on patient experience outcomes (e.g. preventable inpatient readmissions). We believe our long-term success is directly related to our ability to make a positive impact on those we serve. It is further believed that a reduction in unnecessary emergency department visits would make this impact.

Due to our agency placing high priority on the right care, in the right place, at the right time, our regional project focuses on RHP Milestone I-15: Satisfaction with telemental services. We believe that satisfaction is an integral milestone when focusing on the right care, in the right place, and right setting. As telemedicine systems have been indicated only in very limited capacity currently in this region other outside resources must be examined for efficacy. It is commonly accepted in private sector management that customer satisfaction is an important factor in determining utilization. It is believed that data will begin to

demonstrate this belief after implementation in DY 3. Our intention in the implementing of this project will be to show an increase in the number of those who would not normally be able to receive these services having greater access and greater satisfaction as a result.

Goals and Relationship to Regional Goals

Project Goals:

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

This project meets the following Regional Goals:

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

Challenges:

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

5- Year Expected Outcome for Provider and Patients:

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

Starting Point/Baseline:

Baseline will be determined over the course of DY 2 and implemented in DY3. This will be found through data collection sources such as local hospitals, law enforcement, and other sources as indicated.

Rationale
Community Need Addressed:

Community Need Area: CN.2 - Limited access to mental health/behavioral health services
Specific Community Need: CN.2.6 – Limited access to behavioral health services for rural populations in Comanche and Eastland Counties.

Central Texas MHMR Center dba Center for Life Resources or agent thereof, will identify existing infrastructure for high speed broadband communications technology (such as T-3 lines, T-1 lines) in (Brown and Eastland) Counties as defined as a mental health professional shortage area. This will be accomplished by assessing the local availability of and need for video communications equipment in areas of the state that already have (or will have) access to high speed broadband technology. Further, we will assess the applicable models of deployment of telemedicine, telehealth, and telemonitoring equipment. This process will be done to determine first feasibility and then determine if the project would be capable of offsetting the costs associated with unnecessary emergency department services. Some of the possible cost deferments are listed below although are not limited to these specific examples.

According to txpricepoint.org, the average cost accounted for just one possibly preventable condition such as psychosis at Brownwood Regional Medical Center (BRMC) is $6,030 a day with a median charge of $14,472. Another example of a possibly preventable condition is an acute adjustment & psychosocial dysfunction. BRMC has an average charge per day of $7,699 with a median charge of $16,939. Further research shows the average cost to transport an individual to a local hospital by local EMS services is $655. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, were an officer is on hand, can range from 1 to 3 hours. A law enforcement deputy's average pay can range from $12.50 to $25+ per hour, so in an average situation this would be an additional $30-$75 cost. When multiplied by the average number of preventable situations per year, 24, the total costs for EMS transport and law enforcement time is around $17,000 per year. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services. The given $17,000 is solely an average and our best estimation based on prior experience prior to extensive data being collected.

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

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

right care at the right time in the right place and addressing local needs, telemedicine provides great promise.

Continuous Quality Improvement: CFLR is committed to continuous quality improvement and learning related to this project. We will establish quality improvement activities such as rapid cycle improvement and will perform other activities such as "lessons learned" and identifying project impacts.

We do not currently receive any U.S. Department of Health and Human Services funding that will be directly used for the implementation of telemedicine services. Given the need for the right care at the right time in the right place and addressing local needs, telemedicine provides great promise.

Related Category 3 Outcome Measure(s):

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

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

Relationship to other Projects:

We are proposing to implement/enhance telemedicine services in seven counties covering RHP 8 (Project #133339505.1.1), RHP 11(Project #13339505.1.1 & #13339505.1.2), and RHP13 (Project #133339505.1.1). Each of these projects will work to in tandem with the intended purpose of greatly increasing the likelihood of right care, at the right time, in the right setting. Projects #13339505.1.1 & #13339505.1.2 are both dealing with telemedicine services but deal with different levels of implementation. Project #13339505.1.1 is putting telemedicine in a new area where not previously available. Project #13339505.1.2 affords that some telemedicine services are being provided but the type of provision will be enhanced. Clearly stated, we intend to build a new system in Comanche (13339505.1.1) and provide new services in Brown and Eastland Counties (13339505.1.2) as well as in our other RHPs as possible.

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

Central Counties Services is also proposing a telemedicine project (Project # 081771001.1.2) but it will cover Bell, Lampasas and Milam Counties. Collaboration is greatly encouraged and will be

a part of our overall implementation and success. Further, as part of DY2 or DY3 as appropriate, CFLR will contact other similar providers to discuss the planning necessary for a learning collaborative and implementation.

Project Valuation:

This project seeks to provide 108 telemedicine encounters in DY4 and 120 in DY5. We plan to do this where no known similar services are being provided currently. Our goal is to implement new services which will include diagnostics, counseling, peer support and other services as need is determined. Due to the nature of these locations and their distinction as mental health professional shortage areas, it is often difficult or even prohibitive for individuals to receive appropriate services in the right setting. Our valuation places priority on patient and community benefit through our pursuit of providing the right care at the right time in the right place. We have attempted to demonstrate the current cost of providing these services and the advantages of providing them locally through our proposed telemedicine project. The data will clearly demonstrating the need to attempt telemedicine services in this area.

Given the data provided above from txpricepoint.org and independent local research found in the rationale section, costs were determined to be roughly $17,000.00 per event. The stated per event cost multiplied by the number of individuals we plan to serve is significant and offers tremendous value through telemedicine. For instance, providing the same 108 encounters we intend to provide in DY4 in the current system would cost over 1.8 million dollars (108 *17,000 = 1,836,000). When adding in the additional services in DY5 the costs of provision for just those two years in the current system would be over 3.8 million dollars (120* 17,000 = 2,040,000 + 1,836,000= 3,876,000). Given the total four-year incentive payment of $1,853,205 the cost savings and value of providing right care in the right setting is a fraction of the cost (47%). It is our belief that our commitment to right care, at the right time, in the right setting offers an alternative option that would greatly improve patient and community care through local access at a comparatively lower cost. We do not believe that the value is limited to just cost savings.

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

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

Central Texas MHMR Center dba Center for Life Resources 133339505.1.2 (Project 1.11.2) Category 1 Milestones and Metrics			
133339505.1.2	**1.11.2**	**1.11.2.a – 1.11.2.h**	**Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers**
Central Texas MHMR Center dba Center for Life Resources			**133339505**
Related Category 3 Outcome Measure (s):	**133339505.3.2**	**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]: Identify Texas Counties having availability of high speed broadband communication lines. **Metric 1** [P-1.1]: Documentation of assessment of counties that identifies areas of state that have or lack capacity for high speed broadband connections capable of supporting telemedicine, telehealth, telemonitoring **Baseline/Goal:** Baseline - Results of the assessment rationale/evidence; Goal - Implement telemedicine in	**Milestone 2** [P-7]: Hiring of tele-presenters, as needed, for remote site equipment operation. **Metric 1** [P-7.1]: Number of staff hired and trained. **Baseline/Goal:** Hire appropriate staff for expanded services and site operation. **Data Source:** Interviews with staff, review of hiring or payroll records, appropriate licensure records. **Milestone 2 Estimated Incentive Payment: $455,535**	**Milestone 3** [P-10]: Evaluate and continuously improve telemedicine, telehealth, or telemonitoring service. **Metric 1** [P-10.1]: Project planning and implementation documentation that describes plan, do, study act quality improvement cycles. b. Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (i.e. how the project continuously uses data such as weekly run charts or monthly dashboards to drive	**Milestone 4 5**[I-15[: Satisfaction with telemental services. **Metric 1** [1.15.1]: XX #% of consumer, peer and provider surveys indicates satisfaction with telemental services. a. Numerator÷90 of patients, peers and providers reporting satisfaction b. Denominator: 120 of patients, peers and providers surveyed **Baseline/Goals:** We set as our goal for 90 of the 120 (75%) encounters we plan to provide to be classified as satisfying to the individual by the end of DY5. Depending on the actual

underserved area to improve access and provide right care, right setting service. **Data Source:** Filed record of research. **Milestone 1 Estimated Incentive Payment: $364,428**		improvement). Project reports also include output measures which describe the number and type of telemental transactions which occur. **Baseline/Goal:** After implementation we will use real-time data analysis of our Anasazi database system. Specifically, telemedicine will have its own tracking code through which we can run real-time monitoring. **Data Source:** Standards will be set and routinely monitored through Anasazi **Milestone 3 Estimated Incentive Payment: $~~469,201~~ 234,600.50** **Milestone 4** [I-X]: Provide telemedicine services. **Metric 1** [I-X.1]: Provide documentation of telemedicine encounters.	encounter numbers, should they vary, we maintain a goal that 75% of encounters will be classified as satisfying to the individual. **Data Source:** Use of evidenced based satisfaction tools used in appropriate format. **Milestone 5Estimated Incentive Payment: $282,020.50** **Milestone 6** [I-X]: Provide telemedicine services. **Metric 1** [I-X.1]: Provide documentation of telemedicine encounters. **Baseline/Goal:** Provide 120 telemedicine encounters. **Data Source:** Standards will be set and routinely monitored through Anasazi our electronic health record system. **Milestone 6 Estimated Incentive Payment: $282,020.50**

		Baseline/Goal: Provide 108 telemedicine encounters over baseline. **Data Source:** Standards will be set and routinely monitored through Anasazi our electronic health record system **Milestone 4 Estimated Incentive** **$ 234,600.50**	
Year 2 Milestone Bundle Amount: $364,428	**Year 3 Estimated Milestone Bundle Amount: $455,535**	**Year 4 Estimated Milestone Bundle Amount: $469,201**	**Year 5 Estimated Milestone Bundle Amount: $564,041**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $ 1,853,205			

Pass 3B
Summary Information: NEW *281406301.1.2* Old *281406301.1.1*

- Provider: Comanche County Medical Center is a 25 bed critical access facility with a primary service area of the counties of Comanche, Eastland, Erath, Brown, Mills, and Hamilton Texas.

- Intervention(s): This project will add primary care capacity to Comanche.

- Need for the project: Capacity for primary care visits is limited and non-emergent visits in the ED have continued to rise.

- Medicaid and Uninsured Target population: Comanche County is a poor county economically and the average age is older than the state average. The target population has a high percentage of Medicaid and uninsured/underinsured individuals.

- Category 1 or 2 expected patient benefits: 1.1.2 Expand Existing Primary Care Capacity – C. Expand Primary Care Clinic Staffing. The project is expected to increase the visit capacity in DY 3 by 1,200, in DY 4 to 2,200, and in DY 5 to 3,200.

- Category 3 outcomes: IT-6.1 Patient Satisfaction

Pass 3b
Project Title: Physician Recruitment Program

Category 1: Infrastructure Development – Primary Care Physician Recruitment

Project Option: 1.1 – Expand Primary Care Capacity

Unique Project ID: New: 281406301.1.2; **Old:** 281406301.1.1

Facility Description: Comanche County Medical Center-281406301

Project Description:

CCMC proposes to use funding to identify and recruit either a family practice or internal medicine physician for its rural health clinic and coverage for patients who are admitted or observed to the hospital.

CCMC has a need to add an additional full-time primary care physician to its rural health clinic and to cover patients who are admitted or observed in the hospital. The facility's rural health clinic provides the majority of primary care physicians to the county and in both 2011 and 2012, the clinic served 27,000 visits. The vast majority of served in the clinic were Medicare and Medicaid for that time period with a growing amount of patients who were without insurance. At the same time, patient volumes in the hospital emergency room for non-emergent conditions continue to rise. It is the facility's goal to care for the patients in a clinic setting where it is much more cost effective than seeing the patients in the emergency room. It is expected that by the end of DY 5 for this new physician to service 3,200 visits annually.

The physician will see all patient types regardless of the ability to pay. The new physician will provide such services as routine checkups, preventative care, health education, family planning services, vaccinations, basic maternal and child healthcare services and take care of all manners of acute, chronic physical, mental and social health issues. According to the RHP 11 Community Needs Assessment, Shortages of healthcare professionals is the third highest need (CN.3).

Comanche County Medical Center (CCMC) is a 25 bed critical access rural facility located in Comanche County Texas on State highway 16 about halfway between the towns of Comanche and De Leon, TX. CCMC is equipped with diagnostic capabilities rivaled by much larger facilities. Those capabilities include a full-service laboratory, imaging departments (including a 64 slice CT scanner, Nuclear Camera, and MRI) and a rural health clinic which gives patients access to nine different primary care providers and 24 hour emergency services staffed with a physician 24 hours each day.

Project Options – 1.1.2 Expand Existing Primary Care Capacity - C. Expand Primary Care Clinic Staffing

Starting Point/Baseline:

The facility with actively recruit a physician in DY 2, then once the physician is recruited the plan is for the physician to service 1,200 visits in the physician's first full calendar year (DY 3), 2,200 visits in DY 4 and 3,200 visits DY 5.

Milestones/Metric for Category 1 Project:

P-5 Process Milestone 1 (DY2): Train/Hire Additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.

P-5.1 Metric: Documentation of increased number of providers and staff and/or clinic sites

a. 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.
b. Rationale/Evidence: Additional staff members and providers may be necessary to increase capacity to deliver care. In each of the past two years (2011 and 2012) clinic volumes have been constant while emergency room volumes have increased mainly for non-emergent reasons. The recruitment of an additional primary care physician will allow more patients to be serviced in the rural health clinic setting which is more cost efficient.

I-15. Improvement Milestone (DY 3, 4 & 5): Increase access to primary care capacity

I-15.1 Metric: Increased number of primary care visits

a. Total number of visits for the reporting period (1,200 visits DY3, 2,200 visits DY4, 3,200 visits DY5)
b. Data Source: Registry, EHR, claims, or other Performing Provider source
c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care

Rationale:

The hospital and clinic's primary service area includes all of Comanche County and parts of Eastland, Erath, Brown, Mills and Hamilton Counties. According to the 2011 estimate from the U.S. Census Bureau, Comanche County has a population of 13,891. Eastland County – 18,633, Erath County – 38,186, Brown County – 38,186, Mills County – 4,848, and Hamilton County – 8,472. The hospital serviced over 27,000 patients in 2011 and the hospital's rural health clinic also had over 27,000 patient visits in both 2011 and 2012. An additional physician will expand primary care clinic staffing, have no change on primary care space, and it is not expected to expand primary care clinic hours, while an expansion in hours is not something that has been ruled out if the need dictates it. According to the RHP 11 Community Needs Assessment, Shortages of healthcare professionals is the third highest need (CN.3). Comanche County also is

listed as Medically Underserved Area. "For too long, our nation has suffered from a shortage of primary care health professionals. The Association of American Medical Colleges estimated that the nation would have a shortage of approximately 21,000 primary care physicians in 2015. Without action, experts project a continued primary care shortfall due to the needs of an aging population, and a decline in the number of medical students choosing primary care." (http://www.healthcare.gov/news/factsheets/2010/06/creating-jobs-and-increasing-primary-care-providers.html)

Related Category 3 Outcome Measures:

CCMC has selected to measure the Category 3 outcome measure, ID-6 Patient Satisfaction: A patient survey for the rural health clinic will be developed in DY 2 which will be implemented for all providers (not just the new provider). The questionnaire and the instrument will include at a minimum all the IT 6.1 questions and additional questions that will be used for target other opportunities to improve the care for the patients we serve. Our survey tool will conform with CG-CAHPS standards. "Patients would much rather their voices be heard than exit out of frustration….we should all work together to hear patients' voices clearly and meet their needs better." (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1116581/).

Relationships to Other Projects:

While this hospital is not coordinating with other hospitals on this project, there are several facilities which have similar projects. With the distance between providers in this region, it is not expected that there will be any overlap of efforts with other facilities.

Project Valuation:

According to the needs assessment in RHP 11, the access to primary care physicians is a major issue (CN.3). While Comanche County residents do have access to several different providers, the loss of two key physicians is not something that we can ignore. Many of our patients are older and cannot or will not drive to other areas to seek care elsewhere. Without this project, many patients might have to wait to receive their care or go without care and that is not something that is acceptable to the hospital or the board that governs the hospital. This project is of the utmost priority to the public we serve. CCMC used a funding evaluation worksheet as provided to develop the valuation of the project.

Five Year Expected Outcome (Overall goal):

The overall goal of this program is to maintain or increase the access to primary care to the public we serve. It is our goal for this new physician by the end of DY 5 to service an additional 3,500 visits annually. The category 3 survey project will also allow CCMC to better measure the "need" of the public related to primary care and other healthcare needs of the patients we serve. With the increased pressure to reduce costs and increase quality, funding from this program will help us better meet our mission: *"Comanche County Medical Center is committed*

to community trust. We pledge to provide quality healthcare through caring, efficient, responsive, and courteous service every day — while addressing the ever-changing healthcare needs of the people we serve."

Quality Improvement:
CCMC and our Rural Health Clinic team does have a Quality Improvement team for the clinic and this project will be covered in that plan. This will include meetings with a team of individuals who will meet face-to-face at least semi-annually to evaluate the effectiveness of the program, discuss the results of findings and trends, and look for opportunities to expand the reach, the scope and increase the effectiveness of the program overall. An agenda with minutes and materials presented at the meeting will be maintained for reference. While this was not included as a process improvement measure to be evaluated and met for the project, we believe this type of process is inherent to a project like this.

Staffing:
As mentioned this project will hire one additional primary care physician and most likely another nurse to service that physician when he is in practice. Through the QI process and statistics above, we will evaluate the need for additional staffing as needed based on patient demand.

New: 281406301.1.2; **Old:** 281406301.1.1	1.1.2		***PHYSICIAN RECRUITMENT PROGRAM***	
Comanche County Medical Center				*281406301*
Related Category 3 Outcome Measure(s):	New:281406301.3.3 Old:281406301.3.2	IT-6.1	Patient Satisfaction	
Year 2 (10/1/2012 – 9/30/2013)		**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 Metric 1 P-5.1 Metric: Documentation of increased number of providers and staff Baseline/Goal: N/A 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 1 Estimated Incentive Payment (*maximum amount)*: $171,601		**Milestone 2** I-15 Improvement Milestone: Increase access to primary care capacity Metric 1 I-15.1 Metric: Increase number of primary care visits to 1,200 Data Source: Registry, EHR, claims, or other performing provider source Milestone 3 Estimated Incentive Payment: $186,700	**Milestone 3** I -15 Improvement Milestone: Increase access to primary care capacity Metric 1 I-15.1 Metric: Increase number of primary care visits to 2,200 Data Source: Registry, EHR, claims, or other performing provider source Milestone 4 Estimated Incentive Payment: $187,898	**Milestone 4** I -15 Improvement Milestone: Increase access to primary care capacity Metric 1 I-15.1 Metric: Increase number of primary care visits to 3,200 Data Source: Registry, EHR, claims, or other performing provider source Milestone 6 Estimated Incentive Payment: $154,296

New: 281406301.1.2; **Old:** 281406301.1.1	1.1.2		***PHYSICIAN RECRUITMENT PROGRAM***	
Comanche County Medical Center				*281406301*
Related Category 3 Outcome Measure(s):	New:281406301.3.3 Old:281406301.3.2	IT-6.1	Patient Satisfaction	
Year 2 (10/1/2012 – 9/30/2013)	**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): $171,601	Year 3 Estimated Milestone Bundle Amount: $186,760		Year 4 Estimated Milestone Bundle Amount: $187,898	Year 5 Estimated Milestone Bundle Amount: $154,296
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $700,555				

Pass 3B
Summary Information: Project New ID: 137074409.1.4
Old ID: 137074409.1.1
Outpatient Dialysis

- Provider: Eastland Memorial Hospital is a 52-bed hospital in Eastland, Texas serving primarily Eastland County which is a 932 square mile area and a population of approximately 18,500.

- Intervention(s): This project will expand specialty care services by providing outpatient dialysis services to the residents of Eastland County and the surrounding area.

- Need for the project: The closest outpatient dialysis center is located in Abilene, Texas which is 60 miles (one-way) from Eastland. Transportation to receive services may preclude patients from receiving all of the needed treatments. Since missing even one dialysis treatment may cause complications that may lead to preventable admissions to the hospital, it is imperative to improve access to these services.

- Medicaid and Uninsured Target population: The target population is patients needing outpatient dialysis treatments. Once a patient is diagnosed with End-Stage Renal Disease (ESRD), treatments for the first 27 months are paid by the coverage that patients already have in place. Many of these patients are no longer able to work and do not have access to commercial insurance. After 27 months, the patient is automatically transferred to Medicare coverage.

- Category 1 or 2 expected patient benefits: The project plans to serve 24 patients and provide 3,384 patient visits by the end of DY5.

- Category 3 outcomes: IT-2.2 Our goal is to reduce End-Stage Renal Disease Admissions. The amount of reduction will be determined after the baseline for these admissions is determined in DY3.

Project Title: Outpatient Dialysis Center

Category 1: Infrastructure Development – Improve Access to Specialty Care

Project Option: 1.9.2 – Improve Access to Specialty Care

Unique Project ID: New ID: 137074409.1.4
Old ID: 137074409.1.1

Facility Description: Eastland Memorial-137074409

- **Project Description:** The Community Needs Assessment for Eastland County shows a population with low income and a high incidence of diabetes. Unfortunately, one of the complications of diabetes is kidney failure. Patients with kidney failure often require dialysis services. Currently, all dialysis patients in Eastland must travel at least 60 miles one way for services. Outpatient dialysis is not offered in Eastland or the surrounding counties. Dialysis treatments last three to four hours and often require a caregiver to accompany the patient as the patient is often too weak to drive after treatment. Inclement weather may preclude the patient from receiving treatment. Missing even one treatment causes serious complications for the patient that may require an inpatient stay in an acute hospital. The goal of this project is to improve access to specialty care by providing outpatient dialysis services to the area. The plan would be to ramp up to 3,384 patient visits per year in the local facility by DY5.

  The expected result for the project is to expand specialty care access and improve compliance for dialysis patients. It is also expected that the patient experience will be improved by reducing commuting time for treatments and the improvement of outcomes (fewer hospital admissions) for dialysis patients who become compliant due to the improved access to care.

  This project addresses the RHP 11 regional goals to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place and right time. By improving access to specialty care, patients will receive treatment more timely and should reduce ED visits for complications from delaying needed treatments.

- **Starting Point/Baseline:** There are 36 patients in Eastland and the surrounding area that currently receive outpatient dialysis services primarily in Abilene, TX (over 60 miles one way). There are no closer outpatient dialysis centers available to patients in Eastland.

- **Rationale:**

  - **Project options and Core Components:** Eastland Memorial Hospital (EMH) selected 1.9.2 Improve access to specialty care. The RHP Planning Protocol included four options under this selection - a) Increase service availability with extended hours, b) Increase number of specialty clinic locations, c) Implement transparent, standardized referrals across the system, and 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. For the Outpatient Dialysis Center project, EMH felt that increasing the number of specialty clinic locations was the option that represented the best fit for the project for metrics. These options are considered core components for the project. **Core Component 1.9.2a – Increase service availability with extended hours** does not apply to this project because the services are not currently available in the area. The project will increase service availability by adding services and creating hours of service not available to the area. **Core Component 1.9.2c – implement transparent, standardized referrals across the system** does not apply because patients receiving these services have specific needs that can only be addressed by specialized care. Since this will be the only facility in the County providing these services all referrals for dialysis treatments will be made to the facility located in Eastland. **Core Component 1.9.2d – Conduct quality improvement for project using methods such as rapid cycle improvement -** As a part of the Outpatient Dialysis Center project, Eastland Memorial Hospital plans to discuss quality improvement such as 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 at least twice each year.

- **What is the target patient population for dialysis treatments?** According to Wikipedia, "Dialysis may be used for those with an acute disturbance in kidney function (acute kidney injury, previously acute renal failure), or progressive but chronically worsening kidney function–a state known as chronic kidney disease stage 5 (previously chronic renal failure or end-stage renal disease). The latter form may develop over months or years, but in contrast to acute kidney

injury is not usually reversible, and dialysis is regarded as a "holding measure" until a renal transplant can be performed, or sometimes as the only supportive measure in those for whom a transplant would be inappropriate." According to MedlinePlus http://www.nlm.nih.gov/medlineplus/ency/article/000500.htm, "The most common causes of ESRD (end-stage renal disease) in the U.S. are diabetes and high blood pressure."

- **What Community Needs will the Dialysis Center address?** This project will address CN.2 – High costs associated with preventable hospitalization admissions and readmissions and CN.5 – Need to overcome patient access to care barriers.

- **Eastland County has a higher than average adult obesity rate which puts patients at a higher risk for Diabetes.** According to County Health Rankings, University of Wisconsin, Robert Wood Johnson Foundation, in 2008, Eastland County had a 27% adult obesity rate and the rate for both Texas and the nation was 25%. Obesity is a risk factor for adult-onset diabetes, coronary heart disease, and several other serious medical conditions that can lead to poor health and premature death. In Eastland County, the occurrence of diabetes among adults 20 years and older was estimated at 8.8%. Although this is lower than the state average of 9.8%, Eastland County showed that only 69% had diabetic screening as opposed to 80% in the state of Texas. Based on a lower screening rate, the incidence of diabetes is expected to be higher than reported. From 2005 through 2009, the number of hospitalizations for Diabetes Long-term Complications for Adult Residents of Eastland County was 55 with total charges of $3,290,325. These hospitalizations were considered **potentially preventable**.

- **Missing dialysis treatments may lead to more hospitalizations and higher mortality**. As stated in a report found on http://www.kidney-international.org *Missed dialysis sessions and hospitalization in hemodialysis patients after Hurricane Katrina,* "Missing hemodialysis sessions has been associated with adverse biochemical and metabolic changes. In an earlier study including 430 patients, missing even a single hemodialysis session was associated with a 2% reduction in hemotocrit. Weight gain and increased serum phosphate levels have also been significantly correlated with skipped hemodialysis treatments. Also missing treatment has been reported to result in increased blood pressure. Beyond the immediate biochemical consequences, a growing body of literature suggests that missed hemodialysis sessions are associated with adverse outcomes. Hemodialysis patients in the Dialysis Outcomes and Practice Patterns Study who reported skipping at least one treatment per month had a 13% increased hospitalization risk, and several studies have observed missed hemodialysis sessions and other measures of non-compliance to be associated with 14-30% increases in mortality risk."

- **The cost for travelling to Abilene is a concern for dialysis patients residing in Eastland.** Using the standard medical mileage rate as set by the IRS of 23 cents per mile, the round-trip cost to the patient for each treatment is approximately $28. Since most dialysis patients receive three treatments per week, the annual cost for transportation is $4,306. Also, treatments typically last three to four hours, and with the added two hours of commuting, the patient and a caregiver will need to eat one meal. If they spend $10 per day on meals, this calculates to an additional annual cost of $1,560. Total estimated annual cost of travelling to Abilene would be $5,866 per dialysis patient. Total estimated cost for 36 patients is $211,176.

- **Caregivers assisting with transportation have added costs.** For a caregiver to provide the transportation to and from Abilene, he or she may miss time from work or lose a job altogether. Some of the caregivers are retired or chose not to work, but others are forced to lose income that might be available to them if the care was provided closer to the home. Taking an average wage of $10 per hour and multiplying it by six hours three times per week, the estimated loss of annual income would average $9,360 per patient. If all 36 patients have caregivers losing income, the annual amount would average $336,960.

- **Inclement weather can hinder patient compliance.** In February 2011, the area was hit with a major ice storm that made the drive to Abilene difficult for a week. Dialysis patients who did not have access to a four-wheel drive vehicle or were not capable of driving on the ice were forced to rely on the generosity of the community to provide transportation. The Eastland community did help as many dialysis patients as possible, but there were most likely patients who missed treatments during this time due to the inclement weather. If there had been a dialysis center in Eastland, travel to receive treatments would have been less precarious.

- **Eastland Memorial Hospital was approached by the community to build an outpatient dialysis center.** The community approached the hospital and requested that the hospital consider building an outpatient dialysis center. The citizens explained that the added cost and inconvenience of travelling to Abilene for treatments discouraged patients from being compliant. Since the hospital announced the project, administration has received weekly calls from patients in the county and surrounding counties that are extremely interested in transferring to the center in Eastland once complete.

- **What is the plan for the Dialysis Center?** The tentative timeline for the center is presented below:

DSRIP Year	Description	Patients Served	Patient Visits
DY2	Building Complete		
DY2	Begin Services	6	288
DY3	Ramp-up Services	12	1,524
DY4	Ramp-up Services	20	2,544
DY5	Ramp-up Services	24	3,384

- Eastland Memorial Hospital will provide the building. A contract provider with specialization in outpatient dialysis services will operate the facility.

- **Required Quality Improvement –** As a part of the Outpatient Dialysis Center project, Eastland Memorial Hospital plans to discuss quality improvement such as 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 at least twice each year.

- **Related Category 3 Outcome Measure(s):** Eastland Memorial Hospital has selected OD-2 Potentially Preventable Admissions as the Domain for Category 3. The outcome measure selected is IT-2.2 End-Stage Renal Disease (ESRD) Admissions Rate which is a standalone measure. The hospital believes that by increasing patient compliance for treatments that **potentially preventable inpatient admissions will decrease**. Since Eastland Memorial Hospital currently does not offer inpatient dialysis, the hospital currently transfers these patients to larger hospitals in the region; therefore, the hospital will count transfers to other hospitals from the ER as inpatient admissions. Decreasing Potentially Preventable Admissions is a priority for RHP 11. These patients require a higher level of care than is available at most rural hospitals. The burden of care falls on the larger hospitals in the area that provide inpatient dialysis services. The care provided tends to be high-cost. Almost all of these patients are on Medicare and/or Medicaid which increases cost for these payers. Providing outpatient dialysis services at a local facility should increase compliance. Increased compliance should decrease inpatient admissions. Decreasing the potentially preventable admissions for these patients would include low-income families who now struggle to get transportation to receive services.

- **Relationship to other Projects:** The Outpatient Dialysis Center Project 137074409.1.1 and the Expand Surgical Services Project 137074409.1.2 proposed by Eastland Memorial Hospital both are designed to improve access to specialty care in the Eastland area. Both projects will help citizens who have limited access to transportation. Other RHP 11 projects address the need to improve access to specialty care in other areas of RHP 11.

- **Relationship to Other Performing Providers' Projects in the RHP:** The RHP 11 goals are to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place and right time. RHP 11 has a number of collaborations which invests resources into our rural communities where sole providers face burnout and fatigue. The selected DSRIP projects will begin to build the infrastructure needed in our primary care system to be the backbone for improved care coordination, chronic disease management and care transitions, projects of the future. In increasing the capacity of primary care, the cost of care will be impacted. The ED is the highest cost setting for care. When patients over utilize or unnecessarily utilize the ED for primary and preventive care, the cost burden is wasteful. RHP 11, again, has identified projects that seek to bend the cost curve, which is foundational to the transformation of the healthcare system for patients and for providers. The Outpatient Dialysis Center will not only decrease inpatient admissions through compliance but will also reduce ED visits by providing the needed treatments to keep the dialysis patient as healthy as possible.

  Although several providers in RHP 11 have chosen **1.9 Expand Specialty Care Capacity** for projects, no other provider has selected **1.9.2 Improve access to specialty care** in Pass 1.

- **Plan for Learning Collaborative:** RHP 11 plans to develop learning collaboratives for similar projects.

- **Project Valuation:** This project is highly desirable by the Eastland community. This is supported by individual citizens approaching the hospital asking for the project and continuous calls from patients in the area asking to be placed on waiting lists. The project will add jobs to the area and help area citizens go back to work. With a high incidence of Diabetes, the need for dialysis services is expected to rise. The only option for the Dialysis Patients is to travel to areas where the services are provided. Transportation is a high cost for these patients who are sometimes considered low-income. If the patient does not receive the treatments or obtain a transplant, the outcome is death which increases mortality rates. Eastland Memorial Hospital is in the Eastland Memorial Hospital District, but tax revenues are very limited. There are some community funds available to assist with the project, but with lower Medicare and Medicaid rates for the hospital, the community funds are needed to keep the hospital financially viable.

The project plans to serve 24 patients and provide 3,384 patient visits by the end of DY5.

Using the rationale listed above, Eastland Memorial Hospital allocated the available funds between the two proposed projects for Pass 1. The following weights were used:

Category	Project	Achieves Waiver Goals	Addresses Community Needs	Project Scope/Size	Project Investment	Value Weight of Project
1	Outpatient Dialysis	5	5	5	4	19
1	Expand Surgical Svcs	3	4	3	3	13

NewID:137074409.1.4 Old ID: 137074409.1.1	***1.9.2 - IMPROVE ACCESS TO SPECIALTY CARE***	***1.9.2*** a) Increase service availability with extended hours – Not App b)Increase number of specialty clinic locations c) Implement transparent, standardized referrals across the system – Not App	***OUTPATIENT DIALYSIS CENTER***
Eastland Memorial Hospital			137074409
Related Category 3 Outcome Measure(s):	NewID:137074409.3.4 Old ID:137074409.3.1	*IT-2.2*	*End-Stage Renal Disease (ESRD)Admission Rate (Standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1[P-11]: Launch/expand a specialty care clinic <u>Metric 1</u> [P-11.1]: Establish/expand specialty care clinics Baseline/Goal: No services available / Serve first patient Data Source: Contracted Provider Information Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 210,410	**Milestone 3** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services <u>Metric 1</u> [I-23.1] Documentation of increased number of visits. Demonstrate improvement over DY2. Goal: 1,524 visits Data Source: Contract Provider Information Milestone 3 Estimated Incentive	**Milestone 4** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services <u>Metric 1</u> [I-23.1]] Documentation of increased number of visits. Demonstrate improvement over DY3.	**Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services <u>Metric 1</u> [I-23.1]] Documentation of increased number of visits. Demonstrate improvement over DY4. Goal: 3,384 visits (24 patients) Data Source: Contract

NewID:137074409.1.4 Old ID: 137074409.1.1	***1.9.2 - IMPROVE ACCESS TO SPECIALTY CARE***	***1.9.2*** a) Increase service availability with extended hours – Not App b)Increase number of specialty clinic locations c) Implement transparent, standardized referrals across the system – Not App	***OUTPATIENT DIALYSIS CENTER***	
Eastland Memorial Hospital				137074409
Related Category 3 Outcome Measure(s):	NewID:137074409.3.4 Old ID:137074409.3.1	*IT-2.2*	*End-Stage Renal Disease (ESRD)Admission Rate (Standalone measure)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services <u>Metric 1</u> [I-23.1] Documentation of increased number of visits. Demonstrate improvement over baseline. Baseline / Goal : No services available / 288 visits Data Source: Contract Provider Information Milestone 2 Estimated Incentive		Payment: $ 445,591	Goal: 2,544 visits Data Source: Contract Provider Information Milestone 3 Estimated Incentive Payment: $ 446,455	Provider Information Milestone 3 Estimated Incentive Payment: $ 394,626

NewID:137074409.1.4 Old ID: 137074409.1.1	***1.9.2 - IMPROVE ACCESS TO SPECIALTY CARE***	***1.9.2*** a) Increase service availability with extended hours – Not App b)Increase number of specialty clinic locations c) Implement transparent, standardized referrals across the system – Not App	***OUTPATIENT DIALYSIS CENTER***	
Eastland Memorial Hospital				137074409
Related Category 3 Outcome Measure(s):	NewID:137074409.3.4 Old ID:137074409.3.1	*IT-2.2*	*End-Stage Renal Disease (ESRD)Admission Rate (Standalone measure)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment *(maximum amount):* $ 210,410				
Year 2 Estimated Milestone Bundle Amount: *(add incentive*		Year 3 Estimated Milestone Bundle Amount: $ 445,591	Year 4 Estimated Milestone Bundle	Year 5 Estimated Milestone Bundle Amount: $ 394,626

NewID:137074409.1.4 Old ID: 137074409.1.1	***1.9.2 - IMPROVE ACCESS TO SPECIALTY CARE***	***1.9.2*** a) Increase service availability with extended hours – Not App b)Increase number of specialty clinic locations c) Implement transparent, standardized referrals across the system – Not App	***OUTPATIENT DIALYSIS CENTER***	
Eastland Memorial Hospital				137074409
Related Category 3 Outcome Measure(s):	NewID:137074409.3.4 Old ID:137074409.3.1	*IT-2.2*	*End-Stage Renal Disease (ESRD)Admission Rate (Standalone measure)*	
Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
payments amounts from each milestone): $ 420,820			Amount: $ 446,455	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,707,492				

Pass 3B
Summary Information: Project New ID: 137074409.1.5
Old ID: 137074409.1.2
Expand Surgical Services

- Provider: Eastland Memorial Hospital is a 52-bed hospital in Eastland, Texas serving primarily Eastland County which is a 932 square mile area and a population of approximately 18,500.

- Intervention(s): This project will expand specialty care services by providing specialty surgery services to the residents of Eastland County and the surrounding area.

- Need for the project: Currently, there are limited surgical services available at Eastland Memorial Hospital. Patients that require specialty surgical services are required to travel to other area hospitals (often 60 miles one-way). Surgeries may be delayed due to lack of available appointments. Transportation to receive services may preclude patients from receiving all of the needed surgeries. Postponing needed services may cause complications and preventable admissions and ER visits.

- Medicaid and Uninsured Target population: The target population is patients needing specialty surgical services. Eastland County has a high percentage of the population living in poverty. 21.0% of the persons in Eastland County were below the poverty level from 2006-2010 compared to 16.8% for the State of Texas. One of the targeted specialties is Otolaryngology (ENT). This specialty will benefit pediatric patients.

- Category 1 or 2 expected patient benefits: The project plans to provide 100 additional surgical procedures by DY5.

- Category 3 outcomes: IT-9.2 Right Care, Right Setting Our goal is to reduce pediatric ER visits. The amount of the reduction will be determined after the baseline is set in DY3.

Project Title: Expand Surgical Services

Category 1: Infrastructure Development – Improve Access to Specialty Care

Project Option: 1.9.2 – Improve access to specialty care – Expand Surgical Services

Unique Project ID: New ID: 137074409.1.5
Old ID: 137074409.1.2

Facility Description: Eastland Memorial Hospital-137074409

Project Description: Currently, there are limited surgical services available at Eastland Memorial Hospital. Patients that require specialty surgical services are required to travel to other area hospitals as far as 60 miles one way. Surgeries may be delayed due to lack of available appointments. This project will add more specialty surgical services and allow patients better access to services. The facility needs to be updated in order to accommodate more services and to bring the surgical areas up to current state standards. Rotating specialty surgeons will need to be recruited to perform the surgeries.

The expected result for the project is to expand specialty care access by adding additional surgical services provided at Eastland Memorial Hospital. In five years, Eastland Memorial Hospital wants to increase surgeries by 100 or 23% over the current volumes. The added access will reduce the delay of needed surgeries; thereby reducing ER visits for complications caused by not receiving timely care and increase patient satisfaction.

This project addresses the RHP 11 regional goals to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place and right time. By improving access to specialty care, patients will receive treatment more timely and should reduce ED visits for complications from delaying needed treatments.

Starting Point/Baseline: As of December 12, 2011, annual surgical patients receiving services in the Eastland Memorial Hospital Operating Room include 93 Ophthalmology, 7 Podiatric and 326 General Surgery patients (total 426). After the expansion of services, total surgical patients will be between 450 and 526 annually.

Rationale:

Required Core Components:

1.9.2 a) Increase service availability with extended hours – This project will increase service availability by extending hours in the operating room at Eastland Memorial Hospital.
1.9.2 b) Increase number of specialty clinic locations – This core component does not apply

to this project. Eastland Memorial Hospital will increase hours of service in the current location by updating the physical location, purchasing specialty equipment, and recruiting specialty surgeons to perform services in the hospital. The current location will be improved to accommodate the additional capacity, but no locations will be added. **1.9.2 c) Implement transparent, standardized referrals across the system –** This project will bring new services to the area which will make referrals to local services possible. **1.9.2 d) Conduct quality improvement for project using methods such as rapid cycle improvement -** As a part of the Expand Surgical Services project, Eastland Memorial Hospital plans to discuss quality improvement such as 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 at least twice each year.

What specialty surgery procedures are needed in the area? Based on outmigration market information, the following annual surgical procedures could be performed at Eastland Memorial Hospital after renovation of the Operating Rooms and recruitment of the needed specialists:

Surgery Specialty	Procedures
Urology	46
Otolaryngology (ENT)	92
Ophthalmology	214
Orthopedic	71
Total Procedures	423

Eastland County has a high percentage of the population living in poverty. According to QuickFacts provided by the United States Census Bureau located at http://quickfacts.census.gov/qfd/states/48/48133.html, 21.0% of the persons in Eastland County were below the poverty level from 2006-2010 while 16.8% were below the poverty level in the State of Texas. The median household income for 2006-2010 averaged $32,452 in Eastland County and $49,646 in the State. According to County Health Rankings, University of Wisconsin, Robert Wood Johnson Foundation and Kids Count Database, 9.0% of Eastland County children were enrolled in CHIP, 40.4% were enrolled in Medicaid, and 17.3% were uninsured which compares to the State percentages of 7.1%, 34.2% and 23.3% respectively.

What Community Needs will this project address? CN.2 – High costs associated with preventable hospitalization admissions and readmissions and CN.5 – Need to overcome patient access to care barriers.

The cost for travelling to other hospitals is a concern for low income patients and elderly patients. For patients receiving Otolaryngology (ENT) procedures from April 1, 2010 through March 31, 2011 that could be performed at Eastland once the project is complete, 84.8% of the Eastland County patients had services at Texas Midwest Surgery Center which is located 58 miles from the city of Eastland. Using the standard medical mileage rate set by the IRS of 23 cents per mile, the round-trip cost is $27. Although this cost may seem nominal for many patients, low-income patients (such as children on Medicaid or elders on fixed incomes) may not have the funds to travel for the surgical procedure. For some of these higher-risk patients, travelling 58 miles may be a risk in and of itself. For example, elderly patients have more difficulty driving to areas with more traffic.

Chronic conditions may cause complications that require surgical intervention. Delay of needed treatments may cause complications and additional ER visits. A patient may chose to delay the surgical procedure due to a lack of transportation or the lack of funds to travel to another location to receive treatment. For example, a patient with chronic tonsillitis may not respond to other treatments may need surgery quickly. The delay may result in increased ED Visits both emergent and non-emergent.

From http://www.surgeryencyclopedia.com/Ce-Fi/Ear-Nose-and-Throat-Surgery.html "Common surgical procedures of the throat include removal of tonsils (tonsillectomy) or adenoids (adenoidectomy). The tonsils (either side and in back of the throat) and adenoids (higher up the throat behind the nose) are masses of lymph tissue that play an active role in body defenses to fight infection. The tonsils and adenoids can get chronically infected, in which case surgical removal is usually indicated to relieve breathing problems and infection recurrence. Furthermore, chronic inflammation of the adenoids can cause repeated middle ear infections that can ultimately impair hearing." From the same article, "Surgery of the ear also includes myringotomy (insertion of ear tubes to drain fluid in persons with chronic ear infections)."

From http://www.articlecube.com/Article/Why-You-Should-Never-Delay-Cataract-Surgery/1438998 "In the vast majority of cases, there is nothing you could have done to prevent the onset of cataracts; they are simply a side effect, if you will, of growing old. As the lens of your eye ages, it is very common for it to begin to cloud or yellow. The result of this clouding, or what it is known as the formation of a cataract, is that your visual acuity is compromised. You begin to lose the sharp definition in your field of vision. Additionally, the colors you see begin to fade, shrinking your perceptible palette to muted shades, tones and hues."

"Factors such as smoking, steroid use, high blood pressure, and most significantly, diabetes and its associated unstable blood pressure can have an accelerating effect on the growth of

cataracts. Postponing cataract surgery will not give you any advantage; the only cure for the condition is removal of the cloudy lens and replacement with a brilliantly clear intraocular lens."

"If, on the other hand, you choose to postpone your eye surgery, you risk suffering a more difficult surgery in the future, more complications as your condition worsens, and possibly a longer recovery time…Another consequence of a decision to delay cataract surgery is the possibility of sustaining injuries simply because your vision is obscured. The effect that cataracts have on your eyesight is especially noticeable during night driving and in bright sunlight. It's better for you not to expose yourself to the risk of an automobile accident or a preventable fall just because your vision is impaired. As your cataracts grow, the impairment to your vision can cause these and other accidents."

The goal for this project would be to provide services locally to ease the burden for low-income and/or elderly patients. It is difficult to determine the number of surgeries that are delayed due to the lack of access to specialty services. This needed service should **reduce potentially preventable admissions**, **reduce ED visits** for complications related to delayed treatment, and **increase patient satisfaction.**

What is the plan for the Expansion of Surgical Services? The tentative timeline for the project is presented below:

DSRIP Year	Description	Additional Surgical Visits
DY2	Planning	
DY3	Complete planning and installation of needed specialty equipment	
DY3	Recruit 1 additional specialty surgeon	
DY4	Recruit 1 additional specialty surgeon	
DY5	Provide additional services to patients	100

Required Quality Improvement – As a part of the Expand Surgical Services project, Eastland Memorial Hospital plans to discuss quality improvement such as 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 at least twice each year.

Related Category 3 Outcome Measure(s): Eastland Memorial Hospital has selected OD-9 Right Care, Right Setting as the domain for Category 3. Using IT-9.2 ED appropriate utilization (Standalone measure), Eastland plans to reduce pediatric Emergency Department visits (CHIPRA Core Measure). Currently, Eastland Memorial Hospital has 2,318 ED visits for patients aged 19 and under. A new baseline will be set in DY3 using DY2 information. For years DY4 and DY5, Eastland Memorial Hospital plans to reduce pediatric ED visits by a percentage to be determined. The other options for IT-9.2 are
Reduce all ED visits (including ACSC)
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

Eastland Memorial Hospital selected the reduction of pediatric ED visits because the addition of Otolaryngology (ENT) services would primary affect pediatric patients and would be more related to the project being considered.

Relationship to other Projects: The Outpatient Dialysis Center Project 137074409.1.1 and the Expand Surgical Services Project 137074409.1.2 proposed by Eastland Memorial Hospital both are designed to improve access to specialty care in the Eastland area. Both projects will help citizens who have limited access to transportation. Other RHP 11 projects address the need to improve access to specialty care in other areas of RHP 11.

Relationship to Other Performing Providers' Projects in the RHP: The RHP 11 goals are to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place and right time. RHP 11 has a number of collaborations which invests resources into our rural communities where sole providers face burnout and fatigue. The selected DSRIP projects will begin to build the infrastructure needed in our primary care system to be the backbone for improved care coordination, chronic disease management and care transitions, projects of the future. In increasing the capacity of primary care, the cost of care will be impacted. The ED is the highest cost setting for care. When patients over utilize or unnecessarily utilize the ED for primary and preventive care, the cost burden is wasteful. RHP 11, again, has identified projects that seek to bend the cost curve, which is foundational to the transformation of the healthcare system for patients and for providers. The Expand Surgical Services project will reduce ED visits by providing the needed treatments to keep patients as healthy as possible.

Although several providers in RHP 11 have chosen 1.9 Expand Specialty Care Capacity for projects, no other provider has selected 1.9.2 Improve access to specialty care in Pass 1.

Plan for Learning Collaborative: RHP 11 plans to develop learning collaboratives for similar projects.

Project Valuation: This project is needed by the Eastland County Community and surrounding counties. The project will assist RHP 11 meet **CN.5 Need to overcome patient access to care barriers** and **CN.2 High Costs associated with preventable hospitalization admissions and readmissions**. By adding these services, the patients will have a better patient experience and possibly a better quality of life. Since one of the specialties that Eastland Memorial Hospital is planning to recruit is Otolaryngology (ENT), pediatric patients in the area who need tubes and/or tonsillectomies will have improved access to care and may receive treatment sooner than if forced to go to another hospital in the area. With earlier treatment, non-emergent ED visits for ear and throat infections for these pediatric patients will be reduced. This supports the RHP 11 goal of right care, right place and right time.

The project plans to provide 100 additional surgical procedures by DY5.

Using the rationale listed above, Eastland Memorial Hospital allocated the available funds between the two proposed projects for Pass 1. The following weights were used:

Category	Project	Achieves Waiver Goals	Addresses Community Needs	Project Scope/Size	Project Investment	Value Weight of Project
1	Outpatient Dialysis	5	5	5	4	19
1	Expand Surgical Svcs	3	4	3	3	13

NewID:137074409.1.5 OldID:137074409.1.2	***1.9.2- IMPROVE ACCESS TO SPECIALTY CARE***	***1.9.2*** a) Increase service availability with extended hours b)Increase number of locations c) Implement transparent, standardized referrals	***EXPAND SURGICAL SERVICES***
Eastland Memorial Hospital			137074409
Related Category 3 Outcome Measure(s):	*NewID:137074409.3.5* *OldID:137074409.3.2*	*IT-9.2*	*Reduce pediatric 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-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 Data Source: Documentation of Provider plan Milestone 1 Estimated Incentive	**Milestone 2** [P-13]: Complete planning and installation of new specialty systems for surgical services Metric 1 [P-13.1] Documentation of planning and installation of new systems a. Data Source: Documentation of specialty system implementation plan. b. Rationale/Evidence: Additional equipment is needed to provided additional	**Milestone 4** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-23.1] Increase specialty care volume of visits and evidence of improved access for patients seeking services Goal: 50 procedures more than baseline Data Source: Surgery Case Log	**Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-23.1] Increase specialty care volume of visits and evidence of improved access for patients seeking services Goal: 100 procedures more than baseline Data Source: Surgery Case Log

NewID:137074409.1.5 OldID:137074409.1.2	***1.9.2- IMPROVE ACCESS TO SPECIALTY CARE***	***1.9.2*** a) Increase service availability with extended hours b)Increase number of locations c) Implement transparent, standardized referrals	***EXPAND SURGICAL SERVICES***	
Eastland Memorial Hospital				137074409
Related Category 3 Outcome Measure(s):	*NewID:137074409.3.5* *OldID:137074409.3.2*	*IT-9.2*	*Reduce pediatric 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)**
Payment *(maximum amount):* $ 284,775	surgical services Milestone 2 Estimated Incentive Payment: $ 162,087 **Milestone 3** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties <u>Metric 1</u> [I-22.1] Increase number of specialist providers, clinic hours and/or procedure		Milestone 4 Estimated Incentive Payment: $ 325,547	Milestone 5 Estimated Incentive Payment: $ 243,118

NewID:137074409.1.5 OldID:137074409.1.2	***1.9.2- IMPROVE ACCESS TO SPECIALTY CARE***	***1.9.2*** a) Increase service availability with extended hours b)Increase number of locations c) Implement transparent, standardized referrals	***EXPAND SURGICAL SERVICES***	
Eastland Memorial Hospital				137074409
Related Category 3 Outcome Measure(s):	*NewID:137074409.3.5* *OldID:137074409.3.2*	*IT-9.2*	*Reduce pediatric 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)**
	hours in targeted specialties Numerator: Number of specialist providers in targeted specialties over baseline or change in the number of specialist providers in targeted specialties Denominator: Number of specialist providers in targeted specialties at baseline Milestone 3 Estimated Incentive Payment: $ 162,087			

NewID:137074409.1.5 OldID:137074409.1.2	***1.9.2- IMPROVE ACCESS TO SPECIALTY CARE***	***1.9.2*** a) Increase service availability with extended hours b)Increase number of locations c) Implement transparent, standardized referrals	***EXPAND SURGICAL SERVICES***
Eastland Memorial Hospital			137074409
Related Category 3 Outcome Measure(s):	*NewID:137074409.3.5* *OldID:137074409.3.2*	*IT-9.2*	*Reduce pediatric 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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 284,775	Year 3 Estimated Milestone Bundle Amount: $ 324,174	Year 4 Estimated Milestone Bundle Amount: $ 325,547	Year 5 Estimated Milestone Bundle Amount: $ 243,118
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 1,177,614			

Summary Information: Project 137074409.1.3 Physician Recruitment

- Provider: Eastland Memorial Hospital is a 52-bed hospital in Eastland, Texas serving primarily Eastland County which is a 932 square mile area and a population of approximately 18,500.

- Intervention(s): This project will expand primary care capacity by increasing the number of Primary Care Providers available to the residents of Eastland County and the surrounding area.

- Need for the project: Eastland County is currently designated as HPSA for primary care. There are eight primary care physicians and three nurse practitioners with clinics located in the county. Of these providers, all but two have clinics within the Eastland city limits. There are cities in the county that do not have a local primary care provider. There is currently no primary care providers in Eastland County that are certified in Internal Medicine. Patients needing to see an internist are required to travel outside of Eastland County (often 60 miles one-way).

- Medicaid and Uninsured Target population: The target population is patients needing primary care services. Eastland County has a high percentage of the population living in poverty. 21.0% of the persons in Eastland County were below the poverty level from 2006-2010 compared to 16.8% for the State of Texas. The addition of Internal Medicine to the area will help these patients by reducing the need to travel.

- Number of patients served: By DY5, this project is expected to serve an additional 955 patients with 3,820 clinic visits. Based on at least 20% of the patients being either Medicaid or Uninsured, this project would serve 191 patients with 764 clinic visits in the targeted population.

- Category 1 or 2 expected patient benefits: The project plans to add two primary care physicians (including one internist) and one nurse practitioner to Eastland County. The number of increased clinic visits will be determined by DY3.

- Category 3 outcomes: IT-9.2 Right Care, Right Setting Our goal is to reduce ER visits. The amount of the reduction will be determined after the baseline is set in DY3.

Pass 2
Project Title: Physician Recruitment Program

Category 1: Infrastructure Development – Primary Care Physician Recruitment

Project Option: 1.1 – Expand Primary Care Capacity

Unique Project ID: 137074409.1.3

Facility Description: Eastland Memorial Hospital 1307074409

Project Description:

Physician Recruitment – Eastland Memorial Hospital plans to recruit primary care providers to Eastland County. The goal of the project is to add two physicians (including one internal medicine) and one nurse practitioner to serve the residents of Eastland County by September 2016.

Number of people served: Based on each provider averaging 206 workdays each year and seeing 20 patients per day, each provider will have 4,120 patient visits in a year. From http://www.cdc.gov/nchs/pressroom/08newsreleases/visitstodoctor.htm dated August 6, 2008 "Patients in the United States made an estimated 1.1 billion visits to physician offices and hospital outpatient and emergency departments in 2006, an annual rate of nearly 4 visits per person annually, according to new health care statistics released today by CDC's National Center for Health Statistics (NCHS)." This would mean that the 4,120 patient visits would translate into 1,030 patients served annually by each provider. By adding 3 providers, the goal would be to serve an additional 3,090 patients or 12,360 patient visits annually once the clinics are at full capacity.

Expected Ramp Up for Providers:

For Each Provider	First Year	Second Year	Third Year
Patients Served	300	665	1,030
Patient Visits	1,200	2,660	4,120
Estimated Medicaid/Indigent Visits (20%)	240	532	824

Based on this expected ramp-up for providers, the project is expected to increase clinic visits as follows:

First Provider	DY3	DY4	DY5
Patients Served	300	665	1,030
Patient Visits	1,200	2,660	4,120
Estimated Medicaid/Indigent Visits (20%)	240	532	824

Second Provider	DY3	DY4	DY5
Patients Served	150	480	850
Patient Visits	600	1,920	3,400
Estimated Medicaid/Indigent Visits (20%)	120	384	680

Third Provider	DY3	DY4	DY5
Patients Served		150	480
Patient Visits		600	1,920
Estimated Medicaid/Indigent Visits (20%)		120	384

Total for Providers	DY3	DY4	DY5
Patients Served	450	1,295	2,360
Patient Visits	1,800	5,180	9,440
Estimated Medicaid/Indigent Visits (20%)	360	1,036	1,888

There will be cannibalization of patients from existing providers. An estimate would be that 50% of the new provider's business would be patients who had previously seen existing providers in the area. Based on this estimate, increased patient visits overall would by 900 in DY3, 2,590 in DY4, and 4,720 in DY5. The estimated metrics for increased visits would be 1,690 for DY4 (over DY3) and 2,130 for DY5 (over DY4).

The county has been designated as HPSA for primary care effective May 2012. As of October 2012, there were eight primary care physicians and three nurse practitioners with clinics located in the county. Of these providers, all but two have clinics within the Eastland city limits. There are cities in the county that do not have a local primary care provider. Two clinics located in the city of Eastland require patients to wait months for an initial non-emergent appointment with a physician.

Recruiting physicians to a rural area such as Eastland is often difficult. Physicians are often drawn to larger urban areas with newer facilities, larger patient markets, and large financial incentives that are not available in the rural market. The funds from this project will be used to assist Eastland in Physician Recruitment that will not be possible without additional funding.

Although the physicians practicing in the area are certified in family practice and pediatrics, there is no physician that is certified for internal medicine. Patients needing to see an internist are required to travel to Abilene (60 miles away) for appointments. Travel is sometimes difficult for elderly patients who have difficulty driving in urban areas. Travel is also difficult for patients with limited funds and may not own a car. If services were available, these patients could receive services in a more timely manner and thus preventing some of the complications that send the same patients to the Emergency Department.

This project addresses the RHP 11 regional goals to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place and right time. By improving access to primary care, patients will receive treatment more timely and should reduce ED visits for complications from delaying needed treatments.

Starting Point/Baseline:

As of October 2012, there were eight primary care physicians and three nurse practitioners with clinics located in the county.

Rationale

Project Options:

Eastland Memorial Hospital has selected 1.1.2 – Expand existing primary care capacity as the project option. This option has three required project components of a) expand primary care clinic space, b) expand primary care clinic hours, and c) expand primary care clinic staffing. In order to reach the goals set for this project, Eastland Memorial Hospital will expand primary care clinic space by adding two clinics in other cities in the county for one physician and one nurse practitioner. The hospital will also expand primary care clinic staffing by two physicians and one nurse practitioner to the area. The hospital does not plan to expand primary care clinic hours in the existing clinics as part of this project, but the total number of clinic hours for the county will increase by adding new locations.

This project will address CN.2 – High costs associated with preventable hospitalization admissions and readmissions and CN.5 – Need to overcome patient access to care barriers.

Related Category 3 Outcome Measure(s):

Eastland Memorial Hospital has selected OD-9 Right Care, Right Setting as the domain for Category 3. Using IT-9.2 ED appropriate utilization (Standalone measure), Eastland plans to Reduce all ED visits (including ACSC). For the year ended October 31, 2012, Eastland Memorial Hospital had 8,685 ED visits for patients of all ages. These visits included 1,125 (13%) non-emergent visits. A new baseline will be set in DY3 using DY2 information. For years DY4 and DY5, Eastland Memorial Hospital plans to reduce pediatric ED visits by a percentage to be determined.

The other options for IT-9.2 are

- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
- Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease /Hypertension
  - Behavioral Health/Substance Abuse
  - Chronic Obstructive Pulmonary Disease
  - Asthma

Eastland Memorial Hospital selected the reduction of all ED visits because improving access to primary care should reduce non-emergent ED visits.

Relationship to other Projects:

The Expand Surgical Services Project 137074409.1.2 proposed by Eastland Memorial Hospital through Pass 1 will also use the same Category 3 Outcome Measure, but will look at reducing pediatric ED visits by providing needed surgical care to pediatric patients who have chronic conditions such as tonsillitis or chronic ear infections. Both projects will benefit the community and will reinforce the RHP goal of right care, right place and right time.

Relationship to Other Performing Providers' Projects in the RHP:

The RHP 11 goals are to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place and right time. RHP 11 has a number of collaborations which invests resources into our rural communities where sole providers face burnout and fatigue. The selected DSRIP projects will begin to build the infrastructure needed in our primary care system to be the backbone for improved care coordination, chronic disease management and care transitions, projects of the future. In increasing the capacity of primary care, the cost of care will be impacted. The ED is the highest cost setting for care. When patients over utilize or unnecessarily utilize the ED for primary and preventive care, the cost burden is wasteful. RHP 11, again, has identified projects that seek to bend the cost curve, which is foundational to the transformation of the healthcare system for patients and for providers.

In Pass 1, several other providers selected similar projects. A list of these projects are:

094104901.1.1 Anson General Hospital
094131202.1.1 Hamlin Memorial Hospital
112702904.1.1 Haskell Memorial Hospital
136325111.1.1 Mitchell County Hospital District
138950412.1.1 Palo Pinto General Hospital
128642705.1.1 Stamford Memorial Hospital
138644310.1.2 Hendrick Medical Center
119875604.1.1 Stephens Memorial Hospital

Plan for Learning Collaborative:

RHP 11 plans to develop learning collaboratives for similar projects.

Project Valuation:

A. ***Achieves Waiver Goals:*** The addition of Internal Medicine in the area will allow patients to receive care at Eastland Memorial Hospital instead of being transferred to a larger hospital with higher costs and reimbursement. By serving patients in a lower cost setting, the project will help transform healthcare and contain costs for both Medicaid and Medicare. This project supports the RHP 11 goal of right care, right place and right time.
B. ***Addresses Community Needs:*** This project is needed by the Eastland County Community and surrounding counties. The project will assist RHP 11 meet **CN.5 Need to overcome patient access to care barriers** and **CN.2 High Costs associated with preventable hospitalization admissions and readmissions**. By improving access to primary care, the patients will have a better patient experience and possibly a better quality of life. Several communities have approached Eastland Memorial Hospital about assisting with recruiting primary care physicians.
C. ***Project Scope/Size:*** Although this project may be considered small compared to larger hospitals' projects, for Eastland County increasing the primary care providers in the area by 27% is a large project.
D. ***Project Investment:*** Since this is the only project included in Pass 2, Eastland Memorial Hospital is using its full allocation for Pass 2 for this project. Eastland Memorial Hospital is located within a hospital taxing district but the tax revenues are needed to fund indigent care and lower-income patients needing financial assistance. DSRIP funds are needed to make this project a reality.

- ***Project Goal:*** By DY5, this project is expected to serve an additional 955 patients with 3,820 clinic visits. Based on at least 20% of the patients being either Medicaid or Uninsured, this project would serve 191 patients with 764 clinic visits in the targeted population.

137074409.1.3	***1.1 – Expand Primary Care Capacity***	***1.1.2*** –Expand existing primary care capacity –a) space and c) staffing	***Physician Recruitment***	
Eastland Memorial Hospital				137074409
Related Category 3 Outcome Measure(s):OD-9 Right Care, Right Setting	137074409.3.3	*IT-9.2*	*ED appropriate utilization (Standalone measure) – Reduce all ED visits(including ACSC)*	
Year 2 (10/1/2012 – 9/30/2013)	**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 care clinics for existing providers <u>Metric 1</u> [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites Baseline/Goal: 11 Primary Care Providers (Physician and Nurse Practitioners)/ 12 Primary Care Providers (Physician and Nurse Practitioners)	**Milestone 2**[P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers <u>Metric 2</u> [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites Baseline/Goal: 11 Primary Care Providers (Physician and Nurse Practitioners)/ 14 Primary Care Providers (Physician and Nurse Practitioners)		**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 3</u> [I-12.1] Documentation of increased number of visits. Demonstrate improvement over DY3. Goal: Increase number of patient visits seen in clinics by 1,690 over DY3 Baseline Data Source: Provider Information	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 4</u> [I-12.1] Documentation of increased number of visits. Demonstrate improvement over DY3. Goal: Increase number of patient visits seen in clinics by 3,820 over DY3 Baseline and Impact 955 patients Data Source:

137074409.1.3	***1.1 – Expand Primary Care Capacity***	***1.1.2*** –Expand existing primary care capacity –a) space and c) staffing	***Physician Recruitment***	
Eastland Memorial Hospital				137074409
Related Category 3 Outcome Measure(s):OD-9 Right Care, Right Setting	137074409.3.3	*IT-9.2*	*ED appropriate utilization (Standalone measure) – Reduce all ED visits(including ACSC)*	
Year 2 (10/1/2012 – 9/30/2013)	**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: Contract with Physician to start in DY3 Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 177,639	Data Source: Contracts with Physician and Nurse Practitioner to start in DY4 Milestone 2 Estimated Incentive Payment: $ 194,024		Milestone 3 Estimated Incentive Payment: $ 195,602	Provider Information Milestone 4 Estimated Incentive Payment: $ 159,891
Year 2 Estimated Milestone Bundle Amount: $ 177,639	Year 3 Estimated Milestone Bundle Amount: $ 194,024		Year 4 Estimated Milestone Bundle Amount: $ 195,602	Year 5 Estimated Milestone Bundle Amount: $ 159,891
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 727,156				

Pass 2
Summary Information
Unique Project ID: 112692202.1.1

- **Provider**: Fisher County Hospital District 112692202 is a 14-bed acute care facility located in Rotan, Texas, the *only* healthcare provider for Fisher and Kent Counties, an 1,800 square mile area with a population of approximately 4,569. Annually we serve 66% of the total population, around 3,000 patients. The five-year target goal is to substantially improve FCHD's primary care capacity, as evidenced by a 15% increase in primary encounters, compared to baseline (5,771) to 6,637.

- **Intervention(s)**: This project will expand existing primary care capacity: primary care clinic space; primary care clinic hours; and primary care clinic staffing. Kent/Fisher Counties low income, Medicaid, indigent, uninsured, and minority populations are disproportionately medically disenfranchised, as is common throughout our region. These individuals often have multiple chronic conditions which are likely to become acute episodes, putting patients at risk for disability and premature death, without regular primary care.

- **Community Need**: CN.3 – Shortages of health care professionals, including mental health care providers. According to our Community Needs Assessment as of 2011 Fisher/Kent Counties are Mental Health Professional, Primary Health Professional, Dental Health Professional Shortage Areas and Medically Underserved Areas. Both Counties are designated Frontier. Our providers are stretched to cover clinics, the hospital, the emergency center, Kent County Nursing Home and our two assisted living facilities almost simultaneously, leaving little time for preventative follow-up interventions.

- **Medicaid and Uninsured Target population**: FY 2011, we experienced $500,000 Bad Debt; $174,647, Charity; and $99,423, Indigent care. Additionally our emergency center had 36% users Medicaid, uninsured, charity and indigent; many were non-emergent care.

- **Category 1 expected patient benefits**: By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services. In DY05, clinic visits will increase by 866 patient encounter over the base in 2012. Improved access to primary health care will benefit medically indigent patients, Medicaid and Medicare patients, underinsured patients, and private patients as well,

providing a medical home rather than episodic emergency room visits.

- **Category 3 outcomes:** Diabetes is the most prevalent chronic diagnosis among our clinic patients and the leading chronic diagnosis in the outpatient setting. During 2011, we treated 333 diabetic patients in our clinic and had 273 diabetic encounters in the emergency department. Medically indigent patients, Medicaid patients and elderly Medicare patients with the diagnosis of diabetes will be served. Community benefit: Diabetic patients will experience a better quality of life, with fewer diabetic complications.

  Our goal is to work to improve the treatment of diabetic patients with preventative testing, preemptive timely exams, and monitoring by the health coach team to reduce the incidence of secondary complications and to assure greater patient satisfaction. Costly inpatient care and emergent care will be reduced. These goals are consistent with the efforts of RHP 11 to transform health care in our region.

  Increased primary health capacity and through the use of evidence based care models, we will work to improve health outcomes among diabetic patients. Three outcome improvement milestones will be monitored in DY4 and DY5:

  IT-1.12 Diabetes care: *Retinal eye exam 235 – NQF 0055*

  DY4 – 75% of diabetic patient encounters to be referred for retinal eye exam
  DY5 – 80% of diabetic patient encounters to be referred for retinal eye exam

  IT-1.13 Diabetes care: *Foot exam – NFQ 0056*

DY4 – 75% of diabetic patient encounters to be referred for foot exam
DY5 – 80% of diabetic patient encounters to be referred for foot exam

  IT-1.14 Diabetes care: *Microalbumin and nephropathy exam – NQF 0062*

  DY4 – 80% of diabetic patient encounters to be referred for nephropathy exam
  DY5 – 85% of diabetic patient encounters to be referred for nephropathy exam

Category 1: Infrastructure Development – Expand Primary Care Capacity

Project Option: 1.1 – Expand Primary Care Capacity

Unique Project ID: 112692202.1.1

Facility Description: Fisher County Hospital District-112692202

Fisher County Hospital District, located in Rotan, Texas is the *only* healthcare provider for Fisher and Kent Counties, in an isolated, underserved northwest area of the state, total population, 4,569. Annually we serve 66% of the total population, around 3,000 patients. As stated in our Community Needs Assessment, our folks are basically old, sick and poor. 40% of our combined populations are over age 55; our under age 18 are 25% poverty level with a total poverty, 19%; and *60.8%* live at 2 or more times poverty level. Per capita Income is $21,143.00. Per Hospital financials, 2011, we experienced $500,000 Bad Debt; $174,647, Charity; and $99,423, Indigent care. Additionally we had 75% Medicare, 1.3% Medicaid payers.

Project Description:

Project option 1.12 Expand existing primary care capacity

Both Fisher and Kent Counties are designated as Health Provider Shortage Areas and Medically Underserved Areas. With this project, we will increase primary care capacity through the recruitment of a full-time practitioner and the expansion of primary care clinic hours. Additional clinic capacity will enable us to focus efforts to more effectively manage patients with chronic health care diseases, specifically our diabetic patients, and to implement more preventive care and screening. Patients requiring urgent medical care will be triaged into our clinic when possible, to avoid costly emergency room care. We also propose to increase access to medical transportation through integration with our 112692202.2.2 Chronic Care project.

Project Goal:

Our goal is to increase FCHD's ability to provide "the right care at the right time in the right setting" – to be able to treat more patients in the primary care setting, where they can receive more preventative and proactive care, more efficiently.

By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Currently only two of our Clear Fork clinic physicians work full-time, assisted by a full-time nurse practitioner. Our senior physician, aged 82 has worked part-time for the past fifteen years, but has announced his retirement this year. These practitioners staff the clinic, provide emergency room coverage, direct inpatient and outpatient department care, provide medical coverage for the county EMS service, and provide medical coverage for the Kent County Nursing Home as well as the Fisher County based assisted living programs.

Envision the challenge of our practitioners to manage these multiple priorities. Imagine the challenge we face to recruit and retain these practitioners. Through this project, we hope to recruit one additional full-time practitioner and to expand primary care services. This expansion will allow our practitioners to care for more patients, and to spend more time practicing preventative health care and helping our patients with chronic health care diseases, specifically diabetes.

Five-Year Target Outcomes:

The five-year target goal is to substantially improve FCHD's primary care capacity, as evidenced by a 15% increase in primary encounters, compared to baseline. In DY05, clinic visits will increase by 866 patient encounters compared to 2012. Improved access to primary health care will benefit medically indigent patients, Medicaid and Medicare patients, underinsured patients, and private patients as well.

The expansion of primary care capacity better accommodates the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting, resulting in overall reduced health care costs. These are foundational goals of RHP 11.

Starting Point/Baseline:

From 11/2011 to 10/2012 our 2.3 physicians/1 nurse practitioner had 5,771 encounters in the Clear Fork Rural Health Clinic and 1,513 encounters in our emergency department.

Project Options:

1.1.2 Expand existing primary care capacity – required core components:

a) Expand primary care clinic space – In our Fisher County Hospital/Clear Fork Rural Health Clinic facility, almost every available room is fully occupied, so we'll have to do the old familiar-to-healthcare facilities fruit basket turnover strategy. Namely, borrow from one department, steal from another, and relocate a third to expand our primary care clinic space to accommodate exam rooms, house new provider, conference/classroom space/and work areas for support personnel. This expanded area will also support our Pass 3 B, ~~1~~ Category 2.2.2 redesign of the outpatient delivery system to coordinate care for patients with chronic diseases education and support initiatives. Careful thought and planning will be used to maximize function and efficiency in our newly developed multi-use primary care center. When the assisted living space is remodeled during Pass 3B ~~1~~, consultation space will also be made available for our medical staff.

b) Expand primary care clinic hours – We will expand the capacity of primary care to better accommodate the needs of our patient population, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. We will review the Wagner Chronic Care model and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care. An evaluation of that assessment will determine the community's needs for expanded primary care clinic hours and make those changes.

c) Expand primary care clinic staffing – We will recruit and hire a new provider and assure that he/she have trained quality support personnel. Kent/Fisher Counties low income, uninsured, and minority populations are disproportionately medically disenfranchised, as is common throughout our region. These individuals often have multiple chronic conditions, which are likely to become acute episodes, putting patients at risk for disability and premature death, without regular primary care. Although FCHD provides affordable preventive and primary care to our residents, regardless of ability to pay, our providers are stretched to cover clinics, hospital, and the emergency center, almost simultaneously. Currently, our support staff is time-limited to provide follow-up interventions. Additionally, the advent of the electronic medical record system has further encroached on the day of the busy physician/mid-level, reducing the time spent in patient's clinic visits.

Rationale:

We selected this project because physician recruitment is vital for the future sustainability of our clinic and hospital. In our current system, patients frequently receive services in the emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner, and a lack of knowledge about what types of services can be provided in the primary care setting.

By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system, resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Community Need:

CN.3 Shortages of health care professionals, including mental health care providers. According to our Community Needs Assessment as of 2011 Fisher/Kent Counties are Mental Health Professional, Primary Health Professional, Dental Health Professional Shortage Areas and Medically Underserved Areas.

Related Category 3 Outcome Measure(s):

Significant milestones include Milestone P-1.1, number of additional clinics or expanded hours or space, and Milestone P-4.1, an expansion of clinic hours, and outcome measure I-12, which will chronicle an overall 15% increase in primary encounters over three years, compared to baseline (866 patient encounters).

Patients will benefit from improved access to primary care and preventative health care, as well as improved management of chronic health conditions. Increased primary health capacity and through the use of evidence based care models; we will work to improve health outcomes among diabetic patients. Three outcome improvement milestones will be monitored in DY4 and DY5:

IT-1.12 Diabetes care: *Retinal eye exam 235 – NQF 0055*
DY4 – 75% of diabetic patients to be referred for retinal eye exam
DY5 – 80% of diabetic patients to be referred for retinal eye exam

IT-1.13 Diabetes care: *Foot exam – NFQ 0056*

DY4 – 75% of diabetic patients to be referred for foot exam

DY5 – 80% of diabetic patients to be referred for foot exam

IT-1.14 Diabetes care: *Microalbumin and nephropathy exam – NQF 0062*

DY4 – 80% of diabetic patients to be referred for nephropathy exam

DY5 – 85% of diabetic patients to be referred for nephropathy exam

We hope that another consequence of this project will be greater practitioner satisfaction resulting in long-term practitioner retention.

Rationale/Evidence:

Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

Approximate annual costs of care: Diabetes with no complications, ranges from $6 - $10,000 with no complications; Diabetes, Out of control, end-stage renal, dialysis, $100,000. Currently in our low-population county (3,974) we have 3 patients traveling outside the area for dialysis.

Locally, in FY2011 we had 333 diabetic encounters in our clinic, and 273 encounters in our emergency room/hospital. Diabetes remains one of the most serious health problems in Texas as well as nationally. About 1.8 million adults in Texas have diagnosed diabetes, and another 460,040 are estimated to have undiagnosed diabetes. It is the sixth leading cause of death in Texas. Regional data indicates that the incidence of type 2 diabetes is increasing among children and adults. Approximately one-third to one-half of area admissions to our regional transfer hospital are diabetes related. The implementation of evidence based medical care, as a means of improving health outcomes and reducing health care costs is consistent with the goals and priorities of the RHP 11 plan.

Relationship to Other Projects in the RHP:

Our 112692202.1.1 project, Expand Primary Care Capacity/Expand existing primary care capacity supports our pass 3 B ~~1~~ project, 112692202.2.2, Expand Chronic Care Management Models/Redesign the outpatient delivery system to coordinate care for patients with chronic diseases. The addition of a physician or mid-level provider, increased clinic space, and expanded hours will enable us to meet our goals. We do not have a similar project for practitioner recruitment currently funded by the U. S. Department of Health and Human Services.

Relationship to Other Performing Providers' Projects in the RHP:

RHP 11 has developed a regional approach to address the health care needs of Medicaid and uninsured patients. Other area performing providers with similar projects to expand primary care capacity include Rolling Plains Hospital in Sweetwater; Stamford Memorial Hospital; Haskell Memorial Hospital; Hamlin Memorial Hospital; Palo Pinto General Hospital; Comanche County Medical Center; Eastland Memorial Hospital; Hendricks Medical Center; Mitchell County Hospital and Stephens Medical Center.

Plan for Learning Collaborative:

Fisher County Hospital welcomes an opportunity to participate in the learning collaborative planned by Palo Pinto Hospital in association with other performing providers. We will share lessons learned and attend collaboration meetings.

Project Valuation:

We value Category 1.1 as $316,615 with a combined total of $348,497.

A. Size factor: From 11/2011 to 10/2012 our providers had 5,771 encounters in our clinic and 1,513 encounters in our emergency department. More often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. By DY5, clinic visits will increase by 866 visits per year, compared to baseline.

B. Project scope: We will expand existing primary care capacity through the recruitment of one practitioner. Clinic space and clinic hours will also be expanded. Patients will receive the right care at the right time in the right setting, and will be aligned

in the primary care system. Additionally in our rural isolated area health care practitioners are scarce, extremely difficult to recruit, harder to retain. Forced to cover clinics, hospital, and the emergency center, almost simultaneously, they succumb to burnout and begin to eye placements in the cities where they are not expected to work days, nights and weekends. By increasing access to care, we will transform medical care in our community. This project is consistent with the RHP 11 goals and objectives.

C. Populations served: The increased access to preventive and primary care will especially benefit our uninsured, underinsured, indigent and Medicaid population. Medicare patients and private care patients will also benefit.

D. Community benefit: Additional clinic capacity will allow patients to have a primary provider, resulting in better health outcomes, increased patient satisfaction, appropriate utilization of services, and reduced cost of services. Medical practitioners will have more time for preventive care and the effective management of chronic diseases, specifically diabetes. 60% of our population have one or more chronic diseases; diabetes is the most prevalent chronic disease treated in our clinic, and the incidence of diabetes is increasing throughout the region. DY5 outcomes will be:

IT-1.12: 80% of diabetic patients will be referred for retinal eye exam
IT-1.13: 80% of diabetic patients will be referred for foot exam
IT-1.14: 85% of diabetic patients will be referred for nephropathy exam

E. Cost avoidance: Preventive care is very cost efficient, as is the provision of medical care at the right time and in the right setting. Proper intervention and management of diabetes will reduce secondary complications, therefore reducing unnecessary hospital admissions and the total cost of health care.

F. Addressing priority community need: CN.3 Shortages of health care professionals, including mental health care providers. Fisher/Kent counties are designated as Health Provider Shortage Areas and Medically Underserved Areas.

G. Fisher County Hospital District will provide local funding for the total IGT of $185,531.

112692202.1.1	1.1.2	1.1.2.A,B,C	1.1 Expand Primary Care Capacity	
Fisher County Hospital District				112692202
Related Category 3 Outcome Measure(s):	**112692202.3.2 112692202.3.3 112692202.3.4**	**IT1.12 IT1.3; IT1.14**	**Diabetes care: Retinal eye exam235—NQF 0055 Diabetes care Foot exam- NQF 0056 Diabetes care: Microalbumin/Nephropathy- NQF 0062**	
Year 2 (10/1/2012 – 9/30/2013)	**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. Milestone: Establish additional/expand existing/relocate primary care clinics Metric 1 P-1.1. Metric: Number of additional clinics or expanded hours or space a. Documentation of detailed expansion plans b. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider. c. Rationale/Evidence Baseline/Goal: our 2.3 physicians/1 nurse practitioner/5,771 encounters: *goal of 5% per year increase in visits*]	Milestone 3 P-5. Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites. a. 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 b. Rationale: Additional staff		**Milestone 4** P-4. Milestone: Expand the hours of a primary care clinic, including evening and/or weekend hours P-4.1. Metric: Increased number of hours at primary care clinic over baseline a. Data Source: Clinic documentation b. Rationale/Evidence: Expanded hours not only allow for more patients to be seen, but also provide more choice for patients.	Milestone 5 I-12. Milestone 1: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Goal: 15% increase from year 2 To . Goal: 15% increase from year 2 by 866 encounters. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period Total number of visits for reporting period: 6,637 b. Data Source: Registry, EHR,

112692202.1.1	1.1.2	1.1.2.A,B,C	1.1 Expand Primary Care Capacity	
Fisher County Hospital District				112692202
Related Category 3 Outcome Measure(s):	112692202.3.2 112692202.3.3 112692202.3.4	IT1.12 IT1.3; IT1.14	Diabetes care: Retinal eye exam235—NQF 0055 Diabetes care Foot exam- NQF 0056 Diabetes care: Microalbumin/Nephropathy- NQF 0062	

Year 2 (10/1/2012 – 9/30/2013)	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: clinic records Milestone 1 Estimated Incentive Payment *$34,767* **Milestone 2** P-5. Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites. a. Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report,	members and providers may be necessary to increase capacity to deliver care. Milestone 3 Estimated Incentive Payment: $78,590	Milestone 4 Estimated Incentive Payment: $84,019	claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care Milestone 5 Estimated Incentive Payment: $84,471

112692202.1.1	1.1.2	1.1.2.A,B,C	1.1 Expand Primary Care Capacity	
Fisher County Hospital District				112692202
Related Category 3 Outcome Measure(s):	112692202.3.2 112692202.3.3 112692202.3.4	IT1.12 IT1.3; IT1.14	Diabetes care: Retinal eye exam235—NQF 0055 Diabetes care Foot exam- NQF 0056 Diabetes care: Microalbumin/Nephropathy- NQF 0062	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
policy, contract or other documentation b. Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care. Milestone 2 Estimated Incentive Payment *$ 34,768*				

Year 2 Estimated Milestone Bundle Amount: 69,535	Year 3 Estimated Milestone Bundle Amount: $78,590	Year 4 Estimated Milestone Bundle Amount: $84,019	Year 5 Estimated Milestone Bundle Amount: $84,471
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $316,615			

Pass 3B
New ID: 094131202.1.3
Old ID: ***094131202.1.1***
Expand Primary care Capacity
Summary Information:

- Provider: Hamlin Memorial Hospital is a 25 bed hospital in Hamlin Texas, Jones County serving a 21 square mile and a population of approximately 14,500.

- Intervention(s): This project will help reduce unneeded visits to the ER and also help patient get into the clinic in a more timely

- Need for the project: We currently have 65% of our ER visits as things that could be seen in a clinic setting. We have only 2 providers covering our clinic and hospital, in which one is 70+ years old. We also need the availability of appointments for patients to get in the clinic in a timely manner. The goal by DY 5 is to reduce non ER visits by 420 and increase clinic visits by 800

- Medicaid and Uninsured Target population: The cost to Medicaid and uninsured is very high for these ER visits while the costs in the clinic are 1/3 the costs.

- Category 1 or 2 expected patient benefits: The project seeks to bring in an additional provider to lower the non-emergent ER visits by 50% and increase clinic visit by 2000. The goal is to give the patient an actual doctor that will be there provider in the clinic and not have to come to the ER for care.

- Category 3 outcomes: IT-9.2 goal is to decrease the number of non-emergent ER visits by 50% and increase clinic visits by 20%

K. Category 1: Infrastructure Development

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

Narrative for each Category 1 Project shall include:

- The narrative for each Category 1 Project is limited to 6 pages.
- **Identifying Project and Provider Information:** Reduce ED visits for non-emergent care (old ID 094131202.1.1) new ID 094131202.1.3, Hamlin Memorial Hospital 094131202
- **Project Description:** With 65% of our ED visits are for what could be described as non-emergent care. Our 2 providers each see approx. 3000 visits per year and getting patient into the clinic is a challenge. You add on to that the physicians cover the ED along with patient rounds. One of our physicians is over 70 years of age. Our expectation is to see a decrease in the non-emergent ED visits by a minimum of 50% and an increase of 20% in clinic visits for this project Our project follows with the RHP 11 goals which are to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. RHP 11 has chosen to focus on increasing the capacity of primary care, increasing strategies related to disease prevention, and expanding behavioral health services. We anticipate that all the projects will reduce the burden on Emergency Departments and improve health outcomes across the region. RHP 11has a number of collaborations which invests resources into our rural communities where sole providers face burnout and fatigue. The selected DSRIP projects will begin to build the infrastructure needed in our primary care system to be the backbone for improved care coordination, chronic disease management and care transitions, projects of the future. In increasing the capacity of primary care, the cost of care will be impacted. The ED is the highest cost setting for care. When patients over utilize or unnecessarily utilize the ED for primary and preventive care, the cost burden is wasteful. RHP 11, again, has identified projects that seek to bend the cost curve, which is foundational to the transformation of the healthcare system for patients and for providers.
- **Starting Point/Baseline:** 65% of ED (total ED volume 1300 per year) visits are considered potentially non emergent and each provided sees approx. 3000 clinic visits per annum. Our goal at DY 5 will be to reduce ER visits by 420 and increase clinic visits by 800

- **Rationale** Our project, Expand Primary Care Capacity with the main focus on project option 1.1.2 with a major input on 1.1.2c- Expand primary care clinic staffing and a minor focus on 1.1.2b expand primary clinic hours. With close to 65% or our ED visits being considered non emergent, not that they don't meet the requirement of emergent care but could be taken care of in a clinic setting, and with 29.1% of Hamlin's population is below the current poverty level.as of December 2011 had two full time physicians providing primary and preventive care in the clinic setting. Because these providers have been experiencing fatigue and burnout, plus the age of one of the provider is 70 it is critical that we recruit another physician to alleviate the burden. Our physicians, as family practitioners, also cover the Emergency Department in the hospital. This adds to their stress and burnout fatigue as well. If we don't recruit another physician to provide relief, we are at high risk of losing our current physicians due to the extreme burnout. Our clinic is close to full capacity with our current staffing model. By providing additional primary care capacity, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction costs associated with non-emergent care treatment in the ED. This is an item that will cover our CN.3, Shortages of healthcare providers and CN.5, need to overcome patient access barriers as shown in our RHP11 community needs.

- **Related Category 3 Outcome Measure(s):** OD-9, IT 9.2 ED Appropriate Utilization; We expect the follow outcome measures to be
  1. We will be able to track the actual decrease in the number of ED visit for non- emergent care
  2. We will be able to track the increase in clinic visits, following our cat 1 project
     - We will be able to allow better access to health for the 29.1% of Hamlin residents currently living below the federal poverty level and with our county having an uninsured rate of 25.6%. With the cost of an ER visit being approximately 3.5-4 times as much as clinic visit
- **Relationship to other Projects**
- **Relationship to Other Performing Providers' Projects in the RHP** other local facilities in our RHP are looking at the same sort of projects as it results in lower ER visits
- **Plan for Learning Collaborative NA**
- **Project Valuation** The valuation of the overall project is covered in many areas. First of all, the goal to increase patient visits in the clinic by 20%, with this we will have a decrease of ED visits which helps in many areas.
  A. Reduce the volume thru the ED; this reduces costs to the taxpayers for coving losses at the hospital, a large community benefit.
  B. Wait times in the clinic are less, thus improving patient satisfaction of the overall healthcare organization

C. Community need and cost avoidance is addressed with the cost being considerably less for a clinic visit versus an ED visit.

OLD 094131202.1.1 NEW 094131202.1.3	***1.1.2 EXPAND PRIMARY CARE CAPACITY***	***FROM RHP PP - E.G. 1.X.X.X]***	***REDUCES ED VISITS***	
Hamlin Memorial Hospital				*094131202*
OD-9	*OLD 094131202.3.1 NEW 094131202.3.3*	*IT-9.2*	*Reduce non emergent 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-1 Establish additional/expand existing/relocate primary care P-1.1Metric- Number of additional hours or expanded hours or space Documentation of detailed expansion plans Data Source: New primary care schedule or other performing provider Rationale/Evidence: It is well known the national supply of primary care does not meet the demand for primary care	**Milestone 2** [P-5]: **Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing provider** Metric 1 P-5.1 Documentation of increased providers and staff and/or clinic sites Goal: increase volume by 5% or 100 visits Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other performing provider		**Milestone 4** : P-4 Expand the hours of the primary care clinic, including evening and/or weekend hours Metric 1 : P-4.1 Increase number of primary care clinic over base line Goal: Expand 6 additional hours per week, Increase visits by 5% or 100 visits Data Source: clinic documentation Rationale/Evidence: Expanded hours not only allow for more patients to be	**Milestone 7** :I-12 Increase primary care clinic volume of visits and evidence of improved access for patient seeking services Metric 1 : 1-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period Goal: increase volume 10% or 200 visits Data Source: Registry, EHR, Claims or other performing provider source

OLD 094131202.1.1 NEW 094131202.1.3	***1.1.2 EXPAND PRIMARY CARE CAPACITY***	***FROM RHP PP - E.G. 1.X.X.X]***	***REDUCES ED VISITS***	
Hamlin Memorial Hospital				*094131202*
OD-9	*OLD 094131202.3.1 NEW 094131202.3.3*	*IT-9.2*	*Reduce non emergent 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)**
services. Moreover, it is a goal of health care improvements to provide more preventive and primary care in order to keep individuals and families healthy and therefor ovoid more costly ER and inpatient care. RHP's are in a real need of expanding primary care capacity in order to be able to implement the kind of delivery system reforms needed to provide the right care at the right time in the right settings for all patients Milestone 1 Estimated Incentive Payment *(maximum amount):* $128,925	report, policy contract or other documentation Rationale: Additional staff members and providers may be necessary to increase capacity to deliver care Milestone 2 Estimated Incentive Payment: $74,720 **Milestone 3** :P-8 Develop an automated tracking system for measuring time to the next available offered appointment Metric 1] P-8.1 Documentation that providers and staff are aware of nest available appointment using real time scheduling data to ensure that patients can		seen, but also provide more choice for patients. Milestone 4 Estimated Incentive Payment: $50,328 **Milestone 5** :I-12 Increase primary care clinic volume of visits and evidence of improved access for patient seeking services Metric 1 : 1-12.1 Documentation of increased number of visits. Demonstrate improvement over prior reporting period Goal: increase volume 10% Data Source: Registry, EHR,	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 Milestone 7 Estimated Incentive Payment: $60,681 **Milestone 8** : I-11 Patient satisfaction with primary care services

OLD 094131202.1.1 NEW 094131202.1.3	***1.1.2 EXPAND PRIMARY CARE CAPACITY***	***FROM RHP PP - E.G. 1.X.X.X]***	***REDUCES ED VISITS***	
Hamlin Memorial Hospital				*094131202*
OD-9	*OLD 094131202.3.1 NEW 094131202.3.3*	*IT-9.2*	*Reduce non emergent 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)**
Add more milestones and metrics as applicable	receive primary care services according to acuity and need Baseline/Goal: wait times less than 3 business days for high acuity Data Source: Documentation of performing providers policies for assessing and communicating time to the next available appointment and response to patient care needs reporting and communication tool. Performing provider administrative records from patient scheduling system Rationale: Regular tracking and assessment of time to		Claims or other performing provider source 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 Milestone 5 Estimated Incentive Payment: $50,328 Milestone 6: I-13 Enhanced capacity to provide urgent care services in the primary care setting. Metric 1: Percent of patients receiving urgent care appointments in the primary	Metric 1 : I-11.1 Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores Goal: 80% in the very good or excellent range Numerator: Sum of all survey scores Denominator: Number of survey completed Data Source: GC-CAHPS or other developed evidence based satisfaction

OLD 094131202.1.1 NEW 094131202.1.3	***1.1.2 EXPAND PRIMARY CARE CAPACITY***	***FROM RHP PP - E.G. 1.X.X.X]***	***REDUCES ED VISITS***	
Hamlin Memorial Hospital				*094131202*
OD-9	*OLD 094131202.3.1 NEW 094131202.3.3*	*IT-9.2*	*Reduce non emergent 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)**	
	next available appointment by staff and providers allows for enhanced ability to identify scheduling gaps, patient needs and appropriately triage patients to receive necessary care. Milestone 3 Estimated Incentive Payment: $74,720	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 Goal: Decrease ED non emergent ED visits Goal by 50% or 200 Numerator: Number of patients receiving urgent care appointment within 2 days of request Denominator: Number of patients requesting urgent care appointment. Data Source: Registry, EHR,	assessment tool, available in formats and language to meet patient population Rationale: Patient satisfaction with primary care services is largely related to utilization of primary care services. Understanding strengths, needs and receiving patient feedback allows providers and staff to better understand how to tailor care delivery to meet their patients needs. Metric 2: I-11.2 Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the	

OLD 094131202.1.1 NEW 094131202.1.3	***1.1.2 EXPAND PRIMARY CARE CAPACITY***	***FROM RHP PP - E.G. 1.X.X.X]***	***REDUCES ED VISITS***	
Hamlin Memorial Hospital				*094131202*
OD-9	*OLD 094131202.3.1 NEW 094131202.3.3*	*IT-9.2*	*Reduce non emergent 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)**
			claims or other performing provider scheduling source Rationale: Identifying patient flow as it relates to urgent cae 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 apponitments Milestone 5 Estimated Incentive Payment: $50,328	opportunity to respond to the survey Demonstrate improvement over prior reporting period Goal: 100% of all patients receive survey Numerator: Number of surveys distributed during the reporting period Denominator: Total number of primary care visits during the reporting period Data Source: Performing provider documentation of

OLD 094131202.1.1 NEW 094131202.1.3	***1.1.2 EXPAND PRIMARY CARE CAPACITY***	***FROM RHP PP - E.G. 1.X.X.X]***	***REDUCES ED VISITS***	
Hamlin Memorial Hospital				*094131202*
OD-9	*OLD 094131202.3.1 NEW 094131202.3.3*	*IT-9.2*	*Reduce non emergent 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)**	
			survey distribution, EHR Rationale: Patient satisfaction with primary care is largely related to utilization of primary care services. Understating strengths, needs and received patient feedback allows for providers and staff to better understand how to tailor care delivery to meet their patients' needs Milestone 8 Estimated Incentive Payment: $64,680	

OLD 094131202.1.1 NEW 094131202.1.3	***1.1.2 EXPAND PRIMARY CARE CAPACITY***	***FROM RHP PP - E.G. 1.X.X.X]***	***REDUCES ED VISITS***	
Hamlin Memorial Hospital				*094131202*
OD-9	*OLD 094131202.3.1 NEW 094131202.3.3*	*IT-9.2*	*Reduce non emergent 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):* $128,925	Year 3 Estimated Milestone Bundle Amount: $149,441		Year 4 Estimated Milestone Bundle Amount: $150,985	Year 5 Estimated Milestone Bundle Amount: $129,361
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $558,711				

Pass 2: Category 1: Infrastructure Development

- **Identifying Project and Provider Information:** Enhance Performance Improvement and Reporting Capacity 094131202.1.2, Hamlin Memorial Hospital 0094131202

- Provider: Hamlin Memorial Hospital is a 25 bed hospital in Hamlin Texas, Jones County serving a 21 square mile and a population of approximately 14,500.

- Intervention(s): **:** The goal of this project is to implement a process improvement measures and methodologies to improve safety, quality efficiency and patient satisfaction.

- Need for the project:

- Medicaid and Uninsured Target population:

- Category 1 or 2 expected patient benefits

- Category 3 outcomes: OD-6, IT 6.1(1)Percent improvement over baseline of patient satisfaction scores

Category 1: Infrastructure Development

- **Identifying Project and Provider Information:** Enhance Performance Improvement and Reporting Capacity **OLD** 094131202.2.1,Hamlin Memorial Hospital 094131202
- **Project Description:** The goal of this project is to implement a process improvement measures and methodologies to improve safety, quality efficiency and patient satisfaction. Using a structure model we will implement process to improve through employee training and education and focus on a data collection system that allows us to drive continuous quality improvement through real time and timely data**.** Our project follows with the RHP 11 goals which are to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. The selected DSRIP projects will begin to build the infrastructure needed in our primary care system to be the backbone for improved care coordination, chronic disease management and care transitions, projects of the future. In increasing the capacity of primary care, the cost of care will be impacted
- **Starting Point/Baseline**: Limited Data, not strong QA process or patient satisfaction process
- **Rationale** Performance improvement and reporting is a very large component of success of all of the project areas across the categories. The necessity for quality and safety improvement initiatives permeates health care. Quality health care is defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". According to the Institute of Medicine (IOM) report, To Err Is
  Human, the majority of medical errors result from faulty systems and processes, not individuals. Processes that are inefficient and variable, changing case mix of patients, health insurance, differences in provider education and experience, and numerous other factors contribute to the complexity of health care. With this in mind, the IOM also asserted that today's health care industry functions at a lower level than it can and should, and it put forth the following six aims of health care: effective, safe,
  patient-centered, timely, efficient, and equitable. The aims of effectiveness and safety are targeted through process-of-care measures, assessing whether providers of health care perform processes that have been demonstrated to achieve the desired aims and avoid those processes that are predisposed toward harm. The goals of measuring health care quality are to determine the effects of health care on desired outcomes and to assess the degree to which health care adheres to processes based on
  scientific evidence or agreed to by professional consensus and is consistent with patient preferences. Because errors are caused by system or process failures, it is important to adopt various process improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems. Each of these

techniques involves assessing performance and using findings to inform change. This chapter will discuss strategies and tools for quality improvement—including failure modes and effects analysis, Plan-Do-Study-Act, Six Sigma, Lean, and root-cause analysis—that have been used to improve the quality and safety of health care. Whatever the acronym of the method (e.g., TQM, CQI) or tool used (e.g., FMEA or Six Sigma), the important component of quality improvement is a dynamic process that often employs more than one quality improvement tool. Quality improvement requires five essential elements for success: fostering and sustaining a culture of change and safety, developing and clarifying an understanding of the problem, involving key stakeholders, testing change strategies, and continuous monitoring of performance and reporting of findings to sustain the change. right now being a small facility and having limited understanding of focus. Our target population will be all the patients that use our facility but will focus on the items that may need to be changed to improve overall quality.
We will include the following the core components, a) Provide training and education to clinical and administrative staff on process
improvement strategies, methodologies, and culture. b) Develop an employee suggestion system that allows for the identification of issues that impact the work environment, patient care and satisfaction, efficiency and other issues aligned with continuous process improvement. c) Design data collection systems to collect real-time data that is used to drive continuous quality improvement in the form of monthly and yearly dashboards. CN.5, community needs, we are working to overcome patient access to care barriers, with our barrier being patient satisfaction and safety.

- **Related Category 3 Outcome Measure(s):** OD-9, IT 6.1(1)Percent improvement over baseline of patient satisfaction scores; We expect the follow outcome measures to be
  3. We will be able to track and improve the actual percentage score of patients receiving timely care coming into the facility and information on discharge. Our plan will be to establish a baseline score in DY2, and then follow the milestones we have set up.

- **Relationship to other Projects NA**
- **Relationship to Other Performing Providers' Projects in the RHP** NA
- **Plan for Learning Collaborative NA**
- **Project Valuation** The valuation of the overall project is covered in many areas. First of all, the goal to increase patient satisfaction in the hospital while ensuring the highest quality of care thru the cat 1 project by potentially reducing errors that could lead to extended hospital stays or un needed readmissions. The potential challenges will be in the use of a new tool at the patient level and the employee level. Creating a more detailed QA process based of off patient input put some

employee's at odds on processes and out comes Our goal by DY 5 is to have 75% of our patients filling out patient satisfaction surveys, which would be approx. 3000 surveys being completed annually with an overall aggregate score at 92% or above.

094131202.1.2	*1.10.2 ENHANCE IMPROVEMENT CAPACITY THROUGH TECHNOLOGY*	*1.10.2.A,B,C*	*ENHANCE PERFORMANCE IMPROVEMENT*
Hamlin Memorial Hospital			*094131202*
OD-6	094131202.3.3	*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 Establish a performance office to collect, analyze and manage real time data and to monitor the improvement trajectory and improvement activities across the preforming providers delivery system Metric 1: P-1.2. Documentation that the performance improvement office in engaged in collecting, analyzing and managing real time data Baseline/Goal: 7 performance indicators outside normal core measures Source: TBD by provider	**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 will be required to lead an improvement project in their department within 6 months of completing training Metric 1 P-2.1.Train the trainer program established Goal: 12- Number of staff trained through the train the trainer program and create quality dashboard and set guidelines for goals Data Source: HR	**Milestone 3** : I-7 Implement quality improvement data systems, collection and reporting capabilities Metric 1 :I-7.1 Increase number of reports generated through these quality improvement data systems Data Source: Quality improvement data systems Rationale/Evidence: It is important to accurately collect data on quality outcomes and patient experience as well as present the data in a format that can be analyzed in a way to draw meaningful and actionable conclusions. These reports should be generated monthly,	**Milestone 4** : I-8 Create a quality dashboard or scorecard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures Metric 1 : I-8.1 Submission of quality dashboard or scorecard Data Source: Quality improvement data systems Rationale/Evidence: It is important to accurately collect patient experience and quality outcome data and have the data in a format that can be analyzed in a way to draw meaningful and

094131202.1.2	*1.10.2 ENHANCE IMPROVEMENT CAPACITY THROUGH TECHNOLOGY*	*1.10.2.A,B,C*	*ENHANCE PERFORMANCE IMPROVEMENT*	
Hamlin Memorial Hospital				*094131202*
OD-6	094131202.3.3	*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)**
Rationale/Evidence: Real time data collection and regular reporting to provider is critical to demonstrate efficiency of improvement Milestone 1 Estimated Incentive Payment *(maximum amount):* $32,458 *Add more milestones and metrics as applicable*	documentation of total hours(TBD) need to complete the training Rationale/Evidence: Ongoing training throughout the organization in quality care improvement will increase the capacity for quality improvement activities on an ongoing basis. Milestone 2 Estimated Incentive Payment: $37,667		if not more frequently, to measure the impact of improvement activities on the improvement goals/targets Metric 2 :I-7.2 Demonstrate how quality reports are used to drive rapid cycle performance improvement Rationale/Evidence: It is important to use the data on quality outcomes and patient experience to design new processes and measure the results once those new processes are implemented in order to continually improve the interventions over time Data Source: Documentation	actionable conclusions. Examples of the dashboards used include (1) Clinical Dashboard: Nursing Unit Census, Current patients for emergency room, average patient length of stay; (2) Hospital Dashboard: Admissions, Emergency room wait times, quarterly income, departmental spending: (3) Patient Dashboard: number of patients, patient satisfaction, number of new patients: (4) Physician Dashboard: Number of new patients, Patient satisfaction Milestone 4 Estimated Incentive Payment: $16,216

094131202.1.2	*1.10.2 ENHANCE IMPROVEMENT CAPACITY THROUGH TECHNOLOGY*	*1.10.2.A,B,C*	*ENHANCE PERFORMANCE IMPROVEMENT*	
Hamlin Memorial Hospital				*094131202*
OD-6	094131202.3.3	*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)**
			from quality improvement office Milestone 3 Estimated Incentive Payment: $38,255	**Milestone 5** : I-10 Enhance performance improvement and reporting capacity Metric 1 : I-10.2 Demonstrate how quality reports are used to drive rapid cycle performance improvement: Number of performance activities that were designed and implemented based on the data in the reports Data Source: Documentation form quality improvement office Rationale/evidence: It is important to use the data on quality outcomes and patient experience to design new processes and measure the results once these new

094131202.1.2	***1.10.2 Enhance Improvement Capacity through Technology***	***1.10.2.A,B,C***	***Enhance Performance Improvement***	
Hamlin Memorial Hospital				*094131202*
OD-6	094131202.3.3	*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)**
				processes are implemented in order to continuously improve the interventions over time Milestone 4 Estimated Incentive Payment: $16,216
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $32,458	Year 3 Estimated Milestone Bundle Amount: $37,667		Year 4 Estimated Milestone Bundle Amount: $38,255	Year 5 Estimated Milestone Bundle Amount: $32,432
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $140,812				

Add additional projects using same format above

Pass 3B
Project NEW ID:112702904.1.2 PHYSICIAN RECRUITMENT
OLD ID: 112702904.1.1 PHYSICIAN RECRUITMENT

Summary Information:

- Provider: Haskell Memorial Hospital is a 25 bed critical access hospital serving a population of approximately 6000 people. The community has a population of approximately 25% over 65 years old and 22.6% below the federal poverty level and is designated as a primary care health provider shortage area.

- Intervention(s): The project is to recruit an additional primary care provider to ease the burden and burnout on the existing providers who are nearing retirement age. This will enable the community to have better access to care currently and in the future. This was a number one priority in a local community assessment project done in 2011.

- Need for the project: Currently providers are at capacity in their clinics and unable to see more patients. Local community assessment need survey performed cited the need for additional providers and the number one need for our community related to health care.

- Medicaid and Uninsured Target population: The Medicaid and uninsured population will benefit from the additional access to care at the clinic and alleviate some of the use of the emergency room as a clinic. Medicaid and uninsured currently make up approximately 25% of our patient encounters and many of these currently come to the hospital emergency room rather than the clinics because of the full capacity at the clinic and inability to see more patients. This will result in improved patient care and outcomes.

- Category 1 or 2 expected patient benefits: The project will give the community better access to care for patients and assist in the region wide goal of right care, right place, right time. We anticipate patient encounters for DY 3 for the new provider to be **500** and anticipate a 3% (**515)** increase in encounters for DY3 to DY4 and another 3% **(530)** from DY4 to DY5. Of these encounter approximately 20% will be for uninsured and Medicaid patients who will be aided by this provider addition. The overall patient base and community population is 5900 people that can potentially be served by an additional provider.

- Category 3 outcomes: IT-6.1-Our goal is to have improved outcomes on patient's satisfaction scores of 2% in DY 4 over the baseline of DY 3 and 2% in DY 5 over DY 4.The base scores will be established in the first surveys that will be performed in DY 3. We anticipate a 30% survey return each year which will be 150 in DY 3, 155 in DY 4, and 159 in DY 5.

Pass 3B

Category 1: Infrastructure Development

Project Option: 1.1.2 Expand Primary Care Capacity

Unique Project ID: NEW 112702904.1.2
OLD 112702901.1.1

Facility Description: Haskell Memorial Hosptial-112702904

Project Description:

Haskell Memorial Hospital, as a Critical Access Hospital, serves a rural area of uninsured, Medicaid, and Medicare households. Based on the 2010 Census quick facts, 22.6% of the population live below the federal poverty level, 24.7% of the County population is 65 year of age or older, and within 10 years, an additional 15% of the county population will be of retirement age. Haskell Memorial Hospital is also located within a Health Professional Shortage Area. Based on these factors, we will transform and improve access to primary and preventive care by enhancing access points and increasing capacity for the growing need for appropriate care. We will add a physician and support staff to access care in the clinic. This will also improve access for the uninsured. As a regional there is an overall primary care shortage so this will enhance and improve the access to care as a region. Patient care and patient outcomes will improve with more readily available access to care by DY 5 through the recruitment of an additional primary care physician. We believe this project will also advance the RHP 11 regional goals of the Triple Aim: right care, right place, and right time and reduce the burden on Emergency Departments across the region.

- **Starting Point/Baseline:**

We are planning to recruit and get the primary care physician established in DY2 and set DY3 as the baseline for encounters for the physician. We anticipate a 3% increase in encounters from DY 3 to DY 4 and a 3% increase from DY 4 to DY 5. We estimate the baseline encounters for the new providers in DY 3 to be 500 encounters with 20% of those being uninsured or Medicaid. Estimated encounters in DY 4 is 515 and DY 5 is 530

- **Rationale:**

  As of September 2012 Haskell Memorial Hospital had two full time physicians and one nurse practitioner providing primary and preventive care in a clinic setting. Because these providers have been practicing for twenty five to thirty years, they are experiencing burnout, it is critical that we recruit another physician to alleviate the burden. Our physicians, as family practitioners, also provide weekday ER coverage in the hospital. Both physicians are also nearing retirement age which puts us at an even greater risk of not having primary care coverage in the next four years. It is crucial that we recruit now to expand and prepare to replace these physicians due to current and future needs of our community.

  This project falls under the RHP 11 Community needs Identification Number CN.3-Shortages of health care professionals, including mental health care providers.

  In a local community needs assessment conducted by the Texas A&M Public Policy Research Institute for HMH in January 2011, the number one concern cited in the community listening sessions and survey was developing a plan for recruitment of more physicians.

  The required core components under 1.1.2 Expand primary care capacity are (a) expand primary care clinic space-we will not be doing this component due to already having adequate space for additional physicians (b) expand primary care clinic hours-we will expand hours if the need arises and the practitioners are willing to do so but will not include it as a core component due to lack of knowledge at this time of the willingness of the new provider. (c) expand primary care clinic staff-we will accomplish this by adding another physician to do primary care in the existing clinic.

  By providing additional primary care capacity, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction in costs associated with non-emergent care treatment in the ED.

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

  OD-6 Patient Satisfaction
  IT-6.1 Percent improvement over baseline of patient satisfaction scores.

Rationale/Evidence:

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

Adding an additional primary care physician to our community, we believe will increase patient satisfaction in our community with all primary care physicians and help us provide better quality care for all of our patients including those with low incomes. According to an article by CAHPS Clinician and Group Surveys "Users of the CAHPS Clinician and Group Surveys may report the results of the survey publicly to inform health care consumers and/or privately to inform health care providers and other stakeholders and support their efforts to improve patients' experiences with care".

- **Relationship to other Projects:**
  By providing additional primary care capacity, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction in costs associated with non-emergent care treatment in the ED.

  Most of the projects within our region are related to expanding primary capacity or specialty care within the community or region. Many of our rural hospitals face similar needs and similar difficulty in recruiting for primary care and expanding services to provide our communities with the services they need. The RHP 11 goals to transform health care in the total population and advance the goals of right care, right place and right time are goals we are working toward with our expansion of services and a goal that will greatly improve health outcomes and appropriate utilization of services in our region.

- **Relationship to Other Performing Providers' Projects in the RHP:**

RHP 11 goals are to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. RHP 11 has chosen to focus on increasing the capacity of primary care, increasing strategies related to disease prevention, and expanding behavioral health services. We anticipate that all the projects will reduce the burden on Emergency Departments and improve health outcomes across the region. RHP 11 has a number of collaborations which invests resources into our rural communities where sole providers face burnout and fatigue. The selected DSRIP projects will begin to build the infrastructure needed in our primary care system to be the backbone for improved care coordination, chronic disease management and care transitions, projects of the future. In increasing the capacity of primary care, the cost of care will be impacted. The ED is the highest cost setting for care. When patients over utilize or unnecessarily utilize the ED for primary and preventive care, the cost burden is wasteful. RHP 11, again, has identified projects that seek to bend the cost curve, which is foundational to the transformation of the healthcare system for patients and for providers.

Haskell Memorial Hospital's project to expand primary care capacity through the recruitment of an additional provider is in the same category as Anson, Hamlin, Mitchell County, Palo Pinto, and Stamford although we are all doing different variations of the project based on our particular needs and communities. Because of the distance between our communities, we do not see any duplication of these needs and services as being an issue and can hopefully collaborate in a Pass 2 project on more efficiencies and some possible sharing of services in some specialty areas that would benefit us all.

- **Plan for Learning Collaborative:**

N/A [If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.]

- **Project Valuation:**

I have valued our project based on the difficulty of recruiting and retaining a primary care physician with factors considered for: (1) guarantees for the physician until he/she gets established (2) recruitment bonuses, moving expenses, loan

repayments, etc that may be required to successfully recruit someone to our community, (3) the fact that we are a Health Professional Shortage Area and anyone coming to our community will be required to be available more than someone going to a large group clinic or community.

Our value may differ from other performing providers valuations because of various factors and differences in our needs such as (1) the amount of guarantee required in order to get the provider to your community (2) the type practice and/or coverage the physician will provide such as clinic only, emergency room-could be weekend and/or weekday/nights/days, or medical director responsibilities. These all weigh into the value placed on the particular performing provider's project and the value it brings to the community.

We are choosing to do only one project in Category 1 due to the limited amount of funds allocated to our facility so we are putting all of our value in the project to recruit a primary care physician. This was the number one identified need in a local community assessment done in January of 2011 and is also an identified need in our RHP community assessment CN.3. This recruitment will help serve the county population of 5900 people and improve their access to care and provide a valuable community benefit. We anticipate it will also save cost in our emergency room to have more availability of another primary care physician for the community to see for non emergent visits.

The project will give the community better access to care for patients and assist in the region wide goal of right care, right place, right time. We anticipate patient encounters for DY 3 for the new provider to be **500** and anticipate a 3% (**515)** increase in encounters for DY3 to DY4 and another 3% **(530)** from DY4 to DY5. Of these encounter approximately 20% will be for uninsured and Medicaid patients who will be aided by this provider addition. The overall patient base and community population is 5900 people that can potentially be served by an additional provider.

NEW 112702904.1.2 OLD 112702904.1.1	***1.1.2 EXPAND EXISTING PRIMARY CARE CAPACITY***	***1.1.2.C EXPAND PRIMARY CARE CLINIC STAFFING***	***EXPAND EXISTING PRIMARY CARE CAPACITY***	
Haskell Memorial Hospital				*112702904*
OD-6	NEW 112702904.3.3 OLD 112702904.3.1	*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-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. b. Rationale/Evidence: Additional staff members and providers may be necessary to increase capacity to deliver care. We intend to do component 1.1.2 c- Expand primary clinic staff as the	Milestone 2 (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. a. 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		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. a. 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	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. a. 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

NEW 112702904.1.2 OLD 112702904.1.1	***1.1.2 EXPAND EXISTING PRIMARY CARE CAPACITY***	***1.1.2.C EXPAND PRIMARY CARE CLINIC STAFFING***	***EXPAND EXISTING PRIMARY CARE CAPACITY***	
Haskell Memorial Hospital				*112702904*
OD-6	NEW 112702904.3.3 OLD 112702904.3.1	*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)**
primary component of our project Baseline/Goal: Recruit primary care physician and establish in clinic 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 1 Estimated Incentive Payment *(maximum amount):* $ 218,034	the Performing Provider to increase capacity to provide care Baseline/Goal: Establish baseline for visits in first full year of service. Estimate 500 encounters in this base year with 20% being uninsured or Medicaid Data Source: Registry, EHR,claims or other Performing Provider source Milestone 2 Estimated Incentive Payment *(maximum amount):* $ 252,731		increase capacity to provide care Baseline/Goal: 3% (515) increase in clinic visits Data Source: Registry, EHR,claims or other Performing Provider source Milestone 3 Estimated Incentive Payment *(maximum amount):* $ 255,343	increase capacity to provide care Baseline/Goal: 3% (530) increase in clinic visits Data Source: Registry, EHR,claims or other Performing Provider source Milestone 4 Estimated Incentive Payment *(maximum amount):* $ 218,772

NEW 112702904.1.2 OLD 112702904.1.1	***1.1.2 EXPAND EXISTING PRIMARY CARE CAPACITY***	***1.1.2.C EXPAND PRIMARY CARE CLINIC STAFFING***	***EXPAND EXISTING PRIMARY CARE CAPACITY***	
Haskell Memorial Hospital				*112702904*
OD-6	NEW 112702904.3.3 OLD 112702904.3.1	*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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 218,034	Year 3 Estimated Milestone Bundle Amount: $ 252,731		Year 4 Estimated Milestone Bundle Amount: $ 255,343	Year 5 Estimated Milestone Bundle Amount: $ 218,772
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $ 944,880				

Summary Information (RHP11): CAT 1 1.1 Substance Abuse (127373205.1.1)

- Provider: The Helen Farabee Center is a Community Mental Health/Intellectual & Developmental Disability authority/provider with 9 clinics in north-central Texas serving 19 counties across 16,705 square miles and a population of 318,665.

- Intervention(s): This project involves hiring a licensed substance abuse counselor who will provide substance abuse services in the Haskell, Knox, and Stonewall county region.

- Need for the project: 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.

- Medicaid and Uninsured Target population: The Center serves primarily indigent clients and roughly 30% of them have Medicaid.

- Category 1 or 2 expected patient benefits: The project seeks to provide substance abuse services to 35 consumers by 9/30/14, increasing services by 10% (39) and 15% (40) over baseline for Demonstration Years 4 and 5, respectively.

- Category 3 outcomes: IT-10.1. Our goal is improve quality of life scores for 5% of substance abuse service recipients, increasing to 10% in Demonstration Years 4 and 5 respectively.

Category 1: Infrastructure Development – Expand Behavioral Health Services

Project Option: 1.12.2 – EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS.

Unique Project ID: 127373205.1.1.

Facility Description: Helen Farabee Center 127373205

Project Description:

This project involves hiring a licensed substance abuse counselor who will provide substance abuse services in the Haskell, Knox, and Stonewall county region. The target population for this project includes Adults/Children with a single substance-abuse or dependence diagnoses 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 if discharge/referral services are indicated. Services are terminated when the 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. The goal is to establish a substance abuse division in key regional areas by hiring staff members and then providing substance abuse services in those counties. 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. 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. Regional goals are in accordance with CMS' Triple Aim which is Right Service, Right Setting, Right Time. This project provides access to qualified Substance Abuse counselors as opposed to delayed or crisis-oriented services (Right Service). The services are provided at community access points and not in costly emergency departments (Right Setting). Finally, the services are provided at the right time in order to begin treatments quickly if indicated (Right Time). This project improves patient experience by providing timely access to care. It improves health by creating a system to begin treatment sooner. It is designed to reduce costs by using alternative and efficient routes of access to substance abuse professionals and by providing care designed to reduce hospitalization and emergency department usage.

Starting Point/Baseline:

Substance Abuse services are being provided only in Wichita County. The expected outcome at the end of the waiver is to have a staffed Substance Abuse division at additional key locations, providing Substance Abuse services on a routine basis.

Rationale:

During the month of 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 outside Wichita County at this time. Enhancing service availability for substance abuse services will help meet this need. 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 1 in 8 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[13]. Many patients could be diverted from emergency departments if an immediate Substance Abuse screenings/ interventions were available. Enhancing substance abuse service availability for additional counties requires an expansion of those services into that underserved area. The milestones and metrics were chosen based on the elements required to be in place 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). CNA reference numbers are CN.2 and CN.5. The project enhances care delivery by providing the Substance Abuse intervention dimension which 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 healthcare which includes Substance Abuse services.

[13] 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.

Related Category 3 Outcome Measure(s):

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 1 in 8 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[14]. Many patients reporting improved QOL ratings may also be diverted from emergency departments if an 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 developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of patients Haskell, Knox, and Stonewall counties. The milestone increases to 10% for year 5.

Relationship to other Projects:

This Substance Abuse expansion project is related to project "127373205.1.2 Improve access to specialty care" in that it is providing access to a service that would otherwise require a long wait or not be available in the region.

Relationship to Other Performing Providers' Projects in the RHP:

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 Haskell, Knox, and Stonewall counties with the Helen Farabee Center catchment area. We do not believe the project duplicates another provider's intervention for the same target population in these counties.

Plan for Learning Collaborative: N/A

[14] 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.

Project Valuation:

This project serves the population located in Haskell, Knox and Stonewall counties. We estimate ~~providing substance abuse services to~~ 60 persons may be in need of substance abuse services based on substance abuse arrest records by county. The project seeks to provide substance abuse services to 35 consumers by 9/30/14, increasing services by 10% (39) and 15% (40) over baseline for Demonstration Years 4 and 5, respectively. The benefit to the community is in the form of outpatient access to local substance abuse services which avoids costs associated with emergency department usage or hospitalization. Local funding is in the form of IGT from Helen Farabee Center.

Substance abuse imposes a heavy burden on emergency room 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[15]. That savings amount was determined based on costs saved from incarceration, hospitalization, emergency department usage, and homelessness.

[15] 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.***	
[The Helen Farabee Center]				*[127373205]*
Related Category 3 Outcome Measure(s):	*IT-10.1*	*127373205.3.1*	*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)**
Process Milestone 1: P-2. Milestone: Identify licenses, equipment requirements and other components needed to implement and operate options selected Metric 1; P-2.1. Metric: 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.	**Process Milestone 3**: P-6. Milestone: Establish behavioral health services in new community-based settings in underserved areas Metric 3: P-6.1. Metric: Number of new community-based settings where behavioral health services are delivered Baseline/Goal: Provide Substance Abuse services to 35 consumers by 09-30-14. Data Source: Number of patients served at these new community-based sites Milestone 3 Estimated		**Improvement Milestone 1**: I-11. Milestone: Increased utilization of community behavioral healthcare Metric 1: I-11.1. Metric: Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare services from new substance abuse division after access expansion b. Denominator: Number of people receiving community behavioral health services after access expansion. Goal: To increase the provision	**Improvement Milestone 2**: I-11. Milestone: Increased utilization of community behavioral healthcare Metric 2: I-11.1. Metric: Percent utilization of community behavioral healthcare services. a. Numerator: Number receiving community behavioral healthcare services from new substance abuse division after access expansion b. Denominator: Number of people receiving community behavioral health services after access expansion. Goal: To increase the provision

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.***	
[The Helen Farabee Center]				*[127373205]*
Related Category 3 Outcome Measure(s):	*IT-10.1*	*127373205.3.1*	*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)**
▯ 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 *(maximum amount):* $40,938.50 **Process Milestone 2:** P-4. Milestone: Hire and train staff to operate and manage projects selected Metric 2:	Incentive Payment: $44,258 **Milestone 4**: P-7. Milestone: Evaluate and continuously improve services Metric 4: P-7.1. Metric: 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 real-time data is used for rapid-cycle improvement to		of Substance Abuse services by 10% over baseline by 09-30-15 Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 1 Estimated Incentive Payment: $94,635	of Substance Abuse services by 15% over baseline by 09-30-16 Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. Milestone 2 Estimated Incentive Payment: $91,382

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.***	
[The Helen Farabee Center]				*[127373205]*
Related Category 3 Outcome Measure(s):	*IT-10.1*	*127373205.3.1*	*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)**
P-4.1. Metric: Number of staff secured and trained Baseline/Goal: Hire and train one Licensed Chemical Dependency Counselor to provide Substance Abuse services. Data Source: Project records; Training curricula as develop in P-2 Milestone 1 Estimated Incentive Payment *(maximum amount):* $40,938.50	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: $44,259			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $81,877	Year 3 Estimated Milestone Bundle Amount: $88,517		Year 4 Estimated Milestone Bundle Amount: $94,635	Year 5 Estimated Milestone Bundle Amount: $91,382

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.***	
[The Helen Farabee Center]				*[127373205]*
Related Category 3 Outcome Measure(s):	*IT-10.1*	*127373205.3.1*	*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):* $356,410				

Summary Information (RHP 11):CAT 1 1.2 Open Access

- Provider: The Helen Farabee Center is a Community Mental Health/Intellectual & Developmental Disability authority/provider with 9 clinics in north-central Texas serving 19 counties across 16,705 square miles and a population of 318,665.

- Intervention(s): This project expands the hours for psychiatric evaluation by expanding our current contract for telemedicine services. 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.

- Need for the project: Currently, the average wait time for an initial psychiatric evaluation is ten 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 occurring within 1 business day.

- Medicaid and Uninsured Target population: The Center serves primarily indigent clients and roughly 30% of them have Medicaid.

- Category 1 or 2 expected patient benefits: The project seeks to provide on-demand psychiatric evaluations to roughly 11 patients in DY2 increasing to 15 and 16 over Demonstration Years 4 and 5, respectively. Another goal is to increase the number of unique patients from a baseline of roughly 200 in the region by 2.5% over baseline (205) increasing to 5% (210) over Demonstration Years 4 and 5, respectively.

- Category 3 outcomes: IT-10.1. Our goal is improve quality of life scores for 5% of on-demand evaluation recipients, increasing to 10% in Demonstration Years 4 and 5 respectively.

Category 1: Infrastructure Development

Project Option: 1.9.2– Improve Access to Specialty Care

Unique Project ID: 127373205.1.2

Facility Description: Helen Farabee Center 127373205

Project Description:

This project expands the hours for psychiatric evaluation by expanding our current contract for telemedicine services. 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. 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. Currently, the average wait time for an initial psychiatric evaluation is ten 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. 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.

Regional goals are in accordance with CMS' Triple Aim which is Right Service, Right Setting, Right Time. This project provides an on-demand psychiatric evaluation for routine mental health inquiries as opposed to delayed or crisis-oriented services (Right Service). The services are provided at community access points and not in costly emergency departments (Right Setting). Finally, the services are provided at the right time which is within 1 business day of the inquiry in order to begin treatments quickly if indicated (Right Time). This project improves patient experience by providing timely access to care. It improves health by creating a system

to begin treatment sooner. It is designed to reduce costs by using alternative and efficient routes of access to prescribing professionals and by providing care designed to reduce hospitalization and emergency department usage.

Starting Point/Baseline:

Although the Center provides scheduled psychiatric evaluations for these counties per year, 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 up other prescribers to provide quicker follow up encounters. Neufeld, et al. (2012)[16] 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[17], and potentially reduce emergency department usage by individuals in Haskell, Knox and Stonewall counties. The project component (increasing service availability with extended hours) was chosen in order to provide a cost-effective and concrete way to improve access to psychiatric services. Core component (b) "Increase the number of specialty clinic locations" was not address since our region has an adequate number of physical access points. Component (c) "Implement transparent , standardized referrals across the system" is chosen in order to ensure efficient access to the new on-demand evaluation services. Component (d) "Conduct quality improvement for project using methods such as rapid cycle improvement" was selected in order to maintain quality of access while also tracking and reporting on utilization at frequent intervals. The project component (increasing service availability with extended hours) was chosen in order to provide a cost-effective[18] and concrete way to improve access to psychiatric services. 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 efficiency in the referral process. 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. CNA reference numbers are CN.2 and

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[16] 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

[17] The American Psychiatric Association's 2012 Annual Meeting. Abstract SCR10-3, presented May 6, 2012.

[18] 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

CN.5. The project significantly enhances the existing delivery of psychiatric evaluations by eliminating the potentially 10 week wait for medical interventions for routine behavioral health conditions. The open-access model is designed to provide psychiatric evaluations the same day as or next business day following the determination that they are eligible for services.

Related Category 3 Outcome Measure(s):

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 1 in 8 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[19]. 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 developmental year 4 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 Haskell, Knox and Stonewall counties. The milestone increases to 10% for year 5.

Relationship to other Projects:

The Project relates to "127373205.1.1 Expand the number of community based settings where behavioral health services may be delivered in underserved areas" 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 in the RHP:

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 Haskell, Knox, and Stonewall counties within the Helen Farabee Center catchment area. 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.

[19] 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.

Plan for Learning Collaborative: N/A

Project Valuation:

This project serves the population located in Haskell, Knox and Stonewall counties. We estimate providing intakes to 11 patients in DY2 based on past demand and current usage patterns. The impact increases to 15 in DY4 and 16 in DY5. The benefit to the community is in the form of on-demand access to services which avoids costs associated with emergency department usage or hospitalization. Local funding is in the form of IGT from Helen Farabee Center. This project is not receiving other federal funding.

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 room visits that are avoided). In order to make the valuations fair across potentially different types of interventions the common health goal, or outcome, is the number of life-years added. 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)[20] 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)[21] 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.

[20] 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.

[21] 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.

127373205.1.2	***1.9.2***	***1.9.2.A***	***IMPROVE ACCESS TO SPECIALTY CARE.***
[The Helen Farabee Center]			*[127373205]*
Related Category 3 Outcome Measure(s):	*3.10.1*	*127373205.3.2*	*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)**
Process Milestone 1: P-3. Milestone: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1: P-3.1. Metric: Establish baseline for performance indicators a. Numerator: Total number of days patients waited from evaluation request to evaluation encounter. b. Denominator: Number of clients requesting psychiatric evaluations (estimated 11 for DY2) Baseline/Goal: To determine the average wait time for an initial psychiatric evaluation.	**Process Milestone 4:** P-8. Milestone: Develop the technical capabilities to facilitate electronic referral Metric 4: P-8.1. Metric: 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 *(maximum*	**Improvement Milestone 1:** I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). a. Total number of visits for reporting period Goal: To increase the number of psychiatric evaluations by 5% over baseline by 09-30-15 (estimated 15)	**Improvement Milestone 2:** I-23. Milestone: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 2: I-23.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2). a. Total number of visits for reporting period Goal: To increase the number of psychiatric evaluations by 10% over baseline by 09-30-16 (estimated 16)

127373205.1.2	***1.9.2***	***1.9.2.A***	***IMPROVE ACCESS TO SPECIALTY CARE.***	
[The Helen Farabee Center]				*[127373205]*
Related Category 3 Outcome Measure(s):	*3.10.1*	*127373205.3.2*	*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: EHR, Internal Database Milestone 1 Estimated Incentive Payment *(maximum amount):* $4,220.33 **Process Milestone 2:** P-7. Milestone: Complete a planning process/submit a plan to implement electronic referral technology (choose at least one metric): Metric 2: P-7.2. Metric: Development of an implementation plan for e-referral Baseline/Goal: Develop a plan that will guide the implementation and technical needs of e-referrals for the on-	*amount): 5* $5,099 **Process Milestone 5:** P-9. Milestone: Implement referral technology and processes that enable improved and more streamlined provider communications Metric 5: Documentation of referrals technology Baseline/Goal: With improved technology and e-referral, to establish more efficient and fluid communication among providers for the on-demand model of care Data Source: Referral system Milestone 5 Estimated Incentive Payment *(maximum*		Data Source: Registry, EHR, claims or other Performing Provider source 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). 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 1 Estimated Incentive Payment: $16,421	Data Source: Registry, EHR, claims or other Performing Provider source 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). 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 Milestone 2 Estimated Incentive Payment: $15,919

127373205.1.2	***1.9.2***	***1.9.2.A***	***IMPROVE ACCESS TO SPECIALTY CARE.***	
[The Helen Farabee Center]				*[127373205]*
Related Category 3 Outcome Measure(s):	*3.10.1*	*127373205.3.2*	*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)**
demand model Data Source: Referral plan, which describes the technical mechanisms needed to operate e-referral system. Milestone 2 Estimated Incentive Payment *(maximum amount):* $4,220.33 **Process Milestone 3:** P-2. Milestone: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties Metric 3: P-2.1. Metric: Training of staff and providers on referral guidelines, process and	*amount):* $5,099 **Process Milestone 6:** P-11. Milestone: Launch/expand a specialty care clinic (e.g., pain management clinic) Metric 6: P-11.1. Metric: Establish/expand specialty care clinics a. 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			

127373205.1.2	***1.9.2***	***1.9.2.A***	***IMPROVE ACCESS TO SPECIALTY CARE.***	
[The Helen Farabee Center]				*[127373205]*
Related Category 3 Outcome Measure(s):	*3.10.1*	*127373205.3.2*	*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)**
technology a. Numerator: Number of staff and providers trained and documentation of training materials b. 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 efficient and effective service for the consumer. Data Source: Log of specialty care personnel trained and Curriculum for training. Milestone 3 Estimated Incentive Payment *(maximum amount):* $4,220.33	Incentive Payment *(maximum amount):* $5,099			

127373205.1.2	***1.9.2***	***1.9.2.A***	***IMPROVE ACCESS TO SPECIALTY CARE.***	
[The Helen Farabee Center]				*[127373205]*
Related Category 3 Outcome Measure(s):	*3.10.1*	*127373205.3.2*	*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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $12,661	Year 3 Estimated Milestone Bundle Amount: $15,297		Year 4 Estimated Milestone Bundle Amount: $16,421	Year 5 Estimated Milestone Bundle Amount: $15,919
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $60,298				

Hendrick Medical Center
Category 1 – Primary Care Physician Recruitment
138644310.1.1
Pass 1

Summary Information:
Provider: Hendrick Medical Center is a 522 bed hospital in Abilene Texas serving a 105 square mile area and a population of approximately 117,000.
Intervention(s): This project will expand primary care capacity through the recruitment of several primary care physicians and will help make up for the lack of primary care that is currently available.
Need for the Project: Currently we are very short in primary care by five physicians according to the 1 per 5000 ratio of primary care physicians to patients served.
Medicaid and Uninsured Target Population: Any patient needing primary care services is our target population. Approximately 22% of our patients are either Medicaid, indigent, or uninsured so we expect about a quarter of the population served to benefit greatly from this expansion of primary care capacity.
Category 1 or 2 Expected Patient Benefits: By hiring an additional 4 primary care physicians we expect to serve an additional 10,000 to 20,000 patients by the end of DY5. The goal will be to see an estimated 2500 patients per year. This would be for DY's 2 and 3. DY 4 will increase by 1% over the established baseline up to 2525 & DY 5 will increase by 2% over the established baseline up to 2550. 22% of our population is considered Medicaid or Indigent care, so about 1 out of every 4 people seen will most likely fall into this category. A good estimate of the Medicaid or Indigent population that would be seen by these physicians would be about 600 to 650 per DY.
Category 3 Outcomes:

IT-12.1. Our goal is to increase primary care volume, thus increasing the amount of breast cancer screenings that are conducted.

IT-12.2. Our goal is to increase primary care volume, thus increasing the amount of cervical cancer screenings that are conducted.

IT-12.4. Our goal is to increase primary care volume, thus increasing the amount of pneumonia vaccinations for older adults.

Project Title: Hendrick Medical Center

Category 1 – Infrastructure Development

Project Option: 1.1.1 – Primary Physician Recruitment

Unique Project ID: 138644310.1.1

Facility Description: Hendrick Medical Center-138644310

Project Description:

Several primary care physicians will be recruited to serve the community. Our goal is to expand the capacity of primary care to better accommodate the needs of the regional patient population and community, as identified by the RHP needs assessment, so that patients have enhanced access to services, allowing them to receive the right care at the right time in the right setting. Project plans related to access to primary care services should address current challenges to the primary care system and patients seeking primary care services, including: expanded and/or enhanced system access points, barriers to transportation, and expanded or enhanced primary care services to include urgent care. There will be additional primary care access points to offer a larger coverage area for the patients in the community. In 5 years we expect to have 4 additional primary care physicians recruited and setup in additional clinic space. This will greatly increase the access to primary care throughout our community. Through the recruitment and retention of these primary care physicians, more patients will have the access to care that they desperately need when they need it. The current challenge that we face as a provider is being able to offer the demand of primary care that this community needs. Because we are so low on primary care physicians, this project will help increase primary care capacity for the community. The project is related to regional goals in the sense that the region as a whole needs more primary care physicians to increase the capacity for the entire region because as a region we are lacking in this area.

Starting Point/Baseline:

Baseline data will be established in DY 2 based on the primary care clinic volume in that year, which is estimated to be about 2500 patients. In DY 3 our goal is to hire an additional primary care physician. In DY 4 & 5 we will increase primary care volume by 1% in DY 4 which will be an estimated 2525 visits and by 2% in DY 5 which will be an estimated 2550 visits over the baseline established in DY2 once that baseline has been established. The total estimated patient volume at the end of DY 5 will be around 10,075.

Rationale:

The project option was selected because through the recruitment of four additional primary care providers over the next four years we will be establishing additional primary care clinic space to serve the community. Recruiting this many primary care physicians in four years will significantly enhance the existing amount of patients being served in the community. The milestones and metrics chosen relate directly to the RHP's population and circumstances by addressing the need of the community in the area of primary care and the additional capacity that is desperately needed for our region and community. This project greatly enhances an existing initiative to expand primary care in our region and community in order to meet the needs of the patients that need this care. In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. By enhancing access points, available appointment times, patient awareness of available services and overall primary care capacity, patients and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, and appropriate utilization and reduced cost of services. American College of Physicians explains the importance of primary care providers by stating, "The research, literature and policy all clearly demonstrate that primary care physicians deliver high-quality care, reduce mortality, provide continuity of care, and reduce health care costs."
(http://www.acponline.org/pressroom/primary_shortage.htm)
This project addresses community need number CN.3.

Related Category 3 Outcome Measure(s):

- OD-12: Primary Care and Primary Prevention
- IT-12.1: Breast Cancer Screening
- IT-12.2: Cervical Cancer Screening
- IT-12.4: Pneumonia vaccination status for older adults

The Category 3 outcomes in DY 4 & 5 include Breast Cancer Screenings, pneumonia vaccination status for older adults & Cervical Cancer Screenings. Reporting on the screenings will help evaluate the population and will help determine those statistics necessary to care for the patients in the community. These outcomes are a priority for the RHP because the cancers screenings yield early detections and the vaccinations can prevent diseases like pneumonia, both of which can save older adults' lives. The related category 1 project of primary care can help achieve the category 3 outcomes measures selected because the primary care physicians will be conducting breast cancer screenings, cervical cancer screenings and pneumonia vaccinations. Giving the low-income population greater access to primary care will lower their healthcare costs because they will avoid emergency department visits which are costly and inappropriate in non-emergent circumstances. This will also help improve the health of low-income populations by giving them a much greater access to primary care.

Relationship to other Projects:

This project supports RHP project identification number 138644310.2.2 because the primary care physicians will help identify patients that need to utilize the chronic care management model. This project also relates to PPA's, PPR's, PPC's, Patient Centered Healthcare & Emergency Department Category 4 measures because it can help reduce the inappropriate emergency room visits, PPA's, PPR's & PPC's significantly through the proper identification of the right care and right setting for the patient by the primary care physician, thus giving them the patient centered healthcare that they deserve.

Relationship to Other Performing Providers' Projects in the RHP:

This project relates to several primary care projects in the region. Providers with similar projects include: Anson, Hamlin Memorial Hospital, Haskell Memorial Hospital, Mitchell County Hospital and Palo Pinto General Hospital, The goal for the region with regard to these projects is to fill the huge gap that we have in relation to primary care physicians and primary care capacity within the region. With an expansion of primary care throughout our region we can make up for that gap and better serve the patients in our region by offering them more access to primary care.

Plan for Learning Collaborative:

There is a potential plan for learning collaborative between Palo Pinto, our Anchor, and the rest of the region in regards to primary care across the region.

Project Valuation:

We plan to expand the capacity of primary care to better accommodate the needs of the regional patient population and communities within. Patients will have enhanced access to services, allowing them to receive the right care at the right time in the right setting. By recruiting physicians we are able to expand primary care health access for the community giving them greater access to the care that they need, when they need it. We will recruit several primary care physicians to serve the community. The investment will be high because we plan on hiring 4 new primary care physicians over the next 4 years to serve the community. Although this is costly it will provide care to approximately 10,000 to 20,000 more patients in the community by the end of DY 5. The goal will be to see an estimated 2500 patients per year. This would be for DY's 2 and 3. DY's 4 will increase by 1% over the established baseline up to 2525 & DY 5 will increase by 2% over the established baseline up to 2550. These factors combined together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and addresses priority community need that is required to establish a valuation. Based on the criteria mentioned above we were able to come up with the valuation.

138644310.1.1	***1.1.1***	***1.1.1***	***PRIMARY CARE PHYSICIAN RECRUITMENT***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.1, 138644310.3.2, 138644310.3.3*	*IT-12.1, IT-12.2, IT-12.4*	*Breast Cancer Screening* *Cervical Cancer Screening* *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-1]: Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1]: *Number of additional clinics or expanded hours or space. Documentation of detailed expansion plans.* Baseline/Goal: The goal is to establish additional primary care clinic space and to establish a baseline for primary care volume in the new clinic space. This volume is estimated to be 2500. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing	**Milestone 3** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: The goal is to hire an additional primary care physician to serve the community. The volume in DY 3 is estimated to be 2500. 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		**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 reporting period (baseline for DY2). Goal: to increase primary care volume by 1% over the baseline established in DY2. The goal will be to see 2525 patients in DY 4. Data Source: Registry, EHR, claims or other performing provider source Milestone 4 Estimated Incentive Payment: $2,798,779	**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 reporting period (baseline for DY2). Goal: to increase primary care volume by 2% over the baseline established in DY2. The goal will be to see 2550 patients in DY 5. Data Source: Registry, EHR, claims or other Performing Provider source Milestone 5 Estimated Incentive Payment: $2,259,883

138644310.1.1	***1.1.1***	***1.1.1***	***PRIMARY CARE PHYSICIAN RECRUITMENT***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.1, 138644310.3.2, 138644310.3.3*	*IT-12.1, IT-12.2, IT-12.4*	*Breast Cancer Screening* *Cervical Cancer Screening* *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. Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,370,370 *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.* *Goal: The goal is to hire an additional primary care provider to serve the community.*	documentation Milestone 2 Estimated Incentive Payment: $2,803,125			

138644310.1.1	***1.1.1***	***1.1.1***	***PRIMARY CARE PHYSICIAN RECRUITMENT***
Hendrick Medical Center			*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.1, 138644310.3.2, 138644310.3.3*	*IT-12.1, IT-12.2, IT-12.4*	*Breast Cancer Screening* *Cervical Cancer Screening* *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)**
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):* $1,370,370			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,740,740	Year 3 Estimated Milestone Bundle Amount: $2,803,125	Year 4 Estimated Milestone Bundle Amount: $2,798,779	Year 5 Estimated Milestone Bundle Amount: $2,259,883
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $10,602,527			

Hendrick Medical Center
Category 1 – Psychiatrist Recruitment
138644310.1.2
Pass 2

Summary Information:
Provider: Hendrick Medical Center is a 522 bed hospital in Abilene Texas serving a 105 square mile area and a population of approximately 117,000.
Intervention(s): Currently we do not have a psychiatrist to provide specialty care to the trauma center in certain situations and also to the rest of the community.
Need for the Project: Currently we do not have a psychiatrist to serve the community and by recruiting a psychiatrist we will be providing specialty care to patients that currently do not have this type of care available to them. This project is funded through the collaboration option. This project will reach the entire region. It gives the region additional access to a psychiatrist and their services. Currently there is not a psychiatrist that serves in the capacity this one will serve in. This psychiatrist will have a clinic and will be able to see patients from the region that needs services for mental health. Also this psychiatrist might be available to the ED in some circumstances. This could really help when patients come into the ED and they need access to a psychiatrist. Right now we are not able to provide that service. This project is truly transformative to the region because it will provide specialty care services that currently are not sufficient or non-existent in the region. Hendrick Medical Center will be the only entity that will be implementing this project.
Medicaid and Uninsured Target Population: Any patient that is in need of psychiatry care is our target population. Approximately 22% of our patients are either Medicaid, indigent, or uninsured so we expect about a quarter of the population served to benefit greatly from this expansion of services.
Category 1 or 2 Expected Patient Benefits: This project seeks to dramatically increase the number of specialty care referrals by DY5. The goal will be for the psychiatrist to provide care to an estimated 600 patients in DY 3, 606 patients in DY 4 and 612 patients in DY 5. About one out of every 4 of these patients will be considered Medicaid, Indigent, or Uninsured. This volume is difficult to estimate at this time because we currently do not offer these types of services and this will truly be a new practice so these are just based upon estimates. If our Psychiatrist sees 600 patients in DY 3, 606 patients in DY 4 and 612 patients in DY5 then by the end of DY 5 the Psychiatrist would see an estimated 1,818 patients.
Category 3 Outcomes: IT-9.1. The goal is to decrease mental health admissions and readmissions to criminal justice settings such as jails or prisons by 1% in DY4 under the baseline established in DY3 and by 2% in DY5 under the baseline established in DY3.

Pass 2
Project Title: Hendrick Medical Physician Recruitment

Category 1: Infrastructure Development – Psychiatrist Recruitment

Project Option: 1.9.2 – Expand Specialty Care Capacity – Psychiatrist Recruitment

Unique Project ID: 138644310.1.2

Facility Description: Hendrick Medical Center-138644310

- The suggested ratio for psychiatry is 1 physician per 17,000 patients. Our service area is about 13 short according to this ratio. Our level 3 trauma center has no psychiatry coverage and a psychiatrist is needed to cover the emergency room in certain situations. The only psychiatrists in town are associated with the Behavioral Health Community Center and the Psych Hospital (Acadia). We are hoping to recruit 1 solo psychiatrist to serve both the emergency department and to expand specialty care access to patients in the community and the region. Our intent is to increase referrals from the community and region to the specialty care clinic that houses the psychiatrist, through our specialty care gap analysis and the expansion of ambulatory care. This project is based on the community need of expansion of specialty care. It is evident that there is poor performance in this area within the community and region because we currently do not have a psychiatrist to serve the community.

Project Description:

- Our purpose of this project is to expand specialty care through the recruitment of a psychiatrist. The goal of this project is to increase the capacity in order to provide specialty care services and increase the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty care. We estimate about 1818 patients will be seen by the end of DY 5 based on the estimated DY's 3, 4 & 5 volume. If our Psychiatrist sees 600 patients in DY 3, 606 patients in DY 4 and 612 patients in DY5 then by the end of DY 5 the Psychiatrist would see an estimated 1,818 patients. The services that will be provided are psychiatric services geared toward improving mental health. The challenge we currently face with this is the fact that we currently do not have a psychiatrist and by recruiting one we would definitely be addressing that challenge. With regard to specialty areas of greatest need, the recent report of the Committee on Physician Distribution and Health Care Access cites psychiatry, general and preventive medicine, and child and

adolescent psychiatry where the ratios per 100,000 populations are 56.7%, 60.2%, and 67% of the US ratios, respectively. Federal funding (Medicare Direct Graduate Medical Education or DGME) for residency training is capped at 1996 levels for the direct support of graduate medical education. The cap only supports a third of the costs of 4,056 of the 4,598 actual positions in Texas, leaving the residency programs to cover the cost of two-thirds of the 4,056 positions and the full cost of 542 positions. Texas is currently over its Medicare cap by 13%. Residency programs require 3 to 8 years of training, depending on the specialty. Medicare funding only covers years 1 through 3. In 2011, Texas had more than 550 residency programs, offering a total of 6,788 positions. Only 22% (1,494) of theses were first-year residency positions. According to the Coordinating Board, conservative estimates indicate that the cost to educate a resident physician for one year is $150,000. Hence, a great need for extended residency programs in Texas and increase in the number of specialists. By recruiting a psychiatrist we are able to expand behavioral health access for the community giving them greater access to the care that they need. In 5 years the psychiatrist will have established its clinic and presence in the region and community and will have seen many patients in the region and community. This will also help to serve the patients in an emergency room setting. Our expected result is to have developed a workforce enhancement initiative to support access to specialty providers in underserved markets and areas (recruitment and retention). This project is related to regional goals because as a region we would like to expand behavioral health and access to specialty care such as a psychiatrist so that the communities in our region can benefit from that care since we are extremely short in this specialty.

Starting Point/Baseline:

- Baseline data will be established in DY 3 because we currently do not have a Psychiatrist to serve the community and that will be the first year they will serve the community. The baseline data will be based off of expected patient visits and is expected to be an estimated 600 patients. In DY 2 the goal is to conduct a needs assessment to try and affirm the need for recruitment of a psychiatrist. DY 3 will be the actual year that we hire a psychiatrist to serve the community and also providing additional expanded care for the ED, as well as determine our baseline. In DY 4 the goal is to increase the number of referrals of targeted patients to the specialty care clinic by 1% compared to the baseline. In DY 5 the goal is to Increase the number of referrals of targeted patients to the specialty care clinic by 2% compared to the baseline.

Rationale:

- This project option and core project components were selected because it directly relates to the recruitment of a psychiatrist. This project will allow us to increase the service availability with extended hours because we will recruit a new psychiatrist. The plan is to also increase clinic space which will increase the number of specialty clinic locations. The implementation of transparent, standardized referrals across the system will occur within this new clinic. Quality improvement for this project will continually be dynamic because there will be a constant identification of lessons learned and key challenges faced associated with the implementation of the project. Also, we will meet internally semi-annually to

discuss the items identified from the quality improvement process. 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. The milestones and metrics chosen relate directly to the RHP's population and circumstances by addressing the need of the community in the area of specialty care and the additional capacity that is desperately needed for our region and community. This project represents a new initiative because we currently do not have a psychiatrist that serves our community. The Rhode Island Psychological Association discusses the importance of mental health in the community by stating, "Mental Health Improves the Quality of Life. Mental health strengthens and supports our ability to: have healthy relationships, make good life choices, maintain physical health and well-being, handle the natural ups and downs of life, discover and grow toward our potential. Many research studies have shown that when people receive appropriate mental health care, their use of medical services declines. For example, one study of people with anxiety disorders showed that after psychological treatment, the number of medical visits decreased by 90%, laboratory costs decreased by 50%, and overall treatment costs dropped by 35%. Other studies have shown that people with untreated mental health problems visit a medical doctor twice as often as people who receive mental health care. Excessive anxiety and stress can contribute to physical problems such as heart disease, ulcers, and colitis. Anxiety and stress can also reduce the strength of the immune system, making people more vulnerable to conditions ranging from the common cold to cancer. Psychological problems also increase the likelihood that people will make poor behavioral choices which can contribute to medical problems. Smoking, excessive alcohol or drug use, poor eating habits, and reckless behavior can all result in severe physical problems and the need for medical services. (http://www.ripsych.org/index.php?option=com_content&view=article&id=38)

- This project addresses community need number CN.3.

Related Category 3 Outcome Measure(s):

- OD-9: Right Care, Right Setting
- IT-9.1: Decrease in mental health admissions to criminal justice settings such as jails and prisons.
- Category 3 outcome measures include in DY4 & DY5 the right care in the right setting. This outcome measure was chosen because it measures the decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. A psychiatrist can directly affect this population. This category 1 project will help achieve the category 3 outcome measure because hiring a psychiatrist will give people better access to specialty care when they need it. Because we currently don't have a psychiatrist to serve this population it is definitely a priority. Most of the prison population and others in the community are considered low income and indigent. These populations will benefit from this because they will have the right care in the right setting when they need it.

Relationship to other Projects:

- This project supports RHP project identification number 138644310.1.1 by also increasing the capacity of care available to the community. If we can provide a specialty care provider then we are able to meet the needs of the community in relation to specialty care. This also relates to PPA's, PPR's, PPC's, Patient Centered Healthcare & Emergency Department Category 4 measures. It relates to PPA's, PPR's and PPC's through the proper identification of the right care and right setting for the patient by the psychiatrist, thus giving them the patient centered healthcare that they deserve.

Relationship to Other Performing Providers' Projects in the RHP:

- This project relates to several specialty care projects in the region. Providers with similar projects include: Betty Hardwick Center, Eastland Memorial Hospital, Helen Farabee Center, Pecan Valley Centers, and Rolling Plains Memorial Hospital. The goal for the region with regard to these projects is to fill the huge gap that we have in relation to specialty care. With an expansion of specialty care through the recruitment of a psychiatrist, throughout our region, we can make up for that gap and better serve the patients in our region by offering them more access to specialty care.

Plan for Learning Collaborative:

- At this time there is no plan for learning collaborative with this project.

Project Valuation:

- The goals are to increase the capacity to provide specialty care services, and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty care. A psychiatrist will be recruited and will begin serving the local community and the region. The goal will be for the psychiatrist to treat an estimated 1818 patients by the end of DY 5. The goal will be for the psychiatrist to provide care to an estimated 600 patients in DY 3, 606 patients in DY 4 and 612 patients in DY 5. The suggested ratio of psychiatrist to patients is about 1 per 17,000 population. According to that ratio we are about 13 short for our county and surrounding areas. This is why recruiting a psychiatrist is so valuable and important to our community and the surrounding region. Our region desperately needs a psychiatrist to serve the local communities of our region because of this shortage. This specialist will serve the community and cut costs because patients will have other options besides the ED. By recruiting a psychiatrist we are able to expand behavioral health access for the community giving them greater access to the care that they need. The project size will reach a huge population. All of Taylor county and the surrounding counties do not have a psychiatrist to serve the community in this capacity. Recruiting one would serve many people in the community. This investment will be large because it will entail hiring a specialist that will serve Taylor County and potentially surrounding communities. These factors combined together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and addressing priority community need. Based on the criteria mentioned above we were able to come up with the valuation.

138644310.1.2	***1.9.2***	***1.9.2.A, 1.9.2.B, 1.9.2.C, 1.9.2.D***	***PSYCHIATRIST RECRUITMENT***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.8*	*IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need. Metric 1 [P-1.1]: Documentation of gap assessment. Demonstrate improvement over prior reporting period. Baseline/Goal: The goal will be to conduct a specialty care gap assessment based on the community need in order to identify the need for a psychiatrist. Data Source: Needs Assessment Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,988,911	**Milestone 2** [P-4]: Expand the ambulatory care medical specialties referral management department and related functions. Metric 1 [P-4.1]: Referral Management system utilization. Numerator: Number of unique referrals placed and tracked within the system during the reporting period. Denominator: total number of referrals made to the specialty practice during the reporting period. Baseline/Goal: The goal will be to track the number of referrals placed and tracked within the system. Data Source: Reports generated by the referral management system, EMR and		**Milestone 4** [I-29]: Increase the number of referrals of targeted patients to the specialty care clinic. Metric 1 [I-29.1]: Targeted referral rate. Number of referrals of targeted patients. Goal: to increase referrals of targeted patients by 1% over the baseline established in DY 3. The goal is to increase referrals to an estimated 606. Data Source: Registry and/or paper documentation as designated by Performing Provider. Milestone 4 Estimated	**Milestone 5** [I-29]: Increase the number of referrals of targeted patients to the specialty care clinic. Metric 1 [I-29.1]: Targeted referral rate. Number of referrals of targeted patients. Goal: to increase referrals of targeted patients by 2% over the baseline established in DY 3. The goal is to increase referrals to an estimated 612. Data Source: Registry and/or paper documentation as designated by Performing Provider. Milestone 5 Estimated Incentive Payment: $1,633,172

138644310.1.2	***1.9.2***	***1.9.2.A, 1.9.2.B, 1.9.2.C, 1.9.2.D***	***PSYCHIATRIST RECRUITMENT***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.8*	*IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	other administrative reports as needed. Milestone 2 Estimated Incentive Payment: $1,018,299 **Milestone 3** [I22]: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]: Number of specialist providers in targeted specialties over baseline or change in the number of specialist providers in targeted specialties. Denominator: Number of monthly or annual referrals into targeted medical specialties clinic or number of		Incentive Payment: $2,044,026	

138644310.1.2	***1.9.2***	***1.9.2.A, 1.9.2.B, 1.9.2.C, 1.9.2.D***	***PSYCHIATRIST RECRUITMENT***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.8*	*IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	specialist providers in targeted specialties at baseline. Baseline/Goal: The goal is to hire a psychiatrist to help serve the community. The baseline will also be established in DY 3 based on the patients seen by the psychiatrist. This is estimated to be about 600 patients. Data Source: HR documents or other documentation demonstrating employed/contracted specialists. Milestone 3 Estimated Incentive Payment: $1,018,298			

138644310.1.2	***1.9.2***	***1.9.2.A, 1.9.2.B, 1.9.2.C, 1.9.2.D***	***PSYCHIATRIST RECRUITMENT***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.8*	*IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons.*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,988,911	Year 3 Estimated Milestone Bundle Amount: $2,036,597		Year 4 Estimated Milestone Bundle Amount: $2,044,026	Year 5 Estimated Milestone Bundle Amount: $1,633,172
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $7,702,706				

Pass 3B
Summary Information
Unique Project ID: New 136325111.1.2
Old 136325111.1.1

- Provider: Mitchell County Hospital is a 25 bed critical access hospital serving a population of over 10,000 people. The population we serve is every aging with 22.95 % between the ages of 55-64, 14.91 % between the ages of 65-74,19.5 % over 75 with 19 % below the federal poverty level.

- Intervention(s): The plan that we are proposing is to hire two (2) additional Primary Care Providers for our Rural Health Clinic which will allow us to offer additional office visits for our community.

- Need for the project: We currently have three (3) Primary Care Physicians in our Rural Health Clinic. One (1) has submitted his resignation which will put us in an position to fill a slot immediately. We had a Community Health Needs Assessment conducted in 2011 and the one of the major factors coming out of the report was the community feels that we need additional Primary Care Providers. With the every aging population here we feel the need to add one (1) additional Primary Care Provider to meet the future needs of the community.

- Medicaid and Uninsured Target population: The target population will be those patients that are not able to get the same day visit with our Primary Care Providers and are going to our Emergency Department to be seen. This would be all patient financial classes including our Medicaid and uninsured population.

- Category 1 or 2 expected patient benefits: Patients that currently have to visit our emergency department due to not being able to schedule a same day visit with our Rural Health Clinic will be able to have greater access to a Primary Care Provider with the hiring of additional Providers. This will reduce costs to our patients as the cost for an Rural Health Clinic visit is less than an emergency room visit.

- Category 3 outcomes: IT-9.2 The goal of this plan/project is to provide the right care in the right setting by increasing the number of patient appointments in DY 4 and DY 5 over the baseline in DY 3 by 5%.

Category 1: Infrastructure Development

Project Option: 1.1.2 – Expand Primary Care Capacity

Unique Project ID: New 136325111.1.2
Old 136325111.1.1

Facility Description: Mitchell County Hospital District 13632511

Project Description:

Mitchell County Hospital District is a designated Critical Access Hospital with Level IV Trauma Certification located on Interstate 20; 80 miles west of Abilene, 79 miles east of Midland, 85 miles north of San Angelo and 90 miles south of Lubbock. The 2010 census reports 9426 residents of the county. Per capita income of these residents for the period 2006-2010 was $13358. Mitchell County Hospital District supports the entire county as well as patients from Big Springs in RHP-14, San Angelo in RHP-13, and Snyder in RHP-12. The catchment area includes approximately 12000 patients and is located in a Health Professional Shortage Area. We will develop a plan that sustains our current provider level this year and increases our provider by one next year. RHP-11 is known to have a shortage of primary care physicians confounding the transformation from curative to evidence based to preventive care models.

Starting Point/Baseline:

We are planning to initiate physician recruiting activity during year 1 and open this providers practice during year 2. The performance metric will be established using Year two data with the baseline being 10 scheduled patient clinic visits per day. In years three, four and five we anticipate a 5% increase in scheduled clinic visits per day.

Rationale:

Mitchell Counties RHC has been staffed by three Family Physicians for many years. As two of our physicians have been in practice here for 26 and 24 years respectively the remaining primary care physician is relocating back to Florida to be nearer to his children. Statistically our largest population grouping is the 15-24 year olds, the second is the 64+ grouping and the third is the 0-14 grouping. The zero-14 and 64+ groupings make up the majority of RHC and ED visits. Our family physicians are responsible for seeing the approximately 4800 ED visits and 14000 clinic visits each year. The desired transformation from curative practice to preventive practice will require more well visits in order to reduce the number of Emergency Department visits for a given reporting period. It is crucial that we recruit now to sustain our current level of services and expand appointment availabilities to our current and future community needs.
RHP Plan for Mitchell County Hospital District

Project option 1.1.2-Expand Primary Care Capacity Below we have identified utilization of core components.

Required core project components:

a. Expand Primary Care Space, Not Applicable
b. Expand Primary Care Clinic Hours: We may be able to extend hours once we have the additional staff in place to provide coverage.
c. Expand Primary Care Staffing: This is the foundational need of our community and therefore the focus of this project. We hope to add at least 2 primary care physicians as well as other primary care staff.

This project falls under RHP 11 Community Needs Identification Number CN.3 Shortages of Health Care Professionals, including mental health care providers.

Community Needs Assessment:

Mitchell County Hospital District contracted with Dave Clark & Associates to perform a community health needs assessment to comply with requirements of being a 501c3 organization and gain community input on which to develop a Strategic Plan. Eight of the top 10 "health problems" include;

1. Obesity/Overweight 65.83%
2. Cancer 55.96%
3. Aging Problems 49.77%
4. Ability to Pay for Care 49.08%
5. Diabetes 38.99%
6. Teenage Pregnancy 36.01%
7. Heart Disease 35.09%
8. Mental Health 32.11%
9. Elderly Care 29.59%
10. Poor Oral/Dental Health 16.51%

Eight of these ten issues are problems directly associated with Primary Care for prevention, early identification or appropriate levels of health maintenance and/or coordination of care. While 87.38% of survey respondents felt we have a good healthcare system, 10% reported difficulty in obtaining appointments due to non- availability within their time frames.

Category 3 Related Outcomes

Adding the additional primary care provider is expected to minimize the complaints about availability and through proper selection grant us additional physician skills and interest to address the various combinations of issues in our top ten findings and enhance patient satisfaction. Also with the replacement of the one provider we are losing in our Rural Health Clinic (RHP) and one additional provider to bring us to a total of four (4) primary care providers we will be able to facilitate right care, right setting with more available appointment times in our RHP. We will at the time of hiring of our two new providers will screen those non urgent patients from our emergency department to our RHP.

Plan for Learning Collaborative: NA

Project Valuation:

We view the planning for and recruitment of additional primary care providers is the highest priority in meeting the continuing needs of Mitchell County residents. and will allow us to provide access in our baseline year to an additional 10 scheduled patients per day with an anticipated increase of 5% in the following years. The most common thread in meeting nine of the top ten needs is the maintenance of our physician staff. This recruitment effort will assist in serving the 9300 residents of Mitchell County and the approximately 3000 patients outside our county who choose to use us for their healthcare needs. The recruitment of additional providers to our RHC will allow us to provide access in our baseline year to an additional 10 scheduled patients per day with an anticipated increase of 5% in the following years. This effort is also expected to reduce our "non-emergent" ED visits by providing a less costly opportunity.

New 136325111.1.2 Old 136325111.1.1	1.1.2 Expand existing primary care capacity	1.1.2 c) Expand primary care clinic staffing	***EXPAND PRIMARY CARE ACCESS***	
Mitchell County Hospital District				*136325111*
Related Category 3 Outcome Measure(s):	*New 136325111.3.2* Old 136325111.3.1	*IT-9.2*	**Right Care, Right Setting**	
Year 2 (10/1/2012 – 9/30/2013)	**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: Develop a plan to sustain current level of providers along with a plan to increase primary care providers (PCP) Metric 1 P-5.1.b: Plan will document process for retention, recruitment and actions to hire additional PCP/PCP's Data Source: Documentation of plan and plan progress Milestone 1 Estimated Incentive Payment *(maximum amount):* $358,124	**Milestone 2** P-5: Implement plan to hire additional PCP's Metric 1 [P-5.1]: Baseline/Goal: 3/ current level of PCP's is 3 but we will be losing 1 in December 2012. Plan will be to replace the loss of the 1 along with hiring of 1 additional PCP which will give us a total of 4 Data Source: Documentation of implementation of plan to hire additional PCP's Milestone 2 Estimated Incentive Payment: $195,347 **Milestone 3** P-5: Hire 1 or 2 PCP's which will depend on search for right PCP that will be a good tie to our current		**Milestone 4** 1-12: Increase the number of patient visits in our RHC due to greater access to PCP's by 10 scheduled patients per day. Metric 1 1-12-1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 5 % increase in number of patient appointments Data Source: EHR Scheduling System Milestone 4 Estimated Incentive Payment: $195,915 **Milestone 5** 1-12: Increase the number of patient visits in our	**Milestone 6** 1-12: Increase the number of patient visits in our RHC due to greater access to PCP's Metric 1 1-12-1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 5 % increase in number of patient appointments Data Source: EHR Scheduling System Milestone 6 Estimated Incentive Payment: $323,686

New 136325111.1.2 Old 136325111.1.1	1.1.2 Expand existing primary care capacity	1.1.2 c) Expand primary care clinic staffing	***EXPAND PRIMARY CARE ACCESS***	
Mitchell County Hospital District				*136325111*
Related Category 3 Outcome Measure(s):	*New 136325111.3.2* Old 136325111.3.1	*IT-9.2*	**Right Care, Right Setting**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Medical Staff Metric 1 [P-5.1]: PCP Roster which will show increase in number of PCP's on staff in our RHC Milestone 3 Estimated Incentive Payment: $195,347		RHC due to greater access to PCP's Metric 2 1-12-1: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 5 % increase in number of patient appointments Data Source: EHR Scheduling System Milestone 5 Estimated Incentive Payment: $195,915	
Year 2 Estimated Milestone Bundle Amount: $358,124	Year 3 Estimated Milestone Bundle Amount: $390,694		Year 4 Estimated Milestone Bundle Amount: $391,830	Year 5 Estimated Milestone Bundle Amount: $323,686
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $1,464,334				

Palo Pinto General Hospital District

Category 1 – Increase Primary Care Capacity
Pass 3B, New: 138950412.1.3 (OLD: 138950412.1.1)
Unique Project ID

Summary Information

- Provider: Palo Pinto General Hospital District is a 99 bed hospital in Mineral Wells, Texas (Region 11) serving a 951.8 square mile area and a population of approximately 28,115.

- Intervention(s): This project will establish a primary and specialty care clinic where currently the Medicaid and uninsured will be able to seek treatment regardless of their payor source. The private physicians in Mineral Wells take very few Medicaid patients and no physician takes the uninsured patient.

- Need for the project: The hospital currently is in need of a larger clinic to treat more patients and to seek to reduce the number of patients using the ED for their primary care. The cost to treat a patient in the ED is more than $800.00.

- Target Population: The target population is the Medicaid and uninsured patients as those are the patients that frequent the ED. If treatment could be received early in the disease, it would reduce the number of ED visits and reduce the number of admissions. This new clinic will provide that early intervention for the Medicaid and uninsured population. It is estimated that 7,000 patient encounters in DY 4 and 5.

- Expected Patient Benefits: The project seeks to build a new clinic building, hire and train physicians and staff to provide care to a population that does not currently receive healthcare unless it is in the ED.

Category 1: Increase Primary Care Capacity

Project Option: 1.1.2 – Expand primary care clinic, expand primary care hours and expand primary care staffing

Unique Project ID: Pass 3B, New: 138950412.1.3 (OLD: 138950412.1.1)

Facility Description: Palo Pinto General Hospital-138950412

Project Description:

Palo Pinto General Hospital District is located in Mineral Wells, Texas. Palo Pinto County is an impoverished rural county and is in desperate need of access to primary care to reduce the number of patients using the Emergency Department for low levels of care.

The hospital would (1.1.2) expand primary care capacity, (1.1.2(a) expand primary care clinic space (1.1.2(b)), expand primary care clinic hours, and (1.1.2(c) expand primary care clinic staffing. This will expand access and increase the number of indigent and underinsured patients who can be seen in the primary care setting by qualifying more patients for the hospital charity program (CAPS).

The current space being utilized by the hospital's health clinic is limited in its ability to meet the demands of the growing need for primary and preventive care. The primary health clinic, on the other hand, has only 1 physician and 2 nurse practitioners and no room to expand. PPGH expects to expand to 1 more family practice physician and 1 more nurse practitioner at the end of DY 3 and have the ability to treat an additional 500 patients per month by DY 4. A new clinic will be built on property owned by the hospital. The private primary care physicians in the community provide care to a very limited number of Medicare patients and most do not take Medicaid patients: thereby, leaving the residents of the county with no healthcare or utilizing the Emergency Department for their primary care. By moving the clinic to another building, the hospital can provide better access to care for all residents of Palo Pinto County. This project will be addressing and focusing on the needs of the uninsured, under insured and Medicaid.

By DY 4, we expect to have expanded clinic space, increased clinic hours, and increased clinic staffing in order to increase the capacity within the system for patients to access to appropriate care settings. We expect this to reduce unnecessary or lower levels of ED visits. RHP 11 identified support for projects that enhance the Triple Aim. This project will increase patients' ability to seek appropriate care, in the appropriate settings, at the appropriate time.

Starting Point/Baseline:

The Emergency Department treats approximately 58% or 11,600 patients per year who do not require the level of care given by the ED physicians or staff. This will be the starting point with a reduction in the end of DY3 of 1% of the 11,200 low level ED visits and picking up 1,500 visits for elopements and better provider access. In DY 4, visits to the clinic will increase to 4,000 and by DY 5 the visits will be up to 6,000.

Rationale:

More often than not, when a patient does not have a regular primary care physician, does not have any funding or very little funding but needs medical care, the only place to get that care is with an Emergency Care physician. By expanding primary care physicians in a primary care clinic, the care of the patient can be coordinated with one physician where the patient will have better health outcomes, appropriate utilization, reduce costs, and increase the health of the community.

Community Needs:

In the Community Needs Assessment, the county has a (CN.3), "Severe primary care provider shortage and (CN.5) low utilization of preventative care services. Also, the Community Needs Assessment shows twenty-one percent (21%) are uninsured and thirty percent (30%) are Medicaid, CHIP, or Medicare.

Collaboration: The project was moved from Pass 1.

Project Option:

With the addition of a primary care building and the addition of primary care**,** the hospital would (1.1.2) expand primary care capacity, (1.1.2(a) expand primary care clinic space (1.1.2(b)), expand primary care clinic hours, and (1.1.2(c) expand primary care clinic staffing. As identified in the milestones and metrics below, capacity will be measured by the number of increased visits to the primary care clinic through the EHR by demographics, i.e. uninsured, underinsured and the Medicaid population.

An emphasis will be put on uninsured, underinsured and Medicaid patients, as these are the patients that need the most attention as they do not receive adequate care in the current healthcare system.

The hospital was the recipient of disaster funds and if a disaster were to occur, the hospital space could and would be used for disaster, which would also cause a burden on the current clinic space and capacity.

Related Category 3 Outcome Measure(s):

With the growing costs of providing care to the Medicaid and uninsured population grows due to the unavailability of care, the expansion of the clinic will be able to address many needs of the patient population now being treated in the ED. ED visits will decrease as this population will now have a place to seek medical treatment. High blood pressure (IT-1.7) was chosen as a focus indicator due to the fact that the county has a higher than average number of cardiovascular patients with untreated hypertension and the obesity rate continues to increase. Data gleamed from the ED department indicated hypertension to be the underlying cause of 11% of ED visits. By treating and educating patients, the number of ED visits will decrease and the clinic will be able to treat a larger population at a significant cost savings over the ED department.

Relationship to other Projects:

In *Project 1*, (Pass 3B, New: 138950412.1.3 (OLD: 138950412.1.1)) the hospital will be focusing on High Blood Pressure due to the number of cardiovascular related illnesses, the high obesity population within the county and how the clinic can avoid hospital admissions for this population and reduce the number of ED visits.

In *Project 2*, (138950412.2.1) the hospital will be focusing on the low birth weights of newborns due to the lack of prenatal care. In addition, due to the higher than state average for teen pregnancies and the high school dropout rate, the clinic will be focusing on educating teens on contraceptives and the importance of early prenatal care. Both are a focus on care in low cost settings which aim to reduce higher acuity episodes of care in the hospital or ED. We expect these projects to have direct correlation to the PPAs, PPRs and ED measures in Category 4.

Relationship to Other Performing Providers' Projects in the RHP:

As evidenced through other performing provider projects, access to care and services is a challenge for the entire region. For rural providers, primary care, preventative services and wellness projects are a common theme. As the anchor, we plan to develop learning collaborative initiatives including face-to-face meetings to allow providers with clinics to learn how to better manage the growing number of patients with chronic conditions, specifically in rural settings where access is a huge issue. Education and learning symposiums cannot happen in silos for rural providers; therefore we will consolidate the effort to address the real health issues facing Region 11. This will provide services to the entire region, creates a cohesive environment for providers to build upon and compliments other projects with the RHP.

Plan for Learning Collaborative:

We expect to host learning collaborative for various chronic illnesses that will educate not only the specialists but also the regional primary care providers on the impact of the project, the lessons that are being learned from the implementation of this

project and the opportunities to improve upon the project throughout the region, which we expect is the best way to impact total population health, the goals of Category 4.

Project Valuation:

The project valuation was determined by the number of patients not receiving adequate primary care due to no method of paying the provider and the patient visiting the ED for treatment. The goal is to be able to accept the patients that are currently turned away because of the number of patients wanting to be treated (which ultimately seek treatment in the ED) or go AMA because the wait is so long. Adding a new structural building to be able to treat the sheer volume of patients, adding medical staff and mid-levels will provide significant savings by treating them in the correct setting and not in the ED. Currently, the cost of treating an ED patient is over $800.00 per visit. The project anticipates a decrease in inpatient admissions of 42 in DY 4. On average, a PPGH admissions costs $17,832. The project has been valued based on the costs of expanding the primary care clinic to another building, moving the Emergency Department into the current clinic area. Community efforts will be utilized to attract the clients that the clinic will be treating and personnel will be hired to assist those patients with qualifying for the hospitals indigent care program.

Additionally the project valuation supports the quarterly learning collaborative components, face to face meetings and best practice tools which we will seek to provide to the other providers in the region in order to transform patient care from the ED and back to the clinic and home community.

Pass 3B, New: 138950412.1.3 (OLD: 138950412.1.1)	PROJECT 1.1.2	1.1.2.A, B, C	INCREASE PRIMARY CARE CAPACITY	
Palo Pinto General Hospital				138950412
Related Category 3 Outcome Measure(s):	138950412.3.1	IT-1.7	CONTROLLING HIGH BLOOD PRESSURE	
Year 2 (10/1/2012 – 9/30/2013)	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 [RHP PP Milestone – P-X.]: Complete a planning process/submit a plan in order to do appropriate planning for the implementation of major infrastructure development and program/process redesign. Develop drawings for new clinic. Metric 1: P-X.1 Complete a planning process/submit a plan, in order to do appropriate planning for the implementation of major infrastructure development and program/process redesign.	Milestone 3 P-X. Establish a baseline, in order to measure improvement. Metric 1: P-X.3 Develop baseline and goals for documenting the number of patients treated at the expanded clinic and the decreased number of patients treated in the Emergency Department. Baseline is the current 9,000 visits per year with an increase of 1,000 visits by the end of DY 3.	Milestone 5 [P-X.]: Evaluate intervention, modify intervention as appropriate, develop policies and procedures and share lessons learned. Metric 1: P-X.1. Documentation of Plan. Baseline/Goal: Use evaluation to share lessons learned and improve similar projects across the region. Reduce ED visits by 3% more from base year and increase the primary care facility by 4% over base year.	Milestone 7 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-12.1]: Documentation of increased number of visits. Demonstrate improvement 5% over prior reporting period. a. Total number of visits for reporting period b. Date Source: Registry, HER, claims or other performing provider source. c. Rationale/Evidence:

Baseline/Goal: Complete the Plan for Expanding Clinic Space for Expanded Capacity. Data Source: Clinic Plan Milestone 1 Estimated Incentive Payment: $954,742.50 Milestone 2 [RHP PP Milestone – P-X.2]: Engage stakeholders, identify resources and potential partnerships and develop intervention plan (including implementation, evaluation and sustainability. Metric 1 P-X.2]: Engage stakeholders, identify resources and potential partnerships and develop intervention plan (including implementation, evaluation and sustainability. Baseline/Goal: Work with Stakeholders to develop partnerships and support the clinic plan.	P-X.4 Participate in face-to-face learning seminars at least twice per year with other providers and the RHP 11 team to promote collaborative learning around shared or similar projects. All providers should identify and agree upon several improvements. Each provider will publicly commit to implementing these improvements. Baseline/Goal: Reduce ED visits 2% (400 visits) and increase clinic visits by 1,500 at end of DY 3. Data Source: Clinic Plan Milestone 3 Estimated Incentive Payment: $1,041,572.50 Milestone 4 [RHP PP Milestone -[P-4]: Expand the hours of the primary care clinic, including evening and weekend hours. Metric – P-4.1 – Increase	Data Source: Plan Milestone 5 Estimated Incentive Payment: $1,044,599.50 Milestone 6 [I-12]: Increase primary care clinic volume by 2,000 visits by end of DY 4 and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period b. Date Source: Registry, HER, claims or other performing provider source. c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the performing provider to increase capacity to provide	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: Reduce ED visits by 10% (total of 2,000 visits) over base year. And have an additional 5,000 patient encounters by end of DY 5. Milestone 7 Estimated Incentive Payment: $1,725,860

Data Source: Stakeholder reports. Milestone 2 Estimated Incentive Payment: $954,741.50	number of hours at primary care clinic over baseline. a. Data Source; Clinic documentation. b. Rationale/Evidence: Expanded hours for more patients to be seen and also provide more choices for patients. Baseline/Goal: Expand to evening hours (2-3 hrs) and 8-10 weekend hours. Milestone 4 Estimated Incentive Payment: $1,041,571.50	care. Baseline/Goal: Reduce ED visits by 4% (800 visits) more from prior year and increase the primary care facility by 3% over second year of 10,500 visits. Milestone6 Estimated Incentive Payment: $1,044,599.50	

Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,909,483	Year 3 Estimated Milestone Bundle Amount: $2,083,143	Year 4 Estimated Milestone Bundle Amount: $2,089,199	Year 5 Estimated Milestone Bundle Amount: $1,725,860
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $7,807,685			

Palo Pinto General Hospital District

Category 1 – Expand Specialty Care Services
138950412.1.2
Pass 2

Summary Information

- Provider: Palo Pinto General Hospital District is a 99 bed hospital in Mineral Wells, Texas (Region 11) serving a 951.8 square mile area and a population of approximately 28,115.

- Intervention(s): This project will implement specialty care to the Medicaid and uninsured population and keep those patients in the community. There are no providers for this payer group so they use the ED and end up being transported to Dallas/Ft. Worth for treatment.

- Need for the project: The hospital currently is in need of a general surgeon, pulmonologist and a pediatrician. Currently these patients go to the ED and then are care flight to Dallas/Ft. Worth at a huge expense. The current pediatrician does not see children beyond the age of 2 and the pulmonary and general surgery patients are being transferred from the ED to Ft. Worth. General Surgery cases transferred each week average 7.

- Medicaid and Uninsured Target population: The target population is the Medicaid and uninsured patients as those are the ones that frequent the ED and if treatment could be received early in the disease, it would possibly decrease the number of ED visits and transfers to Dallas/Ft. Worth.

- Category 1 or 2 expected patient benefits: These projects seek to decrease the transfers for specialty care to the Dallas/Ft. Worth area hospitals by 25% by recruiting and providing a new clinic in which the physicians can treat the chronic patients before they seek treatment in the ED.

- Category 3 outcomes: IT-9.2 Our goal is to reduce the number of transfers for specialty care by 25% and reduce the number of ED visits for specialty care by 10% and increase the number of visits to specialty care physicians by 50%.

PASS 2

Facility Description: Palo Pinto General Hospital-138950412

Category 1: Expand Specialty Care Capacity

Project Option: 1.9.2 – Expand Specialty Care Capacity
Unique Project ID: 138950412.1.2

Project Description:

Palo Pinto General Hospital District is located in Mineral Wells, Texas, designated as a partially Medically Underserved Area. Palo Pinto County is an impoverished rural county of 28,000 residents and is in desperate need of access to specialty care to reduce the number of patients using the Emergency Department for low levels of specialty care.
Mineral Wells is located 60 miles to the east and 120 miles to the west for Palo Pinto County residents to reach specialty care. Desperately needed is a general surgeon, a pulmonologist and a pediatrician.
If approved, the hospitals Project 1.1 (Category 1, Pass 3B, New: 138950412.1.3 (OLD: 138950412.1.1)) will be expanding the primary care services and will have enough additional space for use by these specialty providers.

Project Goal is to increase the capacity to provide specialty care services and the availability of targeted specialty providers (specifically, general surgeon, pulmonologist and pediatrician) and to accommodate the high demand for specialty services within the county.
To decrease the cost of providing these services in the ED department to having to transport the patients to a higher level of care because they did not have access to the care when interventions would have prevented care at a higher level.
General Surgery cases transferred each week are approximately 7, the pediatrician sees approximately 60 patients per day and does not take children over the age of 2 (they are seen by family practice physicians or go to the ED). A pediatrician will have a full practice (40-50 patients) as soon as he/she begins. This will free up the family practice to see mor indigent patients. Pulmonology patients are referred to Ft. Worth. As family practice physicians were polled, they state approximately 15 patients are referred to Ft. Worth per week in addition to the patients already driving to Ft. Worth each week. Most of these patients have no insurance and have no means to see specialists in the metropolis. Therefore, when they come to the ED at an average cost of $800.00 per visit, they are chronically ill and have to be transferred by ground or air at a huge expense. Patient education will be a priority with various disciplines providing information to the patients and the community.

Project Options:

1.9.2 Improve access to specialty care

a. Increase service availability with extended hours
b. Increase number of specialty physicians
c. Implement transparent, standardized referrals across the system
d. Conduct quality improvement for project using methods such as rapid cycle 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.

Starting Point/Baseline:

Starting point/baseline data has been obtained from HER, ED transfer records, primary care physician polls and the only pediatrician servicing the county. Reductions of ED visits will be obtained by providing specialty care in the appropriate care setting with significantly lower costs.

Starting point will be recruiting a general surgeon, pulmonologist, and pediatrician with the baseline of cases transferred each week from the ED and the excess pediatric patients from the 1 pediatrician in town.

Specialty Care physicians would be able to expand care within the county to include COPD, CHF, and other chronic diseases. In addition, basic surgeries could be performed such as appendectomies, colons, gallbladders, biopsies and etc. that are now being transported to the larger cities due to the lack of specialty care physicians within the community and county.
Children between the ages of 2-12 will be treated by a pediatrician.

This project would focus on the uninsured, underinsured and the Medicaid population as these demographics are the patients most likely to wait until their disease is chronic and then seek treatment in the ED when all the ED can do is transport the patient to a higher level of care.

Rationale:

An emphasis will be put on uninsured, underinsured and Medicaid patients, as these are the patients that need the most attention as they do not receive adequate care in the current healthcare system.

More often than not, when a patient does not have a regular specialty care physician, does not have any funding or very little funding but needs medical care, the only place to get that care is with an Emergency Care physician. By providing specialty care

(**138950412.1.9)** within a clinic and coordinating care with the expanded primary care physicians (**Project 1.1, Pass 3B, New: 138950412.1.3 (OLD: 138950412.1.1), Pass 1**) in a primary care clinic, the care of the patient will have better health outcomes, appropriate utilization, reduced costs (reduced ED visits), and increase the health of the community.

Community Needs:

In the Community Needs Assessment (pg. 7), the county has a, "Severe specialty care services shortage and (CN.4) low utilization of preventative care services.

Relationship to Other Performing Providers' Projects in the RHP:

As evidenced through other performing provider projects, access to care and services is a challenge for the entire region. For rural providers, specialty care, preventative services and wellness projects are a common theme.

As the anchor, we plan to develop learning collaborative initiatives including face-to-face quarterly meetings in Abilene, to allow providers with specialty care services to learn how to better manage the growing number of patients with chronic conditions, specifically in rural settings where access is a huge issue. Education and learning symposiums cannot happen in silos for rural providers; therefore we will consolidate the effort to address the real health issues facing Region 11. This will provide services to the entire region, create a cohesive environment for providers to build upon and compliments other projects with the RHP.

Plan for Learning Collaborative:

We expect to host learning collaborative for various chronic illnesses that will educate not only the specialists but also the regional primary care providers on the impact of the project and the lessons that will be learned from the implementation of this project and the opportunities to improve upon the project.

Project Valuation:

The project has been valued based on the costs of expanding the specialty care to a building that will also provide primary care (**Project 1.1, Pass 3B, New: 138950412.1.3 (OLD: 138950412.1.1), Pass 1**) and collaborative efforts can be implemented to assist those patients in need of specialty care. Physicians will be recruited to provide indigent care to those requiring that care to keep patients from seeking treatment in the ED and to keep the ED from having to transfer those patients to a higher level of care.

138950412.1.2	***PROJECT 1.9.2***	***1.9.2 A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
Palo Pinto General Hospital				138950412
Related Category 3 Outcome Measure(s):	138950412.3.3	*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)**
P-1. Milestone: Conduct specialty care gap assessment based on community need. P-1.1 Metric: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). Data Source: Needs Assessment. Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care access. Baseline/Goal: Baseline will be the number of ED visits by pediatric patients,	**P-11 Milestone**: Launch/expand a specialty care clinic. P-11.1 Metric: Establish/expand specialty care clinics Number of patients served by specialty care clinic will be the number of patients transferred from the ED and the excess pediatric patients from the 1 pediatrician in town. Data Source: Documentation of new/expanded specialty care clinic patients Rationale/Evidence: Specialty care clinics improve access for targeted populations in areas where there are gaps in specialty care. Additionally, specialty care clinics allow for		**I-22 Milestone:** Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties. I-22.1 Metric: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties. Numerator: Number of specialist providers in targeted specialties over baseline or change in the number of specialist providers in targeted specialties. Denominator: Number of monthly or annual referrals into targeted medical specialties clinic or number of	**I-23 Milestone:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **I-23.1** Metric: Documentation of increase number of visits. Demonstrate improvement over prior reporting period (baseline for DY 2). Total number of visits for reporting period Data Source: Registry, HER, claims or other performing provider source. 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

138950412.1.2	***PROJECT 1.9.2***	***1.9.2 A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
Palo Pinto General Hospital				138950412
Related Category 3 Outcome Measure(s):	138950412.3.3	*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)**
patients requiring a pulmonologist and those patients transferred to a higher level of care due to no specialty practicing in the community. Begin recruiting these specialty physicians.	enhanced care coordination for those patients requiring intensive specialty services. Baseline/Goal: Decrease the number of ED visits by 6% over prior year. Determine number of visits to specialty care physicians. **P-21 Milestone:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple		specialist providers in targeted specialties at baseline. Data Source: HR documents or other documentation demonstrating employed/contracted specialists. Rationale/Evidence: Increased number of specialists to meet demand and referral demand for in-person visits and procedures will allow patients to receive more timely services. Baseline/Goal: Reduce ED visits for specialty patients by	care. Baseline/Goal: Reduce ED visits over prior year by 5% for specialty care patients and increase specialty care clinic visits by 15% over DY 4.

138950412.1.2	***PROJECT 1.9.2***	***1.9.2 A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
Palo Pinto General Hospital				138950412
Related Category 3 Outcome Measure(s):	138950412.3.3	*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)**
	initiatives that all providers can do to "raise the floor" for performance). Each participating provider will publicly commit to implementing these improvements. P-21.1 Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest		5% over prior year and increase specialty care clinic visits by 10% over DY 3.	

138950412.1.2	***PROJECT 1.9.2***	***1.9.2 A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
Palo Pinto General Hospital				138950412
Related Category 3 Outcome Measure(s):	138950412.3.3	*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 Estimated Incentive Payment: $525,392	quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Baseline/Goal: Share data across the region and hold semi-annual workshops and symposiums with the providers and care givers. Milestone 11: Estimated Incentive Payment: $573,854		Milestone 22: Estimated Incentive Payment: $578,519	Milestone 23 Estimated Incentive Payment: $472,901

138950412.1.2	***PROJECT 1.9.2***	***1.9.2 A-D***	***EXPAND SPECIALTY CARE CAPACITY***	
Palo Pinto General Hospital				138950412
Related Category 3 Outcome Measure(s):	138950412.3.3	*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)**
Year 2 Estimated Milestone Bundle Amount: $525,392	**Year 3 Estimated Milestone Bundle Amount: $573,854**		**Year 4 Estimated Milestone Bundle Amount: $578,519**	Year 5 Estimated Milestone Bundle Amount: $472,901
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,150,666				

Summary Information:
Unique Project ID: 130724106.1.1

- Provider: Pecan Valley Centers is the Local Authority for mental health and developmental disability services for a six county region (1 of which is included in RHP11). The total area covers 4267 sq miles and has a total population of 442,719.

- Intervention(s): 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. The project will add four additional staff, including medical staff, to the Palo Pinto County clinic.

- Need for the project: New individuals are assessed daily for services, however, they currently wait, on average, 40 days to receive services from a psychiatrist. The new design of intake services will shorten the wait times for services, with the goal being 10 days. For individuals on medications when they complete the intake process, medication issues are often resolved in the ER, because they have not seen a psychiatrist. Quicker access to the psychiatrist will aim to reduce the need for ED visits.

- Medicaid and Uninsured Target population: The target population is adults and youth with severe mental illness requesting routine services and meet diagnostic criteria for mental health services. The expected number to be impacted by this project is 300 individuals. Approximately 55% or 206 individuals of our population has no funding source or are indigent and 25% (63 individuals) of adults and 75% (14 individuals) of youth have Medicaid, so this project will impact a large portion of both Medicaid recipients and uninsured individuals. As new individuals are assessed for services the percentages of new patients is expected to maintain the existing percentages of Medicaid/indigent individuals.

- Category 1 or 2 expected patient benefits:

    - In DY 3-it is estimated that 130 referrals for services will be received. The project aims to see a decrease from 40 days to 28 days to see a doctor. The one behavioral health clinic will implement new access procedures. This will impact an estimated 60 individuals, who are seeking eligibility services during the last 6 months of DY 3. 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 patients and can work with the psychiatrist to better meet the needs of the

clients.

- In DY 4-the project benefit will be to see an increase of 15% (of 920 events) or 138 psychiatric events as a result of estimated 35 new patients.

- In DY 5- a 25% increase (of 920 events) or 230 psychiatric events to impact an estimated 120 new patients and 60% of new patients 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 20% by DY5. The improvement targets for Cat 3 are to decrease by 10% in DY 4 and decrease by 20% in DY 5 the number of ED visits of new Pecan Valley patients. The baseline will assist in setting the improvement milestones since the number of patients which utilize the ED at this time is unknown.

Summary Information:
Unique Project ID: 130724106.1.1

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- Medicaid and Uninsured Target population: The target population is adults and youth with severe mental illness requesting routine services and meet diagnostic criteria for mental health services. The expected number to be impacted by this project is 300 individuals. Approximately 55% or 206 individuals of our population has no funding source or are indigent and 25% (63 individuals) of adults and 75% (14 individuals) of youth have Medicaid, so this project will impact a large portion of both Medicaid recipients and uninsured individuals. As new individuals are assessed for services the percentages of new patients is expected to maintain the existing percentages of Medicaid/indigent individuals.

- Category 1 or 2 expected patient benefits:

    - In DY 3-it is estimated that 130 referrals for services will be received. The project aims to see a decrease from 40 days to 28 days to see a doctor. The one behavioral health clinic will implement new access procedures. This will impact an estimated 60 individuals, who are seeking eligibility services during the last 6 months of DY 3. 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 patients and can work with the psychiatrist to better meet the needs of the

clients.

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- Category 3 outcomes: IT-9.2- Our goal is to reduce emergency department visits for behavioral health/substance abuse by 20% by DY5. The improvement targets for Cat 3 are to decrease by 10% in DY 4 and decrease by 20% in DY 5 the number of ED visits of new Pecan Valley patients. The baseline will assist in setting the improvement milestones since the number of patients which utilize the ED at this time is unknown.

Project Title: Expand Specialty Care Capacity-Access Redesign to Target Quicker Access to Psychiatric Services

Category 1: Expand Specialty Care

Project Option: 1.9.2 – Expand Specialty Care Capacity

Unique Project ID: 130724106.1.1

Facility Description: Pecan Valley Center for Behavioral and Developmental Healthcare-130724106

Project Description:

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 service when needed with easy access. The lack of providers and cumbersome systems, have typically made access to behavioral health services difficult and not easily accessible. As behavioral Health Services continue to be a service in 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 Provider Shortage Areas.[22] 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 1 county in Region 11) county service area. Gaps in services exist and this project will aim to close those gaps and provide a wider continuum of 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, additional providers will be added to the workforce in existing clinic to accommodate increased need for behavioral health services.

The aim of the program will be to improve access to identified services, while doing so 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 when their situation has reached the unbearable point and asking them to wait to receive the services they have requested is

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

not well accepted. Expanded access will be implemented for individuals requesting routine services 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 towards 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) to develop treatment goals and provide referrals for additional services. Team members will also include those to provide counseling, nursing and psychiatric services. In Region 11, the team will be located in Palo Pinto County. Pecan Valley currently has a behavioral health clinic in this county. 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 the access to psychiatric care rather than waiting several weeks or months.

The 5 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. As a result, increased access to psychiatry services, this will improve the quality of life for people, reduce utilization of emergency departments (ED), inpatient admissions and unnecessary involvement with law enforcement.

The national average of individuals waiting for mental health services is 47 days. Research shows that each day an individual must wait for a service the less likely they are to actually engage in services. The current initial intake process is structure so that individuals are required to make multiple appointments 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 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. By reducing the number of appointments to two or less, less hardship is placed upon individuals requesting services and provides better and quicker of continuity for services.

The 5-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 20%.

The outcomes measure for this project is to reduce ED utilization due to increased access to services. This project is related to the RHP 11 goals to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. The regional focus on increasing the capacity of primary care, increasing strategies related to disease

prevention, and expanding behavioral health services will result in an anticipated reduction of burden on Emergency Departments and improve health outcomes across the region. RHP 11, again, has identified projects that seek to bend the cost curve, which is foundational to the transformation of the healthcare system for patients and for providers.

Starting point/baseline:

Pecan Valley currently provides behavioral health services, including psychiatry. Since December 2011, an average of 272 clients (adults and youth) has been active clients. Each month an average of 10 new clients are admitted through the regular intake process. The current average waiting period to access a psychiatrist from the first call to an initial visit is 40 days. In the months of May, June and July of 2012 less than 10% of individuals requesting routine services actually receive a psychiatric evaluation within 10 days. The number of staff currently directly linked to access is 4. The proposed additional staff for expanded access would add additional 4 staff members.

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:

Project option:

The Pecan Valley Region is a rural community, with challenges of being medically underserved as well as transportation issues. Often individuals are unable to access care in their own community due to lack or resources. According to statistics for Texas, in 2009 29.6% of individuals in Palo Pinto County were uninsured[23]. Additional research reports that only 6% of people with mental illness are treated in the community mental health system. Improving access to behavioral health services can improve individual's quality of life as well as decreasing the use of more costly services.

[23] www.texmed.org

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, due to lack of providers. By increasing capacity, improved client outcomes and client satisfaction will occur while also reducing ED utilization 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.

Core Components:

The core components of increase service availability with extended hours and
Increased number of specialty clinic locations will be fulfilled by adding an additional behavioral health clinic and extending clinic hours beyond normal business hours in high volume clinics. The core component of implementation of transparent and standardized referrals across the system is not included in project since specialty providers will be internal providers.

Our milestones measures will assess the increased access to services by 1) adding additional behavioral health providers, including a psychiatrist resulting in expanded services 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.

Community needs:

CN-3 Shortages of health care professionals, including mental health care providers
CN-5 Need to overcome patient access to care barrier

This 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-9.2 ED appropriate utilization
By the end of the waiver project, our goal is to show 20% reduction in emergency department utilization for behavioral health/substance abuse

Relationship to other Projects:

CN-3 Shortages of health care professionals, including mental health care providers
CN-5 Need to overcome patient access to care barriers

Relationship to other Category 4: NA

Relationship to Other Performing Providers' Projects in the RHP:

Plan for Learning Collaborative (new):

TBD through discussion with regional partners

Project Valuation:

RHP 11 used a weighting methodology to establish valuation for each project. Thereby starting with the allocations from the state, Pecan Valley determined the weighted value of each of the indicators, to evaluate the value of the project on the community. Each identified area is reflected as follows:

A. **Provider size:** Involves the one mental health clinic in Palo Pinto County that currently operates with 4 staff Monday thru Friday 8am -5pm. Four additional staff are planned as part of the project, as well as expanded clinic hours and expanded services.
B. **Project size:** Involves an average of 120 new clients per year coming in for their first psychiatric evaluation with the doctor (10 new clients admitted per month on average for routine services).
C. **Project scope:** An average of 10 new clients are admitted for routine services each month and we propose to provide their initial psychiatric evaluation within 10 days of their first contact at least 60% of the time. The current wait time for psychiatric evaluation is over 30 days. The increased access to psychiatric evaluations will also provided better access for ongoing services for individuals beyond initial eligibility. As a result the full impact of the project could affect all adults receiving mental health services in Palo Pinto County.
D. **Population served:** The population of Palo Pinto County is 28,111 and 16.8% of that population lives at or below the poverty level according to the 2010 Census (Palo Pinto County Profile, The County Information Project, and Texas Association of Counties). An average of 272 clients (adults and youth) has been provided mental health services each month by Pecan Valley Centers since December 2011. The targeted population of this project will those individuals who meet the diagnostic eligibility for services and who require psychiatric services.

E. **Community benefit:** The community will benefit from the improved access to mental health services by providing quicker engagement to services (shorter wait times for the initial psychiatric evaluation) and by providing expanded services by adding additional mental health providers including a psychiatrist as well as other clinicians.

F. **Cost avoidance:** The establishment of the open access model will increase capacity and decrease wait times. This will impact both the behavioral health and hospital systems. People being engaged and receiving services in a more timely manner may result in less admissions to the ED, because of medication issues and crisis events. The earlier engagement with individuals will also prevent repeated unnecessary ED visits by following up with referrals and linked services. Community-based mental health services cost an average of $12 per day for adults and $13 a day for children. This is by far the most cost effective manner to provide local services. The average cost for an emergency room visit is $ 986 per event. It is obvious that getting people into community-based mental health services in a timely and efficient manner is the best and most cost-effective method of treatment.

G. **Addressing priority community need:** Palo Pinto County is a rural county and transportation issues are a problem for many making access to mental health services difficult. It is also medically underserved which includes a shortage of mental health providers as well. The RHP 11 Summary of Community Needs, CN.3 stated, "Shortages of health care professionals, including mental health care providers." This project is an attempt to alleviate this shortage by providing 4 additional mental health staff including a psychiatrist.

H. **Estimated local funding**: Pecan Valley has sufficient local funding in order to make the necessary IGT allocations to fund the 40% of the total allocation.

130724106.*1.1*	***1.9.2***	***1.9.2.A-B***	***EXPAND SPECIALTY CARE CAPACITY*** ***ACCESS REDESIGN TO TARGET QUICKER ACCESS TO PSYCHIATRIC SERVICES***	
Pecan Valley Centers for Behavioral and Developmental Healthcare				*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: Numerator: Number of individuals receiving psychiatric evaluation within 10 business days Denominator: Number of individuals authorized to routine services Data Source: EHR, Administrative records. Milestone 1 Estimated Incentive Payment *(maximum*	**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: New referrals will be processed and scheduled within 28 days of initiation. Numerator: Sum, for all referrals, of the number of days between when request		**Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [1.23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2) Goal: 15% increase or 138 events (over 920) Data Source: Encounter data, billing records Milestone 5 Estimated Incentive Payment: $ 274,272	**Milestone 6** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [1.23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline for DY2) Goal: 25% increase or 230 events (over 920). Goal will be to have 120 new patients receive psychiatric services within 10 days Data Source: Encounter data, billing records

130724106.*1.1*	***1.9.2***	***1.9.2.A-B***	***EXPAND SPECIALTY CARE CAPACITY*** ***ACCESS REDESIGN TO TARGET QUICKER ACCESS TO PSYCHIATRIC SERVICES***	
Pecan Valley Centers for Behavioral and Developmental Healthcare				*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)**
amount): $ 116,735 **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 Data Source: data collection plan	for referral is received from referring provider and the referral appointment during the reporting period. Denominator: Total number of referrals during the reporting period. Data Source: EHR, Referral Management system, Administrative records. (Generated Reports on file). Milestone 3 Estimated Incentive Payment: $ 128,190 **Milestone 4** [P-17] Implement the re-design of medical specialty clinics in order to increase operational efficiency, shorten patient cycle time and increase provider productivity.			Milestone 6 Estimated Incentive Payment: $ 264,997

130724106.*1.1*	***1.9.2***	***1.9.2.A-B***	***EXPAND SPECIALTY CARE CAPACITY*** ***ACCESS REDESIGN TO TARGET QUICKER ACCESS TO PSYCHIATRIC SERVICES***	
Pecan Valley Centers for Behavioral and Developmental Healthcare				*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 2 Estimated Incentive Payment: $ 116,735	Metric 1 [P-17.1]: Number of medical specialty clinics that have completed clinic redesign. Baseline/Goal: 1 clinic-including 4 additional staff Data Source: Specialty clinic appointment tracking system Milestone 4 Estimated Incentive Payment: $ 128,189			
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ 233,470	Year 3 Estimated Milestone Bundle Amount: $ 256,379		Year 4 Estimated Milestone Bundle Amount: $ 274,272	Year 5 Estimated Milestone Bundle Amount: $ 264,997

Summary Information:

- Provider: Rolling Plains Memorial Hospital is a 42 bed hospital in Sweetwater, TX serving 912 square mile area and a population of approximately 15,000.

- Intervention(s): This project will expand prenatal services for the 100 families that currently leave Nolan County for these services through recruitment of an OB/Family Care doctor.

- Need for the project: We currently have 2 doctors providing OB services, with the possibility of this dropping to 1 within the year.

- Medicaid and Uninsured Target population: The target population is expectant mothers needing prenatal services. Approximately 75% of our patients currently seeking these services is Medicaid.

- Category 1 or 2 expected patient benefits: The project seeks to increase births to 200 by DY5, an increase of 115 over DY2. The project will provide local access to patients needing obstetrical services and result in healthier pregnancies and newborns.

- Category 3 outcomes: IT-8.2 Our goal is to reduce the low birth rate weight from 11.7% currently to 6% by DY5.

L. Category 1: Infrastructure Development

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

Narrative for each Category 1 Project shall include:

- The narrative for each Category 1 Project is limited to 6 pages.
- **Identifying Project and Provider Information:** Expand Specialty Care Capacity 1.9.1, 133244705.1.1, Rolling Plains Memorial Hospital/133244705
- **Project Description:** In 2010, the State of Texas reported 199 births to Nolan County residents and only 85 were born in Sweetwater, where Rolling Plain Memorial Hospital (RPMH) is located and is the sole hospital in Nolan County. The remaining 114 were born in hospitals outside of Nolan County. Based on this report, we believe there is limited access to prenatal and to obstetrical care in Sweetwater and Nolan County. RPMH has two physicians who deliver babies in the hospital, and could possibly be reduced to one within the year. In order to retain and maintain these services, we pay for Labor and Delivery malpractice and an OB on call per diem. It has become very costly to recruit and pay for OB care in rural facilities. The average age of our physicians is 57 years old. Having limited access to physicians who deliver, an aging physician team, and limited staff who will take on call duties further creates a stressor for the two physicians we currently have. Burnout in OB and the stress related to on call are significant challenges to recruiting additional OB physicians to Sweetwater. As most of our OBs are Family Practice physicians, they often also have Emergency Department on call routines which they also serve. In order to recruit and hire another physician practicing OB, we expect to offer a monthly stipend and some type of loan repayment program in addition to the other standard signing bonuses and guarantees or employment.
  We see this project as an opportunity to expand and to provide access to OB physicians for the over 100 births that must go outside the county for services.
  Through this initiative, RPMH plans to expand access to prenatal services. Currently, RPMH coordinates with the local health department to provide low cost prenatal and pregnancy counseling services to women who are typically uninsured and/or have not usual access to care. While this provides an enhanced access point for prenatal care, there is still limited capacity. This clinic is only open a limited number of days and hours throughout the week. Women may come and stand in line to access this service. We work with the high schools and other girls groups to educate pregnant girls on the birth experience

and the need for early intervention for prenatal care, but there remains a gap in education and access options locally. By recruiting and hiring an OB Doctor for our LDR unit, there will be increased capacity and access for pregnant women and girls to receive prenatal care which reduces the potential for preterm and low birth weight babies. Though RPMH doesn't provide clinic services for prenatal care, our physicians do. By recruiting FP/OBs to Sweetwater, access to quality care to improve health outcomes during and post pregnancy will improve. By DY 5 we expect to deliver 200 babies at RPMH.
RHP 11 has chosen to focus on increasing the capacity of primary and specialty care to further advance the goals of the Triple Aim: right care, right place, and right time. We anticipate that all the projects will reduce the burden on Emergency Departments and improve health outcomes across the region.
RHP 11 has a number of collaborations which invests resources into our rural communities where sole providers face burnout and fatigue. This project will begin to build the infrastructure needed in our primary care system to be the backbone for improved care coordination, chronic disease management and care transitions, projects of the future. In increasing the capacity of primary care, the cost of care will be impacted. The ED is the highest cost setting for care. When patients over utilize or unnecessarily utilize the ED for primary and preventive care, the cost burden is wasteful. Other providers have Specialty Care Projects, but none are for Obstetrics services.

- **Starting Point/Baseline:** In 2010, RPMH delivered 85 of the 199 babies born to Nolan County Residents with two OB physicians covering the LDR unit.

Rationale: As supported by CN.6, Nolan County is a Medically Underserved Area and OB services are limited across RHP 11. Required core project components are addressed as follows:

a) Identify high impact/most impacted specialty services and gaps in care and coordination: As demonstrated by the number of Nolan County residents who must go to other counties to have their baby, OB services at RPMH must be expanded to increase capacity and provide access to care.

b) Increase the number of residents/trainees choosing targeted shortage specialties: .. We do not have a residency program in Nolan County, but plan to sponsor someone by paying a stipend to a potential recruit during their residency

c) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention): RPMH will develop a plan to expand OB coverage for Nolan County, recruit an OB/Family

practice physician based on this plan, and increase the number of births over the baseline data in DY4 and increase over DY4 in DY5.

d) Conduct quality improvement for project using methods such as rapid cycle improvement: The Hospital will conduct a rapid cycle improvement project based on increasing the patient population for obstetrics.

50% of the births at RPMH in 2010 were Medicaid. Providing increased local access to these low income individuals is important as the expense to travel is a hardship. The ability to provide for prenatal care locally will result in improved health and outcomes for both Mother and Baby.

- **Related Category 3 Outcome Measure(s):**
  Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 *(Standalone measure)* IT-8.2
  Decrease number of babies with low birth rate by 5% by DY5. **:** Low birth weights result in increased length of stay, increased risk of complications, and future health issues. The ability to provide prenatal care decreases the risk of low birth weight and results in better neonatal outcomes, and positively impacts healthcare costs.

  Relationship to other Projects: [A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.]
- **Relationship to Other Performing Providers' Projects in the RHP:** [If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.]
- **Plan for Learning Collaborative:** [If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.]

- **Project Valuation:** We value this project at $2,061,753 based on the following analysis:

  Provider Size-RPMH Pass 1 allocation is 5.4% of the Pass 1 hospital allocation.

Project Size-We expect that that RPMH would be able to provide LDR services to over 100 pregnant women who left Nolan County to deliver in 2010. Additionally, we expect the recruitment of an OB to Sweetwater, would increase the capacity in the clinics to provide additional access to prenatal care.

Project Scope-We will improve access to quality labor and delivery services by increasing OB coverage and capacity for deliveries and increasing prenatal capacity services. Depending upon the negotiations with the recruited physician, a clinic will be expanded in Sweetwater to provide additional access to prenatal care.

Populations Served: This project will provide improved access to pre-natal coverage to all expectant moms, but especially the low income as continuous travel is not an option for them. By DY5 we expect to deliver 200 babies in Nolan County, an increase of 115 over baseline in DY2.

Community Benefit-Nolan County residents will be provided the access to quality prenatal and LDR services locally which will reduce unnecessary travel and missed work days while improving the health outcomes for mother and baby.

Cost Avoidance: As evidenced by the Medicaid, DSHS, and March of Dimes' Health Baby Initiatives, early prenatal care and increasing the chances that the mother carries the baby to full term results in healthier babies and lower costs.

Priority Community Need: Low income residents cannot afford to travel to distant towns for pre-natal care. Access to local care will increase the possibility of seeking pre-natal care by these individuals and decrease the risk of negative outcomes.

Estimated Local Funding: Local funding is through our Hospital District.

133244705.1.1	***1.9.1***	***1.9.1.A*** ***1.9.1.C*** ***1.9.1.D***	***EXPAND SPECIALTY CARE***
Rolling Plains Memorial Hospital			*133244705*
Related Category 3 Outcome Measure(s):	133244705.3.1	IT-8.2	Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)

Year 2 (10/1/2012 – 9/30/2013)	**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-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 <u>Metric 1</u> P-12.1. Documentation of specialty care access plan Baseline/Goal: a. Numerator: 0 if no documentation is provided, 1 if documentation is provided. b. Denominator: NA Rationale: The need for expanded OB coverage in the	**Milestone 2** I-22: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties <u>Metric 1</u> I-22.1. Metric: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties a. Numerator: Number of specialist providers in targeted specialties over baseline or change in the number of specialist providers in targeted specialties b. Denominator: Number of monthly or annual referrals into targeted medical specialties clinic or	**Milestone 3**: I-X: Increase births at Rolling Plains Memorial Hospital as evidence of improved access for patients seeking services. <u>Metric 1</u>: I-X.1 Goal: Increase births by 75 over baseline year DY2 Data Source: Statistical Report showing number of births Milestone 3 Estimated Incentive Payment: $557,165	` **Milestone 4**: I-X: Increase births at Rolling Plains Memorial Hospital as evidence of improved access for patients seeking services. <u>Metric 1</u>: I-X.1 Goal: Increase births by 115 over DY2 Data Source: Statistical Report showing number of births Milestone 4 Estimated Incentive Payment: $477,366

133244705.1.1	***1.9.1***	***1.9.1.A*** ***1.9.1.C*** ***1.9.1.D***	***EXPAND SPECIALTY CARE***
Rolling Plains Memorial Hospital			*133244705*
Related Category 3 Outcome Measure(s):	133244705.3.1	IT-8.2	Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)

Year 2 (10/1/2012 – 9/30/2013)	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 Baseline: 85 births in 2010; 2 OB Doctors Data Source: Written OB Recruitment Plan Milestone 1 Estimated Incentive Payment (*maximum amount)*: $475,757	number of specialist providers in targeted specialties at baseline c. Data Source: HR documents or other documentation demonstrating employed/contracted specialists d. Rationale/Evidence: Increased number of specialists to meet demand and referral demand for in-person visits and procedures will allow patients to receive more timely services. Baseline/Goal: Recruit 1 new OB/Family practice physician Data Source: Document demonstrating employed or contracted physician Milestone 2 Estimated Incentive Payment: $551,465		

133244705.1.1	***1.9.1***	***1.9.1.A*** ***1.9.1.C*** ***1.9.1.D***	***EXPAND SPECIALTY CARE***
Rolling Plains Memorial Hospital			*133244705*
Related Category 3 Outcome Measure(s):	133244705.3.1	IT-8.2	Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
ear 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $475,757	Year 3 Estimated Milestone Bundle Amount: $551,465	Year 4 Estimated Milestone Bundle Amount: $557,165	Year 5 Estimated Milestone Bundle Amount: $477,366
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $2,061,753			

Pass 3B
Summary Information: New ID: 126842705.1.3
Old ID: 126842705.1.1

- Provider: Stamford Memorial Hospital is a 25-bed hospital in Stamford, Texas serving a 377 square mile area and a population of approximately 20,000.

- Intervention(s): This project will establish a walk-in clinic to expand primary care access points. By DY 5 we expect to increase primary care capacity by 1,000 visits per year by opening this walk-in clinic. This goal is based on the minimum visits a NP is expected to see in a RHC in a year. Our walk-in clinic NP will also be responsible for the ED; therefore, we are reducing his primary care visits goal by 50%.

- Need for the project: We have an RHC that has reached capacity due to the providers' limited working hours. We believe that this is a significant cause for 88% of our non-emergent ED visits.

- Medicaid and Uninsured Target population: The target population is our ED patients that have non-emergent needs that cannot be seen in the clinic the day that they call. Approximately 59% of our ED patients are either Medicaid eligible or indigent.

- Category 1 or 2 expected patient benefits: The project seeks to expand access to primary care by adding a NP in a walk-in clinic with expanded hours which should reduce non-emergent ED visits. Our goal is to increase primary care visits by 1,000 per year starting in DY 5.

- Category 3 outcomes: We have selected IT-9.2 for our standalone measure. Our goal is to increase primary care visits by 1,000 each year starting in DY 5 which should reduce non-emergent ED visits, encouraging appropriate care in the appropriate setting.

Category 1: Infrastructure Development – Walk-In Clinic

Project Option: 1.1.2 – Expand access to primary care

Unique Project ID: New ID: 126842705.1.3
Old ID: 126842705.1.1

Facility Description: Stamford Memorial Hosptial-126842705

Project Description:

88% of our ED visits are classified as non-emergent. We would like to redirect those visits to a more appropriate care setting and then educate the patients on the appropriate use of the ED and medical homes. This hospital-based urgent care clinic would have extended hours and no appointment would be necessary. This would expand access points for non-emergent visits. Our RHC providers have reached capacity due to limited working hours. The goals of this project are to increase capacity, increase access points, and reduce waiting times. Regionally, this would expand our infrastructure and patient education to alleviate the non-emergent needs currently being seen in our EDs across the RHP.

One obstacle that we face in implementing this project is finding a provider and nurse to staff the urgent care clinic. Another obstacle we face is not having an incentive for the patient to not use the ED inappropriately. Our 5-year outcome is increased access to primary care resulting in increased capacity and visits by 1,000 primary care visits annually by DY 5. We expect increases annually starting in DY 3 due to operational efficiencies and increased publicity. This should benefit the entire region's ED utilization by educating the patients on appropriate ED utilization and the importance of establishing a relationship with a primary care physician.

Starting Point/Baseline:

Currently, our RHC has zero capacity to relieve non-emergent ED use; therefore, we are establishing a new urgent care clinic. For 2011, our ED visits were 2,561. 88% of those visits were non-emergent.

Rationale:

Stamford Memorial Hospital is implementing 1.1.2 Expand existing primary care capacity. We will be meeting and doing all required core project components. We will expand primary care clinic space by converting existing offices into a nurse's office, an exam room, and a waiting room. We will expand primary care clinic hours by opening a new clinic which will operate 3 days per week in DY 2 and DY 3, and then expand hours in DY 4 and DY 5. We will expand primary care clinic staffing by hiring a new NP. This will provide an additional primary care access point. The community need identification number is CN 5, the need to overcome patient access to care barriers.

Related Category 3 Outcome Measure:

OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization.

This is a priority for RHP 11 because inappropriate ED use is rampant. 88% of our ED visits are non-emergent with 42% of those visits occurring during regular business hours when our clinic is open. We want to increase access to primary care to encourage appropriate care in the appropriate setting.

Relationship to other Projects:

Several RHP providers, including Haskell Memorial Hospital and Rolling Plains Memorial Hospital, are expanding primary care access to encourage appropriate care in the appropriate setting. Projects include 1.1 and 1.2.

Relationship to Other Performing Providers' Projects in the RHP:

Palo Pinto General Hospital, the anchor, is coordinating a learning collaborative among the entire RHP because even if a provider did not select expanding primary care to encourage appropriate care in the appropriate setting as their project, it is our RHP-wide goal.

Plan for Learning Collaborative:

Palo Pinto General Hospital will coordinate regular meetings on educating patients to use the ED appropriately, increasing access points effectively, and other primary care expansion topics.

Project Valuation:

Our total ED visits for 2011 were 2,561. We project that DY 2 will be slightly increased. An analysis of the type of ED visits showed that 88% of our ED visits are non-emergent. 42% of all ED visits are seen during the hours of 8 a.m. to 5 p.m. By opening an urgent care clinic, we will improve access to care by increasing staff. We will also reduce costs by shifting non-emergent care from the ER to the urgent care setting. It will cost the patients less and the hospital less because the appropriate care is being given in the appropriate setting. We will not be penalized for seeing a patient in the ED with a non-emergent diagnosis. 70% of our 2011 ED visits were Stamford residents. Stamford Memorial Hospital is a hospital district; therefore, we will provide our own IGT to support this project. Approximately 59% of our ER visits are Medicaid or non-insured patients. Expanding primary care capacity is the project by several of the providers in RHP 11. The majority of RHP 11 is located in a HPSA; therefore, having access to additional funds to hire another provider makes a huge difference in caring for our communities. If we can provide access to the appropriate care in the appropriate setting across the region, it will benefit the patients and the providers by increasing access to care and decreasing costs. Medicare expects a NP in a RHC to see 2,100 visits in a full year. Our NP will not meet this standard due to our being 50% through DY 2 and for all years, he will cover the ED and the walk-in clinic; therefore, our goal is 1,000 primary care visits in the walk-in clinic in DY 5. The NP was hired as of January 14, 2013 and has seen 29 primary care patients that would have otherwise been seen in the ED as a non-emergent visit as of February 4, 2013. The population served will be pulled from the RHC that has a capacity issue and also non-emergent visits from the ED.

NEW ID: 126842705.1.3 OLD ID: 126842705.1.1	***1.1.2***	***1.1.2.A 1.1.2.B 1.1.2.C***	**Expand access to primary care**	
Stamford Memorial Hospital				*126842705*
OD-9	New ID: 126842705.3.3 Old ID: 126842705.3.1	*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. Milestone: Establish additional/expand existing/relocate primary care clinics Metric 1 P-1.1. Metric: Number of additional clinics or expanded hours or space: Documentation of detailed expansion plans Baseline/Goal: ED overutilization and the need for another Primary Care Access point. Our goal is to open a new primary care clinic. Data Source: New primary care schedule or other Performing Provider document or other	**Milestone 3** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Baseline/Goal: Based on need and increased capacity, we may need to hire additional providers and staff, and staff will continue to be trained in increasing access to primary care. Data Source: Provider employment contract Milestone 3 Estimated Incentive Payment: $210,340 **Milestone 4** : P-X Establish baseline rates		**Milestone 5** I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period Goal: Increase primary care visits to the NP standard of 2,100 visits adjusted for his coverage of the ED and the walk-in clinic to 750 in DY 4. Data Source: Registry, EHR, claims or other Performing	**Milestone 6** [I-3]: I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period Goal: Increase primary care visits to the NP standard of 2,100 visits adjusted for his coverage of the ED and the walk-in clinic to 1,000 in DY 5. Data Source: Registry, EHR, claims or other Performing

NEW ID: 126842705.1.3 OLD ID: 126842705.1.1	***1.1.2***	***1.1.2.A 1.1.2.B 1.1.2.C***	**Expand access to primary care**
Stamford Memorial Hospital			*126842705*
OD-9	New ID: 126842705.3.3 Old ID: 126842705.3.1	*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)**
plans as designated by Performing Provider. Milestone 1 Estimated Incentive Payment *(maximum amount):* $192,805 **Milestone 2** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Baseline/Goal: Hire a Nurse Practitioner and LVN and increase hours and capacity. Data Source: Provider employment contract Milestone 2 Estimated Incentive Payment: $192,805	Metric 1 [P-X.1]: Baseline/Goal: We will establish a baseline for capacity of primary care visits to then measure the increase year over year in DY 4 and DY 5. Our goal based on standard NP hours is 1,000 annual visits in the walk-in clinic by DY 5. Data Source: Clinic visit stats Process Milestone 4 Estimated Incentive Payment: $210,340	Provider source Milestone 5 Estimated Incentive Payment: $421,903	Provider source Milestone 6 Estimated Incentive Payment: $348,529
Year 2 Estimated Milestone Bundle Amount: *(add incentive*	Year 3 Estimated Milestone Bundle Amount: $420,680	Year 4 Estimated Milestone Bundle Amount: $421,903	Year 5 Estimated Milestone Bundle Amount: $348,529

NEW ID: 126842705.1.3 OLD ID: 126842705.1.1	***1.1.2***	***1.1.2.A 1.1.2.B 1.1.2.C***	**Expand access to primary care**	
Stamford Memorial Hospital				*126842705*
OD-9	New ID: 126842705.3.3 Old ID: 126842705.3.1	*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)**
payments amounts from each milestone): $385,610				
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $1,576,722				

Pass 3B
Summary Information: New ID: 126842705.1.4
Old ID: 126842705.1.2

- Provider: Stamford Memorial Hospital is a 25-bed hospital in Stamford, Texas serving a 377 square mile area and a population of approximately 20,000.

- Intervention(s): This project will establish access to a medical advice line to expand primary care access points and improve the flow between our RHC, walk-in clinic, and our ED. Our goal is to take 300 calls annually starting in DY 5.

- Need for the project: In 2011, 88% of our ED visits were classified as non-emergent signifying that either the clinic was unavailable or the patient does not know the appropriate ED use. We want to proactively direct our patients to the appropriate setting for their acute and chronic healthcare needs via an RN.

- Medicaid and Uninsured Target population: The target population is our ED patients that have non-emergent needs. Approximately 59% of our patients are either Medicaid eligible or indigent.

- Category 1 or 2 expected patient benefits: The project seeks to expand access to primary care by establishing access to an RN via telephone. This should improve the flow between the ED, the RHC, and the walk-in clinic, decreasing non-emergent ED visits and increasing primary care visits. Our goal is to take 250 calls in DY 4 and 300 calls in DY 5 which should support our goal of increasing primary care visits in the walk-in clinic by 1,000 annual visits in DY 5.

- Category 3 outcomes: We have selected IT-9.2 for our standalone measure. Our goal is to reduce non-emergent ED visits by 15% at the end of DY 5, encouraging appropriate care in the appropriate setting.

Pass 2
Category 1: Infrastructure Development-Medical Advice Line

Project Option: 1.6.2-Enhance Urgent Medical Advice Line to Reduce ED Use for Non-Emergent Conditions

Unique Project ID: New ID: 126842705.1.4
Old ID: 126842705.1.2

Facility Description: Stamford Memorial Hospital-126842705

Project Description:

88% of our ED visits are classified as non-emergent. We would like to provide convenient telephonic access to a registered nurse who can direct non-emergent visits to our walk-in clinic established in Pass 1 and also educate the patients on the appropriate use of the ED and medical homes. The RN and the walk-in clinic would expand access points for non-emergent visits. Our RHC providers have reached capacity due to limited working hours. The goals of this project are to increase access points and re-direct non-emergent visits thus reducing ED wait times. Regionally: Infrastructure and education to alleviate the non-emergent needs in our ED. One obstacle that we face in implementing this project is finding RNs to staff the medical advice line. Another obstacle we face is not having an incentive for the patient to not use the ED inappropriately. Our 5-year outcome is 300 calls annually. This should benefit the entire region's ED utilization by educating the patients on appropriate ED utilization. Our goals are to establish the medical advice line in DY 2, train additional RNs in DY 3, and then take 250 and 300 calls in DY 4 and DY 5 respectively. We are going to establish a medical advice line. The responsibility of establishing protocols and answering the medical advice line telephone will be shared by 3 RNs in DY 2. After DY 2, the 3 RNs will train other RNs on the medical advice line protocols. When training is complete, the medical advice line will be rotated through all of the RNs. Our final goal is 300 calls annually. This is our goal, but we do not know the actual demand for this service. The nurses will provide general health information, self-care instructions, when appropriate, guidance on whether to see a doctor, physician and/or service referral, and escalation to emergency services. We feel that this service will complement the walk-in clinic that is our other category 1 project and assist in achieving that project's goal of increasing primary care visits in the walk-in clinic to 1,000 annually starting in DY 5.

Starting Point/Baseline:

Our current access points are our RHC, our new walk-in clinic, and our ED. We would like to establish the medical advice line to improve the patient flow of the RHC, walk-in clinic and the ED. For 2011, our ED visits were 2,561. 88% of those visits were non-emergent.

Rationale:

Stamford Memorial Hospital is implementing 1.6.2 Establish a medical advice line and direction to the appropriate level of care to reduce ED use for non-emergent conditions and increase patient access to health care. We will be meeting and doing all required core project components. We will develop a process, including a call center, to triage patients in a timely manner. We will enhance linkages between the ED, our walk-in clinic, and our RHC by hiring a new RN and using our existing LVNs that work in all three departments. The RN will be tasked with conducting quality improvement projects. The community need identification number is CN 5, the need to overcome patient access to care barriers.

QI: The medical advice line will be set up as a new department and will be included in our monthly Quality Assessment Performance Improvement committee report that is submitted to the QAPI committee monthly. The committee reviews the departmental reports quarterly. The committee consists of Rick DeFoore, CEO, Angie Gass, CNO, Pat McLaren, HIM Manager, Dr. Michael Hart, Chief of Medical Staff and QAPI Chairman.

Related Category 3 Outcome Measure:

OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization.

This is a priority for RHP 11 because inappropriate ED use is rampant. 88% of our 2011 ED visits are non-emergent during regular business hours when our existing RHC is open. We want to increase access to primary care to encourage appropriate care in the appropriate setting. Our population will be the non-emergent ED visits that use the call line.

Relationship to other projects, providers, and our learning collaborative:

In Pass 2, RHP 11 continues to focus on increasing access to primary care in order to decrease our patients' use of the ED in non-emergent situations. We will collaborate on how to best educate our patients and guide them to the appropriate level of care.

Project Valuation:

Our total ED visits for 2011 were 2,561. We project that DY 2 will be slightly increased. An analysis of the type of ED visits showed that 88% of our ED visits are non-emergent. By establishing a medical advice line, we will reduce costs by shifting non-emergent care from the ER to the primary care setting, either our RHC or our walk-in clinic. It will cost the patients less and the hospital less because the appropriate care is being given in the appropriate setting. We will not be penalized for seeing a patient in the ED with a non-emergent diagnosis. 70% of our 2011 ED visits were Stamford residents. Stamford Memorial Hospital is a hospital district; therefore, we will provide our own IGT to support this project. Approximately 59% of our ER visits are Medicaid or non-insured patients. Expanding primary care capacity is the project by several of the providers in RHP 11. The majority of RHP 11 is located in a HPSA; therefore, having access to additional funds to hire another RN makes a huge difference in caring for our communities. If we can provide access to the appropriate care in the appropriate setting across the region, it will benefit the patients and the providers by increasing access to care and decreasing costs. This project will target the uninsured and non-managed care Medicaid.

Various studies have demonstrated the efficacy of a telephone nurse triage program. The state wide New Mexico Nurse Advice line has demonstrated savings of $40.96 per triage call, in total health care costs. O'Connell, JM's study (American Journal of Managed Care) demonstrated a reduction of $1.70 in Emergency Room costs for every $1 invested in nurse telephone triage. The Society of Actuaries return on investment evaluation of nurse telephone triage estimate ratios of 2.5 - 3.5. Our goals are to establish the medical advice line in DY 2, train additional RNs in DY 3, and then take 250 and 300 calls in DY 4 and DY 5 respectively. This is our goal, but we do not know the actual demand for this service. The nurses will provide general health information, self-care instructions, when appropriate, guidance on whether to see a doctor, physician and/or service referral, and escalation to emergency services. We feel that this service will complement the walk-in clinic that is our other category 1 project and assist in achieving that project's goal of increasing primary care visits in the walk-in clinic to 1,000 annually starting in DY 5.

NEW ID: 126842705.1.4 OLD ID: 126842705.1.2	***1.6.2***	***1.6.2.A 1.6.2.B 1.6.2.C***	**Enhance Urgent Medical Advice**
Stamford Memorial Hospital			*126842705*
OD-9	New ID: 126842705.3.4 Old ID: 126842705.3.2	*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. Milestone: Establish clinical protocols for an urgent medical advice line. <u>Metric 1</u> P-1.1. Metric: Submission of complete protocols Baseline/Goal: Establish protocols within 4 years of the demonstration period Data Source: Protocol documents Milestone 1 Estimated Incentive Payment *(maximum amount):* $189,997	Milestone 2 P-3: Train nurses on clinical protocols <u>Metric 1</u> [P-2.1]: Baseline/Goal: Number of nurses trained Data Source: HR records Milestone 2 Estimated Incentive Payment: $207,521	Milestone 3 I-13. Milestone: Increase in the number of patients that accessed the nurse advice line. <u>Metric 1</u> I-13.1. Metric: Utilization of nurse advice line a. Total number of calls for reporting period Goal: Increase calls to 250 based on the baseline established in DY 2 Data Source: Registry, EHR, claims or other Performing Provider source Milestone 3 Estimated Incentive Payment: $209,209	Milestone 4: I-13. Milestone: Increase in the number of patients that accessed the nurse advice line. <u>Metric 1</u> I-13.1. Metric: Utilization of nurse advice line a. Total number of calls for reporting period Goal: Increase calls from DY 4 to 300 Data Source: Registry, EHR, claims or other Performing Provider source Milestone 4 Estimated Incentive Payment: $171,014

NEW ID: 126842705.1.4 OLD ID: 126842705.1.2	***1.6.2***	***1.6.2.A 1.6.2.B 1.6.2.C***	**Enhance Urgent Medical Advice**
Stamford Memorial Hospital			*126842705*
OD-9	New ID: 126842705.3.4 Old ID: 126842705.3.2	*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: $189,997	Year 3 Estimated Milestone Bundle Amount: $207,521	Year 4 Estimated Milestone Bundle Amount: $209,209	Year 5 Estimated Milestone Bundle Amount: $171,014
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: **$777,741**			

Summary Information: **Unique Project ID:** 119875604.1.1

- Provider: Stephens Memorial Hospital is a 40-bed hospital in Breckenridge, TX serving Stephens County with a population of 9,000.

- Intervention(s): This project will expand primary care access.

- Need for the project: We currently have four primary care physicians on staff with two of them being in their mid eighties and soon to retire.

- Medicaid and Uninsured Target population: Our target population are the medically underserved and Medicaid population of Stephens County.

- Category 1 or 2 expected patient benefits: This project seeks to provide more access to physician office visits and reduced visits to the hospital's Emergency Department.

- Category 3 outcomes: It is our goal to improve patient satisfaction survey by 3% over the base-line by the end of the project (DY5).

Category 1: Infrastructure Development-Expand Primary Care Services

Project Option: 1.1.2 expand primary care capacity

Unique Project ID: 119875604.1.1

Facility Description: Stephens Memorial Hospital-119875604

Project Description:

Stephens Memorial Hospital is located in Breckenridge, TX (Stephens County). Stephens County is an impoverished rural county and is in current and future need of primary care services to reduce the number of patients using the Emergency Department for non-acute levels of care.

The hospital would (1.1.2) expand primary care capacity, (1.1.2 (a)) expand primary care clinic space, (1.1.2(b)) expand primary care clinic hours, and (1.1.2(c)) expand primary care clinic staffing.

The current space being utilized by the hospital's rural health clinic was originally designed to house four (4) private practices/businesses and therefore, not optimized for patient and provider flow under the current construct of being operated as one business. Consolidation of wasted and unused square footage and consolidation of three waiting rooms into one are needed to expand capacity, increase space, expand hours of operation and expand clinic staffing.

Starting Point/Baseline:

The Rural Health Clinic currently operates as one business with three physicians and one mid-level provider. Due to the age of two of the physicians, there is an impending need to recruit additional provider staff. One of the physicians is eighty-five (85) years of age and another one is eighty-three (83). Both are set to retire within the next year or so. Furthermore, the Emergency Department of the hospital treats approximately 6,000 patients per year of which 63% do not require the level of care given by ED physicians or staff.

Rationale:

More often than not, lack of primary care providers and resources will drive patient utilization to the hospital's Emergency Department. This is a very costly driver of healthcare expenses and care that does not provide optimal continuity. By replacing retiring physicians in our Rural Health clinic, we can maintain clinic utilization that would otherwise end up in our Emergency Department.

Utilization will be measured by the number of visits seen by physicians that replace the retired physicians, i.e. the volume lost of clinic visits by the retiring physician will be replaced the newly recruited physician over a four (4) year period.

Plan for Patient Satisfaction:

- Complete a planning process/submit a plan, in order to do appropriate planning for the recruitment of primary care providers and clinic re-allocation of space.
- Recruit primary care provider(s).
- Increase visits to rural health clinic lost by retired providers.
- Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
- Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

119875604.1.1	1.1.2. a, b, c: Expand primary care capacity	*Patient Satisfaction*	
Stephens Memorial Hospital			119875604
Related Category 3 Outcome Measures:	119875604.3.1		
Year 2 (10/1/2012 – 9/30/2013)	**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 [RHP PP Milestone P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers.	Milestone 1 [RHP PP Milestone P-5.1]: Metric: Documentation of increased number of providers and staff and/or clinic sites.	Milestone 2 [RHP PP I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care.	Milestone 2 [RHP PP I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. a. Total number of visits for reporting period b. Data Source: Registry, EHR, claims or other Performing Provider source c. Rationale/Evidence: This measures the increased volume of visits and is a method to assess the ability for the Performing Provider to increase capacity to provide care.

119875604.1.1	1.1.2. a, b, c: Expand primary care capacity	*Patient Satisfaction*	
Stephens Memorial Hospital			119875604
Related Category 3 Outcome Measures:	119875604.3.1		
Year 2 (10/1/2012 – 9/30/2013)	**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): $126,682	Year 3 Estimated Outcome Amount: $146,841	Year 4 Estimated Outcome Amount: $148,359	Year 5 Estimated Outcome Amount: $127,110
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD - $ 548,993			

Stonewall Memorial Hospital – 020992601
TPI Summary for Project ID# 020992601.1.1.

Summary Information:

- Provider: Stonewall Memorial Hospital is a Critical Access Hospital in Aspermont, Stonewall County, Texas licensed for 20 beds. This hospital and rural health clinic is the only source for healthcare in Stonewall County, approximately 900 square miles, population 1472 and is the closest source of healthcare for Kent and King counties to the north and west.

- Intervention(s): This project will expand primary care access to healthcare for all residents in the area.

- Need for the project: We currently have four clinic exam room, limited clinic availability, and two primary care providers in this very rural area. Provider turnover, patient access to healthcare, and quality improvements are the goals of this project.

- Medicaid and Uninsured Target population: Expanding our ability to provide primary care to the uninsured and Medicaid population in the area is vital to the overall health and well-being of the community. Decreasing the need for patient referrals outside of the county will be immensely beneficial to the community as well..

- Category 1 or 2 expected patient benefits: This project seeks to increase clinic patient encounters 7% by DY5, reduce non-emergent ERs 3% by DY5 and have three FTE primary care providers by DY4.

- Category 3 outcomes: IT-6.1 Our goal is to increase patient satisfaction by a percentage TBD after baseline HCAHPS scores are established in DY3. Patient satisfaction will improve as we are becoming more capable of fulfilling the healthcare needs in our community.

Project Title: Healthcare Access Expansion and Improvement
RHP Planning Protocol, 1.1.2 – Expand Existing Primary Care Capacity
Unique Project ID# 020992601.1.1

Stonewall Memorial Hospital, TPI#020992601
Project Description - Stonewall Memorial Hospital is a Critical Access Hospital located in Aspermont, Stonewall County, Texas. This facility was built and opened in 1964 after the Stonewall Memorial Hospital District was formed in 1962. The hospital became a Critical Access Hospital in 2001 to ensure continued availability of healthcare in this rural county. Stonewall County is approximately 900 square miles in area with 1472 current residents (1.6 per square mile). 24.9% of the population in Stonewall County are over 65 years of age (10.5% in Texas) and the median household income in the county is $52,222. The Stonewall Memorial Hospital and Rural Health Clinic also serves many residents of neighboring Kent (population 825) and King counties (population 255) to the west and north of Stonewall County because there are no healthcare providers in those counties.
Our project will be to expand our primary care capacity by increasing patient care space availability, increasing the hours of clinic operations, and adding vital clinical staffing needs and training. Better utilization of available space and expanding the hours of operations will emphasize the need to add a third provider and provide further training for medical personnel in the rural health clinic. Recruiting and retaining qualified medical personnel is a difficult task in rural areas that are designated as underserved such as Stonewall County, Texas. Our five year expected outcomes will be an increase of 9% in total patient clinic encounters from the baseline established in DY2 and a decrease of 5% in non-emergency ER encounters from the baseline established in DY2 by increasing the access to healthcare for our citizens through additional exam rooms, expanded clinic hours, and adding a primary care provider. These improvements will be verified through the increase in actual clinic visit encounters and a decrease in the non-emergency ER encounters, coupled with improved patient satisfaction scores in the HCAHPS surveys to be implemented with the Category 3 project outcomes.

Starting Point – Baseline - Stonewall Rural Health Clinic had 3,316 clinic visits and 720 ER visits (of which 641 could be classified as non-emergency) in DY1.
Having only four exam rooms and the clinic open for only six hours per day for patient encounters limits the scheduling capacity to approximately eighteen patients.
The current FTE providers for Stonewall Memorial Hospital in DY1 were 2.15.

Rationale and Goals – 1.1.2 a) Expand primary care clinic space by increasing the available exam rooms from the current four rooms to six exam rooms by relocating two business office personnel to other space within the facility. This will reduce waiting room times in our rural health clinic and allow the providers to see more patients on any given day. The reallocation of space will allow our clinic primary care providers the ability to see at least 500 more patients each year and reduce the number of patients that present to the ER with non-emergent

1.1.2 b) Expansion of clinic hours to increase the accessibility to healthcare for our working residents is an often cited need in this community. Many of our after-hour ER encounters are directly related to this issue. Expansion of clinic hours would reduce the number of non-emergency ER visits and would increase the volume of our clinic visits delivering much more efficient health care to the residents in this very rural area. The goal would be to increase the number of clinic visits by 9% DY1 to DY5 and decrease the ratio of non-emergency ER visits to total ER visits by 5%.

1.1.2 c) Stonewall Memorial Hospital and Rural Health Clinic is currently being served by one full time physician, one full time nurse practitioner, and one semi-retired physician (72 years of age). The clinic, hospital, and ER time requirements for these providers is very daunting and is the root cause of the rapid turnover of providers in this facility. A third full time provider would alleviate much of the stress on our providers and allow for more patient encounters in the clinic setting.

Related Category 3 Outcome Measures

OD-6 Patient Satisfaction

IT-6.1 Percent improvement over baseline of patient satisfaction scores.

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

Increasing our clinic's availability, additional staff training and better medical needs case management through outpatient services, and an additional provider to our community will increase patient satisfaction in our hospital and clinic. This will also help us provide better quality care for all of our patients in ways that reduce the overall costs of care with increased personal interaction, better outcomes, and much better efficiency than the current model.

Our goals for this project will be to establish a baseline HCAPS score in DY2 and be able to show a demonstrable improvement through DY3 to DY5 of at least 10%.

Relationships to other projects and other performing providers in RHP 11 - Over 60% of the participating organizations in RHP11 are focusing on expanding primary care capacity in one form or another. Some are focused on physician recruitment while others focus on expanding services. Stonewall Memorial must focus on all of these areas to reach our goals. Each one is dependent upon our ability to accomplish the other.

We are all working towards the same goals to provide the patients and communities within the regions access to care that meets the growing need of the communities for the right care at the right time in the right setting. And by adding an additional Primary Care physician and expanding our clinic hours and staff we will be able to successfully reach our goals.

Project Valuation - The decision to put all of our value in the project to expand primary care capacity in several areas is an easy one for us. This is the goal we must have to ensure the survivability of our hospital and clinic.

Expanded clinic hours, increasing medical management capabilities through better outpatient processes, and adding a third provider will enable us to better serve our county's population and the two counties neighboring us: including the low income, Medicaid, Medicare and uninsured in these populations. We also anticipate it will decrease the number of non-emergent visits to the ER and allow our physicians to not be overwhelmed and burned out due to the number of hours spent on-call and in the ER for non-emergent care.

The valuation of the overall project is covered in many areas:

A. Reduce the non-emergency ER volume. This reduces costs to the taxpayers for covering losses at the hospital, a large community benefit. Providing care in the less expensive clinic setting where patients can be treated more efficiently and at lower costs is the primary goal of this project.
B. Wait times and costs to the patients are much less in the clinic thus improving patient satisfaction of the overall healthcare organization. Additional exam rooms and access by increasing the hours allows for more patients to be seen in the clinic.
C. Community needs and cost avoidance is also addressed by having the ability to manage more medical issues locally rather than creating hardships on local families having to travel large distances for assistance in managing their medical needs. Increasing the available exam rooms and expanding the hours of operation will allow more patients to be seen in the clinic versus the emergency room.
D. More preventative care can be provided, preventing medical issues from developing into urgent care situations as frequently. Allowing our providers more time with their patients will improve their ability to counsel the patients on managing their medical condition, thus alleviating the need for more extensive care later.

E. Conditions contributing to physician/provider burn-out can be addressed lowering the turnover rate of providers in the facility. Provider recruiting costs are extremely expensive in rural West Texas and Stonewall County is designated as an underserved area and is also designated as a “frontier” area.

***(Note to RHP Anchor) I determined that the table needed to be reworked totally so the first one I have just completed after starting over. The second one has some corrections included with the first submission. Correcting the first table was just going to be too confusing and I think needs to be deleted. Sorry for any inconvenience.**

020992601.1.1	***1.1.2***	***1.1.2 A-C***	***EXPAND PRIMARY CARE CAPACITY***
Stonewall Memorial Hospital			*020992601*
Related Category 3 Outcome Measure(s):	*020992601.3.1*		*Patient Satisfaction*

Year 2 (10/1/2012 – 9/30/2013)	**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 primary care capacity **Metric 1** P-1.1.2 a: Develop plan to expand clinic exam rooms by 33%. b: Develop plan to expand clinic hours. c: Develop plan to increase primary care staffing. **Improvement Milestone** I-12.1: Establish baseline of annual clinic visits I-13.1: Establish base line of non-emergent ER visits to total ER visits **Data Source:** Documentation from performing provider	**Milestone 2** P-1: Expand primary care capacity **Metric 1** P-1.1.2 a: Add additional exam rooms reutilizing existing space. b: Increase clinic hours x 2 hrs M-F. c: Begin recruiting either a physician intern or a mid-level practitioner. **Improvement Milestone** I-12.1 a: Increase total number of clinic visits by 4% in DY3 over baseline I-13.1 a: Decrease non-emergent ER visits as a percentage by 1%.of DY2 baseline. **Data Source:** Documentation	**Milestone 3** P-1: Expand primary care capacity **Metric 1** P-1.1.2 a: Maximize patient scheduling process that includes the two additional rooms. b: Increase clinic hours 8a-12p Saturdays. c: Increase the primary provider FTEs to 3.0. **Improvement Milestone** I-12.1 a: Increase total number of clinic visits by 7% in DY4 over baseline. I-13.1 a: Decrease non-emergent ER visits as a percentage by 3% of DY2 baseline. **Data Source:** Documentation from performing provider **Milestone 1 Estimated Incentive Payment:** $347,860	**Milestone 4** P-1: Expand primary care capacity **Metric 1** P-1.1.2 c: Increase training for all clinic staff through CMEs, certifications improving preventative care. **Improvement Milestone** I-12.1 a: Increase total number of clinic visits by 9% in DY5 over baseline. I-13.1 a: Decrease non-emergency ER visits as a percentage by 5% of DY2 baseline. **Data Source:** Documentation from performing provider

020992601.1.1	***1.1.2***	***1.1.2 A-C***	***EXPAND PRIMARY CARE CAPACITY***	
Stonewall Memorial Hospital				*020992601*
Related Category 3 Outcome Measure(s):	*020992601.3.1*		*Patient Satisfaction*	
Year 2 (10/1/2012 – 9/30/2013)	**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: $295,146	from performing provider. **Milestone 1 Estimated Incentive Payment:** $342,518			**Milestone 1 Estimated Incentive Payment:** $294,917
Year 2 Estimated Milestone Bundle Amount: $295,146	**Year 3 Estimated Milestone Bundle Amount: $342,518**		**Year 4 Estimated Milestone Bundle Amount: $347,860**	**Year 5 Estimated Milestone Bundle Amount: $294,917**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD - $1,280,441				

020 992601.1.2	***1.1.2***	***1.1.2 A-C***	***EXPAND PRIMARY CARE CAPACITY***	
Stonewall Memorial Hospital				*020992601*

Related Category 3 Outcome Measure(s):	*020992601.3.1*		*Patient Satisfaction*	
Year 2 (10/1/2012 – 9/30/2013)	**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-1.1: Expand primary care capacity **Metric 1** P-1.1.2~~a):~~ Expand primary care ~~clinic space~~ capacity **Baseline/Goal:** P-1.1.2a) Expand Clinic Exam Rooms by 33% (4 to 6) allowing for an increase in visit volume. b) Expand clinic hours 2 hrs per day M-F. c) Begin recruiting process for third provider. **Data Source:** Documentation from participating provider **Milestone 1 Estimated Incentive Payment**: $295,146	**Milestone 4** P-1.1: Expand primary care capacity **Metric 1** P-1.1.2~~b)~~: Expand primary care ~~clinic hours: include weekends~~ capacity **Baseline/Goal:** Expand clinic hours on Sat. 8a-12a each weekend: Increase clinic visits by 2% over DY2 **Data Source:** Documentation from participating provider **Milestone 4 Estimated Incentive Payment** : $171,259 **Milestone 5** P-1.1: Expand primary care capacity **Metric 1** P-1.1.2c): Expand primary care clinic staffing **Baseline/Goal:** Hire or contract with a primary care provider **Data Source:** Executed primary care provider contract or other		**Milestone 6** P-1.1: Expand primary care capacity **Metric 1** P-1.1.2~~b)~~: ~~Fully expanded clinic hours~~ **Goal**: Increase clinic visits to 4% over DY2; decrease non-emergency ER by 1% from DY2 **Data Source:** Documentation from participating provider **Milestone 6 Estimated Incentive Payment:** $173,930 **Milestone 7** P-1.1: Expand primary care capacity **Metric 1** P-1.1.2c): Expand primary care clinic staffing **Goal:** FTE primary provider ratio from DY2 2.15 to DY4 2.6 **Data Source:** Participating provider documentation	**Milestone 8** P-1.1: Expand primary care capacity **Metric 1** P-1.1.2~~b)~~: ~~Fully expanded clinic hours~~ **Goal:** Increase clinic visits to 7% over DY2; decrease non-emergency ER by 3% from DY2 **Data Source:** Documentation from participating provider **Milestone 8 Estimated Incentive Payment:** $147,458 **Milestone 9** P-1.1: Expand primary care capacity **Metric 1** P-1.1.2c): Expand primary care clinic staffing **Goal:** FTE primary provider ratio from DY2 2.15 to DY5 3.0 **Data Source:** Participating provider documentation

020 992601.1.2	***1.1.2***	***1.1.2 A-C***	***EXPAND PRIMARY CARE CAPACITY***	
Stonewall Memorial Hospital				*020992601*
Related Category 3 Outcome Measure(s):	*020992601.3.1*		*Patient Satisfaction*	
Year 2 (10/1/2012 – 9/30/2013)	**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 **Milestone 5 Estimated Incentive Payment:** $171,259		**Milestone 7 Estimated Incentive Payment:** $173,930	**Milestone 9 Estimated Incentive Payment:** $147,459
Year 2 Estimated Milestone Bundle Amount: $295,146	**Year 3 Estimated Milestone Bundle Amount: $342,518**		**Year 4 Estimated Milestone Bundle Amount: $347,860**	**Year 5 Estimated Milestone Bundle Amount: $294,917**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD - $1,280,441				

Summary Information (RHP 11): Category: 1.11 Telemedicine Expansion
Project Number: 130725806.1.1
Provider: West Texas Centers is a community center under the provisions of Chapter 534 of the Texas Health & Safety Code Ann., as amended, Serving as the designated local authority for mental health for the established service area through a contractual relationship with the Texas Department of State Health Services. West Texas Centers provides mental health services to two very rural counties in the RHP 13 area.
Intervention: WTC will increase its telemedicine service capacity by purchasing and installing additional equipment, software and bandwidth in Nolan County and potentially Mitchell County, two of the 3 very rural counties in RHP 11 where WTC operates two mental health clinics serving over 600 patients annually. Equipment increases will provide additional hours of provider time to WTC consumers in RHP 11 counties. Additional provider availability will be established once the hardware infrastructure to expand the telemedicine network has been completed. This will increase physician availability across the very rural area, decreasing appointment wait times and inappropriate law enforcement incarcerations and emergency room admissions. This project will be an expansion of West Texas Centers' current telemedicine network.
Need for the Project: Current wait times for appointments in these areas are from 15 to over 30 days, with physician clinics scheduled only weekly or even less often due to the lack of telemedicine infrastructure. Delays in obtaining psychiatric appointments often result in consumers experiencing preventable crisis situations, which frequently require costly hospitalizations. Telemedicine is the only mechanism available in most cases to provide behavioral health care to this large geographic area. Once the network expansion has occurred additional physician and nursing hours can be procured which will increase available appointments and decrease consumer wait times. All counties within the project are designated Federal health professional shortage areas.
Target Population: West Texas Center's patient population is 45% Medicaid and 54% indigent (persons having no pay source). This number has been relatively stable during the previous five years and it is estimated this percentage will be similar throughout the project.
Category 1 expected patient benefits: **.** In DY 3 through the addition of .10 FTE physician time, 8 additional appointment slots(persons seen) monthly will be added. In DY 3 WTC will increase psychiatrist time through recruitment by .10 FTE or two hours available psychiatrist telemedicine time per week, providing 8 additional physician appointment slots per month equaling 8 persons served and shortening appointment wait times. It is expected by DY 4 this project will increase the number of available appointment slots/psychiatric visits to a total of 1978 with an additional annual increase to 2053 in DY 5. This represents a 6% and 4% increase respectively from the DY 2 baseline. Even though every new appointment slot represents a person, it is impossible to estimate the number of *new* patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.
Category 3 outcomes: West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. West Texas Centers has selected the improvement target of IT-6.1(pg 398 of

the protocol): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy.
Category 1: 1.11-Implement Technology Assisted Services

Project Option: 1.11.3-Implement Technology Assisted Services-Other

Unique Project ID: 130725806.1.1

Facility Description: West Texas Center-130725806

Project Title: West Texas Centers Telemedicine Expansion

- **Project Description:** West Texas Centers will expand access to behavioral health care through expansion of our current telemedicine network in Mitchell and Nolan Counties. Acquisition of additional broadband capacity for these counties, hardware, software, office space and addition of remote site support staff will occur. Increased access to hub site providers will increase Psychiatric and assessment screening appointment availability, decrease consumer wait times, improve response time for psychiatric assessments in crisis situations, provide additional opportunity for education and training WTC providers, and provide a cost effective, evidence based mechanism for the delivery of services to this very rural area. Goals will include increase in available psychiatric appointments for medication reviews and assessments as well as decreased time for emergency departments and law enforcement personnel to be involved in crisis response activities. West Texas Center's currently serves a patient population of 45% Medicaid and 54% indigent (persons having no pay source). This number has been relatively stable during the previous five years will be the target population for the project.
  Project Goals: Project Challenges: In DY 3 WTC will increase psychiatrist time through recruitment by .10 FTE or two hours available psychiatrist telemedicine time per week, providing 8 additional physician appointment slots per month equaling 8 persons served and shortening appointment wait times. It is expected by DY 4 this project will increase the number of available telemedicine appointment slots to a total of 1978 with an additional annual increase to 2053 in DY 5. This represents a 6% and 4% increase respectively from the DY 2 baseline.
  Challenges will include limited access to behavioral health care professionals and paraprofessionals. West Texas Centers will expand it's current professional contracts to enable faster project development during DY 3, while performing intensive recruitment activities through DY 4 and 5. As expanded broadband and technology becomes available provider availability should be secured. An additional challenge will include procurement times associated with broadband expansion, as providers of these services are currently close to capacity due to the exceptionally robust economy in the West Texas area. West Texas Centers enjoys long time relationships with technological

providers in the area which should assist with achieving some priority in procurement negotiations. Additionally, experience in the acquisition of such equipment should facilitate faster procurement and installation.

- **Five Year Expected Outcome:** Goals will include reduced patient wait times, decreased time for emergency departments and law enforcement personnel to be involved in crisis response activities. An overall reduction of response times for West Texas Centers to crisis call situations should also occur. Project will increase patient access to psychiatric services through shorter waiting times for appointments as well as provide additional access through increase appointment slots for new patients.
- **Patient Impact:** In DY 3 WTC will increase psychiatrist time through recruitment by .10 FTE or two hours available psychiatrist telemedicine time per week, providing 8 additional physician appointment slots per month equaling 8 persons served and shortening appointment wait times. It is expected by DY 4 this project will increase the number of available appointment slots/psychiatric visits to a total of 1978 with an additional annual increase to 2053 in DY 5. This represents a 6% and 4% increase respectively from the DY 2 baseline. It is impossible to estimate the number of new patients expected during the demonstration years as the increase in psychiatric appointment slots will increase access to care for both established and new patients.
- **Relationship to regional goals:** Project will assist in transforming the health care delivery system 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 will continue to enhance and contribute to a regional approach to health care delivery that leverages and improves on existing programs and infrastructure and is responsive to patient needs throughout the entire region.
- **Starting Point/Baseline:** Baseline encounter data will be obtained from WTC fiscal year 2012 records as well as other data relevant to this project. Data sources will include the Avail Solutions Crisis Hotline data, Anasazi data which is the Centers current behavioral health software provider and Department of State Health Services Encounter data. WTC will continue to identify and refine baseline data with the final baseline being established no later than the end of DY 2.
- **Rationale:** The Community Needs Assessment indicates CN.3, shortage of health care professionals, including mental health care providers is a significant need in our area. This project will address that need. West Texas Centers currently operates telemedicine in the project counties. West Texas Centers primarily serves a population eligible for services only if 200% or less below the Federal Poverty Guidelines; otherwise they are eligible as private pay only. The patient population served is on average 45% Medicaid and 54% indigent or persons with no pay source. Staff turnover, recruitment challenges, travel requirements, and training needs continue to increase. Even though West Texas Centers currently operates a robust telemedicine network ongoing assessment of that network is necessary to insure the most up to date and cost effective technology, equipment and processes are in place. It is clear through review of appointment waiting times and crisis response times; the current network is unable to keep up with the increasing needs. The access problem is acutely demonstrated through the current

availability of WTC psychiatrist appointments for new patients which in Nolan County is currently over twenty five days. As providers move from these rural locations to more urban sites, the availability of local providers is steadily decreasing, putting a heavier burden on the current systems. Additional broadband and equipment will provide the necessary infrastructure to recruit and train "distance" providers, who are in many cases, the only provider available for both non urgent and crisis services. This expansion of telemedicine will increase diversions from emergency rooms and law enforcement incarceration while providing faster more real time assistance to the consumer in crisis. In the non urgent situation, this expansion will provide additional physician clinic days where currently capacity is at maximum with the waiting time for appointments averaging fourteen to twenty-five days. Existing technical infrastructure at these locations is inadequate to provide additional needed access to psychiatric assessment and medication management capacity. It was not possible to utilize project option 1.11.1 for this project as this is not an implementation of telemedicine but an expansion of our current telemedicine network, which will significantly enhance the existing delivery structure so in order to stay as close to the Category 1 protocol document the decision made to select "other" project option of 1.11.3(Cat 1, pg127) This project will be utilizing required core project components from project options 1.11.1 and 1.11.2. Required core project components include those from project option 1.11.1 pg 126: b) assessing the local availability of and need for expanded video equipment in Nolan and Mitchell Counties including expanded access to high speed broadband technology; and the following from project option 1.11.2 pg 126: a) development or adapt current administrative and clinical protocols that will serve as a manual of technology-assisted operations; c)engage in rapid cycle improvement to evaluate the processes and procedures in the expanded telemedicine project and make any necessary modifications; and 1.11.2 pg 126: c) identify and train qualified behavioral health providers and peers that will connect to provide expanded telemedicine, to primary care providers, specialty health providers, peers or behavioral health providers. Connections could be provider to provider, provider to patient or peer to peer; from 1.11.2 pg 127: d) identify modifiers needed to track encounters performed via expanded telehealth technology; from 1.11.2 pg 127 e) develop and implement data collection and reporting standards for expanded electronically delivered services; from 1.11.2 pg 127: h) assess impact on patient experience outcomes (e.g. preventable in inpatient readmissions). West Texas Centers anticipates all required core components described above will be fulfilled during the 5 year demonstration project. This will be accomplished through utilization of current and additional administrative support staff, technical professionals and clinicians to perform needed assessments, procurement/installation of equipment, provide training and perform and develop ongoing quality management measurements to insure rapid address of deficiencies and problem resolution is occurring. West Texas Centers anticipates all required core components described above will be fulfilled during the 5 year demonstration project.

- **Milestones and Metrics:** This project is an expansion of *existing* telemedicine infrastructure so in order to stay as close to the Category 1 protocol document Project Option of 1.11.3: Other was selected however; process milestones for this project were

selected from those identified for Project options 1.11.1 and 1.11.2 (Cat 1 page 126-127). Process milestones were selected to immediately begin assessment of the current systems and begin analysis of the best value, most cost effective decisions regarding equipment, broadband and technology upgrades and procurement. Improvement milestones were selected and customized an annotated I-X however; were adapted from the 1.1 Project Areas: Expand Primary Care Capacity (Cat 1 Improvement Target I-15.2 pg 22).Milestone stated "increase access to primary care capacity", this milestone was revised to better fit this behavioral health project, to "Increase access to behavioral health care." Improvement milestones were selected based upon information identified both in the RHP needs assessment sections CAN 3 and WTCS own needs assessment process. In DY 4 telemedicine expansion procurement, testing and installation will have been completed and the focus will shift to the improvement milestones related directly to patient care and access. In DY 3 WTC will increase psychiatrist time through recruitment by .10 FTE or two hours available psychiatrist telemedicine time per week, providing 8 additional physician appointment slots per month equaling 8 persons served and shortening appointment wait times. It is expected by DY 4 this project will increase the number of available appointment slots/psychiatric visits to a total of 1978 with an additional annual increase to 2053 in DY 5. The project will also increase access to services through recruitment of additional providers utilizing the expanded telemedicine network. Increased access will occur through increasing available physician appointment times, which will be possible due to the increase/improvement of the telemedicine infrastructure.

- **Continuous Quality Improvement:** West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. Metrics chosen for the project will require stakeholder feedback as well as provider service validation to insure achievement. CQI feedback will be utilized to provide real time program resolution. The associated category 3 outcome measures related to patient satisfaction and the corresponding survey instruments will also be used in establishing continuous quality improvement protocols.
- **Related Category 3 Outcome Measure(s):** West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. During DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected the improvement target of IT-6.1(pg 398 of the protocol): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy. The patient satisfaction improvement target was

selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.

- **Relationship to other Projects:** This project will continue to expand access to behavioral health care in a community based setting, rural "underserved" setting. The project will increase service capacity and provide additional behavioral health resources to health care providers.
- **New or Enhanced Initiative:** This project is an enhancement to the current telemedicine network West Texas Centers currently operates in these counties. This is significant in that start up costs and time associated with an initial project of telemedicine installation is extremely significant. This project will have the primary structure and process in place to rapidly develop the enhanced technology components and decrease the amount of time necessary to begin actual service delivery utilizing the new systems.
- **Relationship to Other Performing Providers' Projects in the RHP:** 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). This eligibility includes the geographic locations in the RHP of Nolan and Mitchell counties and are included in the West Texas Center catchment area. The target population for this project will be persons experiencing a non urgent mental health event and meet the eligibility requirements of the Department of State Health Services. Any person experiencing a behavioral health crisis event will be considered the target population for urgent/emergency treatment. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. With defined target populations, this project will promote the RHP goal of seeking to improve the health outcomes for targeted patients as well as the total population. It will compliment, but not duplicate other regional projects which may also be focused on expanding the access to specialty care. Regional projects by other behavioral health providers which are related include 1333380707.1.1 Betty Hardwick Center, Expand Specialty Care Capacity and 133339505.1.1, Central Texas MHMR Center dba Center for Life Resources, Implement technology assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services. These projects cover different geographic areas within the RHP and concurrently support regional goals, but we do not believe this WTC project duplicates another provider's intervention for the same target population in the same geographic area.
- **Plan for Learning Collaborative:** West Texas Centers will partner with regional health care providers in the development of learning collaborative efforts.
- **Project Valuation:** West Texas Centers considered the rural nature of behavioral health care delivery in the RHP the valuation of this project. Access to providers for behavioral health services is so limited; telemedicine has and is providing a mental health "lifeline" to consumers living in these areas. Research continues to support the successful utilization of telemedicine in the diagnosis and treatment of mental illness.

Videoconferencing is a proven viable solution to treating consumers who live too far away to regularly have access to professional care or were too embarrassed to seek it in conventional ways. [1] Research has identified provider satisfaction with telemedicine, noting in many cases increases openness from patients enabling them to obtain better information than from a face to face encounter.[2] Telemedicine not only brings access to care closer to the patient, it has capacity to significantly reduce the stigma often associated with mental illness. In the counties associated with this project there is currently no local access to a psychiatrist other than through West Texas Center's telemedicine network. In DY 3 WTC will increase psychiatrist time through recruitment by .10 FTE or two hours available psychiatrist telemedicine time per week, providing 8 additional physician appointment slots per month equaling 8 persons served and shortening appointment wait times. It is expected by DY 4 this project will increase the number of available appointment slots/psychiatric visits to a total of 1978 with an additional annual increase to 2053 in DY 5. Due to limited provider capacity, delays in treatment often result in increased emergency department utilization, law enforcement involvement and increased potential for endangerment to the patient and/or the community. This project will provide a cost effective mechanism to improve current access to rural behavioral health care, significantly improve patient appointment wait times, decrease timeframes associated with physician access during crisis situations while continuing to provide effective, evidenced based care to the behavioral health consumer.

[1]Media Health Leaders. Telemedicine Offers New Alternatives for Behavioral Healthcare Delivery,
Healthleadersmedia.com September 29, 2012 [2]David Surface. Country Comfort-Mental Health
Telemedicine in Rural America
Social Work Today Vol7 No. 1 P.28

130725806.1.1	1.11.3 OTHER	1.11.3 OTHER	West Texas Centers Telemedicine Expansion
West Texas Centers			130725806
Related Category 3 Outcome Measure(s): OD-6	130725806.3.1	OD-6: Patient Satisfaction IT-6.1 Percent Improvement over baseline of patient satisfaction scores	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-4-1(Cat 1 pg 128) Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment. Metric: Inventory of new equipment purchased Data Source: Review of inventory or receipts for purchase of equipment. Baseline: 2012 Inventory of WTC telemedicine equipment. Goal: Purchase all necessary equipment for the project Milestone 1 Estimated Incentive Payment $119,261.00 Milestone 2 P-5(Cat 1 pg 128) Procurement of additional Broadband Connection	Milestone 3 P-7(Cat 1 pg 128) Hire tele-presenters, as needed, for remote site equipment expansion operation. Metric: Documentation of acquisition of proper staff/training to operate expanded equipment capacity at Provider locations. Data Source: Interviews with staff, review of hiring or payroll records, contracts Baseline: FY 2012 psychiatrist FTE count Goal: Will increase psychiatrist by .10 FTE or two hours available psychiatrist telemedicine time per week., providing 8 additional physician appointment slots per month equaling 8 persons	Milestone 5 I-X.1 Customized from Cat 1 Improvement Target I-15.2 pg 22 (see narrative above under milestones and metrics) Increase access to behavioral health care capacity I-X-5 Metric: Increase number of behavioral health care visits. a. Total number of visits for reporting period. Data Source: Registry, claims or other Performing Provider source Baseline: West Texas Center's 2012 claims, encounter data and other internal data sources. Goal: Will increase the total number of telemedicine visits	Milestone 6 I-X.2 Customized from Cat 1 Improvement Target I-15.2 pg 22 (see narrative above under milestones and metrics) Increase access to behavioral health care capacity I-X-5 Metric: Increase number of behavioral health care visits. a. Total number of visits for reporting period. Data Source: Registry, claims or other Performing Provider source Baseline: West Texas Center's 2012 claims, encounter data and other internal data sources. Goal: Will increase the total number of telemedicine visits

130725806.1.1	1.11.3 OTHER	1.11.3 OTHER	West Texas Centers Telemedicine Expansion	
West Texas Centers				130725806
Related Category 3 Outcome Measure(s): OD-6	130725806.3.1	OD-6: Patient Satisfaction 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)**
Metric: Documentation of presence of active broadband connections Data Source: Review of purchase receipt or demonstration of equipment Baseline: FY 2012 WTC Broadband invoice data Goal: Procure and implement all expansion of all Broadband connections required for project. Milestone 2 Estimated Incentive Payment $119,261.00	served and shortening appointment wait times. Milestone 3 Estimated Incentive Payment: $123,311.00. <u>Milestone 4</u> P-8(Cat 1 pg 128) Training for providers/peers on use of equipment/software Metric: Documentation of completions of training on use of equipment/software Data Source: Training roster Baseline: FY 2012 WTC Provider training records Goal: Complete training on use of equipment/software for all providers utilizing expansion telemedicine in the project.		by 6% from DY 2 baseline for an annual total of 1978. Milestone 5 Estimated Incentive Payment: $263,805.00	by 10% from DY 2 baseline for an annual total of 2053. Milestone 6 Estimated Incentive Payment: $257,185.00

130725806.1.1	1.11.3 OTHER	1.11.3 OTHER	West Texas Centers Telemedicine Expansion
West Texas Centers			130725806
Related Category 3 Outcome Measure(s): OD-6	130725806.3.1	OD-6: Patient Satisfaction 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 Estimated Incentive Payment: $123,311.00		
Year 2 Estimated Milestone Bundle Amount: $ 238,522.00	Year 3 Estimated Milestone Bundle Amount: $ 246,622.00	Year 4 Estimated Milestone Bundle Amount: $263,805.00	Year 5 Estimated Milestone Bundle Amount: $ 257,185.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,006,134.00			

Pass 3B
137074409.1.3Summary Information Pass 2(RHP 11): Category: 1.13
Project: West Texas Centers Mobile Crisis Outreach Team Expansion
New Unique Project ID: 130725806.1.3
Old Unique Project ID: 130725806.1.2
Provider: West Texas Centers is a community center serving as the designated local authority for mental health through a contractual relationship with the Texas Department of State Health Services. West Texas Centers provides mental health services in three counties in the RHP 11 area. West Texas Centers operates two mental health clinics in these extremely rural counties.
Intervention: West Texas Centers will expand its current Mobile Crisis Outreach Team staff by a minimum of one additional qualified mental health provider. These additional staffs will effectively double the current capacity of the Centers crisis response system in these counties. Additional crisis response staff will decrease crisis wait times and result in more appropriate less costly solutions including diversion from emergency departments and law enforcement settings through the delivery of additional "wrap around", preventive and follow-up services to the initial crisis call.
Need for the Project: Current crisis services are averaging over 600 calls annually to WTC for residents in these counties, with over three hundred of those calls "go mobile" calls. These calls are handled currently by only one clinical on call staff person. Crisis response requires extensive travel in this rural area, twenty-four hour on call capability, one hour response time and consistent coordination with law enforcement and emergency rooms. This project will effectively decrease wait times for crisis response, increase and improve crisis wrap around, preventive and support services to facilitate faster Diversions from more costly and inappropriate settings such as emergency departments and law enforcement facilities.
Target Population: West Texas Center's serves a primary population of Medicaid and uninsured patients. This project is expected to serve roughly 44% Medicaid and 53% uninsured with the remaining percentage of patients having some form of third party insurance; however anyone experiencing a mental health crisis and accessing the WTC hotline will be the target population.
Category 1 patient benefits: Process milestones for this project are those identified for project option 1.13.1. These will include conducting stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers to develop a gap analysis of WTC crisis response system. Improvement milestones were chosen to demonstrate an increase in the utilization of appropriate crisis alternatives. In DY 4 This project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 89 diversions or 89 persons diverted. BY DY 5 increase utilization of appropriate crisis alternatives should be at 35% from DY 12 baseline representing 109 diversions or 109 persons diverted.
Category 3 outcomes: : West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. West Texas Centers has selected the improvement target of IT-6.1(pg 398 of the protocol): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was

selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy.

Pass 3b
Project Title: West Texas Centers Mobile Crisis Outreach Team Expansion

Project Option: 1.13.1-Develop and Implement Crisis Stabilization Services to Address Identified Gaps in Current Community Crisis System

New Unique Project ID: 130725806.1.3
Old Unique Project ID: 130725806.1.2

Facility Description: West Texas Center-130725806

- **Project Description: T**his project will expand the capacity of West Texas Center's behavioral health services to better meet the needs of the patient population and the community. It will enable WTC to provide better coordinated care and to insure the patient is being treated as a whole person which research shows will potentially lead to better outcomes and experience of care. West Texas Centers will perform a gap analysis of it's current crisis response system for the counties the Center serves in RHP 11. This analysis will identify barriers, potential cost savings, community needs and overall crisis response processes which may need refinement or expansion. Additionally community needs will be further met through public forums and stakeholder meetings to help identify specific West Texas Centers crisis response system needs. West Texas Centers will expand its current Mobile Crisis Outreach Team staff by a minimum of one additional qualified mental health provider. These additional staffs will effectively double the current capacity of the Centers crisis response system in these counties.
- **Project Goals**: Goals will include increasing access to West Texas Centers Mobile Crisis Outreach team by emergency room and law enforcement personnel as well as individuals in the communities West Texas Center serves in RHP 11. In FY 2012 West Texas Centers received over 600 crisis calls for the RHP 11 West Texas Center counties with over 350 being legitimate "go mobile" response situations. The current Mobile Crisis Outreach team is responding to calls throughout the very rural and vast coverage area of the West Texas RHP 11 counties. Additional assessment of the West Texas Centers crisis response system to identify crisis call patterns, including geographic considerations and increasing the staffing component of the Mobile Crisis Outreach team is expected to significantly increase consumer diversion from the emergency rooms, jails, and inpatient facilities. This will result in more appropriate right care, right setting, and right time treatment for our behavioral health consumers. West Texas Centers currently provides these crisis services with only one Mobile Crisis Outreach staff member in the RHP 11 service area. This one person is responsible for responding to the crisis call within one hour of notification on a 24/7 call rotation. This project would increase by 1.0 FTE the available Mobile Crisis Outreach Worker staff. West Texas Centers currently responds to every crisis, therefore this project will not necessarily increase the number of crisis services delivered, though it will increase the capacity should increased crisis requirements occur. What the project will accomplish with an additional Mobile Crisis Outreach staff is the ability to improve our crisis

response time, increae and improve crisis support services related to prevention, wrap around and follow-up from the crisis event. Increasing our ability to potentially intervene in a behavioral health crisis prior to the consumer being booked into the jail, admitted to the ED or taken to a psychiatric hospital for admission will have a significant impact on consumer quality of life, and quality of care as well as provide a much more cost effective treatment alternative.

- **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). Part of this eligibility includes geographic location limited to Nolan and Mitchell counties within the West Texas Center catchment area. The services provided by the mental health authority are specific to DSHS's Texas Recovery and Resiliency model of care. This population will include those persons experiencing an emergency psychiatric condition. We do not believe the project duplicates another provider's intervention for the same target population. However, because we are the public safety new for behavioral health, the target population for this project would include any person in the WTC service area who contacted the WTC crisis hotline.
- **Project Challenges**: Challenges will include continued difficulty in recruitment of professionals and paraprofessionals to this very rural area. West Texas Centers will increase recruitment activities to include a sign on bonus if necessary and will widen its recruitment area. The addition of a Mobile Outreach Crisis staff member will improve the ratio of crisis calls to staff member which in turn will improve recruitment and retention of staff in this high stress, high travel, critical decision making position. Additional challenges will include administrative support cost associated with patient satisfaction survey instruments and assessment activities to determine current and future crisis system design needs. West Texas Centers plans to utilize highly qualified administrative personnel to design survey instruments and conduct the assessment activities in order to obtain the best most reliable information possible. Research of available crisis systems among other state and national providers will be done to identify progressive, innovative crisis management approaches which may be applied to West Texas Center's current crisis process. Also the Center will utilize professional software packages as needed to obtain the consumer data necessary for a complete crisis system gap analysis and assessment.
- **Five Year Expected Outcome:** West Texas Centers anticipates meeting all core component requirements as identified in Project Option 1.13.1; a-e, and achieving all milestones and metrics within the project by completion of demonstration year 5. It is expected this project will increase West Texas Center's capacity to provide cost effective and appropriate behavioral health intervention, triage and intensive wraparound services for individuals experiencing a psychiatric crisis through increased availability of face to face 24 hour psychiatric consultation via telemedicine (closely related to another WTC project identified below). This project will also increase WTC ability to provide appropriate treatment alternatives to incarceration for individuals with low level charges and serious psychiatric impairment, reduce emergency department utilization

and wait times for individuals experiencing a psychiatric crisis, ensure appropriate triage and maximization of psychiatric inpatient resources and maximize law enforcement time and resources by providing behavioral health crisis intervention services and assessment "real time" in the community. Utilization of appropriate crisis alternatives not only increases the patient's quality of care, improves the patient outcome, but results in cost savings across multiple entities.

- **Relationship to Regional Goals:** This project will work to 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 the existing behavioral health care system; and infrastructure, is responsive to patient needs throughout the region and improves health care outcomes and patient satisfaction. This project relates to RHP 11 goals of transforming health care in the total population of the region and to further advance the goals of the Triple Aim: to provide right care, at the right place, and at the right time.
- **Starting Point/Baseline:** Baseline encounter data will be obtained from WTC fiscal year 2012 records as well as other data relevant to this project. WTC will continue to refine baseline data during DY 2.
- **Rationale:** West Texas Centers currently has one Mobile Crisis Outreach staff member covering the three counties in RHP 11. With over 350 FY 2012 "go mobile" crisis calls, the ongoing ability to provide timely intervention and assistance to consumers and community stakeholders is tenuous. Staff turnover, recruitment challenges, travel requirements, and training needs continue to increase. West Texas Centers, in another project is currently proposing an expansion of its telemedicine services to provide additional psychiatric support to its front line crisis staff but without increasing the number of front line staff this assistance will improve access to services but cannot fulfill the crisis needs of the community. Ongoing assessment of our crisis delivery system is necessary to insure the most up to date and cost effective processes are in place. Additional staffing increases will increase diversions from emergency rooms and law enforcement incarceration while providing faster more real time assistance to the consumer. Crisis services are high risk, high need situations. In these very rural areas providing that service must be done with well trained, well seasoned and extremely competent staff. This project will provide additional staffing and training resources to insure these needs are met. Required components of this project are(Cat 1,pg141): a) convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps; b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service; c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives

that will meet the behavioral health needs of the patients (e.g. a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming Emergency Department settings; d) Explore potential crisis alternative service models and determine accept and determine feasible models for implementation; e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations. CQI efforts will include problem identification and resolution and follow-up to insure effectiveness of performance improvement actions. This will be accomplished through utilization of current and additional administrative support staff, technical professionals and clinicians to perform needed assessments, procurement/installation of equipment, provide training and perform and develop ongoing quality management measurements to insure rapid address of deficiencies and problem resolution is occurring. West Texas Centers anticipates all required core components described above will be fulfilled during the 5 year demonstration project.

- **Continuous Quality Improvement:** West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. Metrics chosen for the project will require stakeholder feedback as well as provider service validation to insure achievement. CQI feedback will be utilized to provide real time program resolution. The associated category 3 outcome measures related to patient satisfaction and the corresponding survey instruments will also be used in establishing continuous quality improvement protocols.
- **Milestones and Metrics:** Process milestones for this project are those identified for project option 1.13.1. West Texas Centers will utilize current administrative staff to design and develop tools and measurements to perform ongoing quality management assessments through the life of the project. These will include conducting stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers to develop a gap analysis of WTC crisis response system. Improvement milestones were chosen to demonstrate an increase in the utilization of appropriate crisis alternatives. In DY 4 This project is expected to increase the utilization of appropriate crisis alternatives by 5% from DY 2 baseline for a total of 268 diversions or 268 persons diverted. BY DY 5 increase utilization of appropriate crisis alternatives should be at 20% from DY 2 baseline representing 307 diversions or 307 persons diverted.
- **Community Needs Identification Number the Project addresses**: RHP 11 Rural Community Needs Assessment number CN.2, Severe lack of mental health services, inability to get an appointment, lock of insurance, need to use ERs for initial contact will be specifically addressed through this project. This need was found to be critical in the rural needs assessment done by the RHP.
- **New or Enhanced Initiative:** This project is an enhancement to the current crisis service network West Texas Centers currently operates in these counties.

- **Related Category 3 Outcome Measure(s):** West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. West Texas Centers has selected the improvement target of IT-6.1(pg 398 of the protocol): Percent Improvement over baseline of patient satisfaction scores. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy.
- **Relationship to other Projects:** This project will be directly related to West Texas Center's RHP 11 Telemedicine Expansion project number 130725806.1. This project and the telemedicine expansion project are closely related in that they will work together to meet both the day to day access needs as well as the crisis needs of the consumer and the community.
- **Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:** Our RHP will encourage participation by all our partners in learning collaborative that will meet annually to discuss local disparities in care and the ways they have successfully gathered relevant data and ultimately better served the populations in their projects. In addition to the face-to-face meeting, we will have an open forum on our website that will foster communication amongst our partners with related projects.
- **Project Valuation:** This project will decrease the cost of care through increased diversion of consumers from emergency rooms and jails as well as decrease the cost of inpatient care through inappropriate admissions to psychiatric facilities. The project will meet the waiver goals additionally through more right care, right setting and right time treatment provision. The project will increase access to crisis response services through additional Mobile Crisis Outreach team members. It will decrease response times for these staff to assist emergency rooms and law enforcement agencies with mental health crisis situations. In DY 4 This project is expected to increase the utilization of appropriate crisis alternatives by 10% from DY 2 baseline for a total of 89 diversions or 89 persons diverted. BY DY 5 increase utilization of appropriate crisis alternatives should be at 35% from DY 12 baseline representing 109 diversions or 109 persons diverted. According to txpricepoint.org, the average cost for just one possible preventable admission, such as severe psychological disorders including Schizophrenia, among all Taylor County hospitals(closest major medical facility to West Texas Centers RHP 11 counties) for Federal Year 2011 was $10,519.00 average charge per average length of stay for this diagnosis.(excludes physician cost). Further research shows the average cost to transport an individual to a local hospital by local EMS services is $535.00. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, where an officer is on hand, can range from 1 to 3 hours, sometimes substantially more. A law enforcement officer's average pay can range from $12.50 to $18 per hour, so in an average situation this would be an additional $30-$45 cost per event. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services.

Additionally, the small rural police or sheriff's department, often employing due to lack of resources, a low ratio of officers to citizens, is left significantly understaffed while an officer is on duty at the emergency department. Even though these financial costs are significant, the human cost which is much harder to measure can be even more significant.

New ID: 130725806.1.3 **Old ID: 130725806.1.2**	1.13.1 : Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system,	West Texas Center Mobile Crisis Outreach Team Expansion
West Texas Centers		130725806
Related Category 3 Outcome Measure(s): OD-6	New:130725806.3.3 Old: 130725806.3.2	OD-6: Patient Satisfaction 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(Cat. 1, pg142) Milestone: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers. P-1.1. Metric: Number of meetings and participants. Data Source: Attendance lists Baseline: N/A Goal: Will conduct a minimum of 2 stake holder meetings. Milestone 1 Estimated Incentive Payment $84,859.00	Milestone 2 P-2(Cat 1, pg 142) Milestone: Conduct mapping and gap analysis of current crisis system. P-2.1. Metric: Produce a written analysis of community needs for crisis services. Data Source: Written plan Baseline: N/A Goal: Will conduct a mapping and gap analysis of current crisis system to determine baseline and identify improvement strategies. Milestone 2 Estimated Incentive Payment: $44,316.00 Process Milestone 3 P-4(Cat 1,pg 143) Milestone: Hire and train staff to	Milestone 4 I-12(Cat 1, pg 146) Milestone: Utilization of appropriate crisis alternatives I-12.1. Metric: 5% increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project sites. This would be measured at specified time intervals throughout the	Milestone 5 I-12 (Cat 1, pg 146) Milestone: Utilization of appropriate crisis alternatives I-12.1. Metric: 20% increase in utilization of appropriate crisis alternatives. a. Numerator: Number of people receiving community behavioral healthcare services from appropriate crisis alternatives b. Denominator: Number of people receiving community behavioral health services in RHP project

New ID: 130725806.1.3 **Old ID: 130725806.1.2**	1.13.1 : Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system,	West Texas Center Mobile Crisis Outreach Team Expansion	
West Texas Centers			130725806
Related Category 3 Outcome Measure(s): OD-6	New:130725806.3.3 Old: 130725806.3.2	OD-6: Patient Satisfaction 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)
	implement identified crisis stabilization services. P-4.1 Metric: Number of staff hired and trained. Data Source: Staff rosters and training records, training curricula Goal: Hire .and/or identify 1.0 FTE staff member to perform Mobile Crisis Outreach Team (MCOT) functions for project area. Baseline: FY12 WTC Human Resource records for project area MCOT staffing Milestone 3 Estimated Incentive Payment: $44,316.00	project to determine if there was an increase. Data source: Claims, encounter, and clinical record data. Baseline: West Texas Centers FY 2012 encounter data, crisis hotline call data and other relevant data sources **Goal:** Goal: Will increase the utilization of appropriate crisis alternatives by 5% from DY 2 baseline for a total of 268 diversions or 268 persons diverted. Milestone 4: Estimated Incentive Payment: $95,309.00	sites. This would be measured at specified time intervals throughout the project to determine if there was an increase. Data source: Claims, encounter, and clinical record data. d. Rationale: see project goals. Baseline: West Texas Centers FY 2012 encounter data, crisis hotline call data and other relevant data sources **Goal:** Will increase the utilization of appropriate crisis alternatives by 20%

New ID: 130725806.1.3 **Old ID: 130725806.1.2**	1.13.1 : Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system,	West Texas Center Mobile Crisis Outreach Team Expansion	
West Texas Centers			130725806
Related Category 3 Outcome Measure(s): OD-6	New:130725806.3.3 Old: 130725806.3.2	OD-6: Patient Satisfaction 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)
			from DY 2 baseline for a total of 307 diversions or 307 persons diverted. Milestone 5 Estimated Incentive Payment: $ 91,122.00
Year 2 Estimated Milestone Bundle Amount: $84,859	Year 3 Estimated Milestone Bundle Amount: $88,632	Year 4 Estimated Milestone Bundle Amount: $95,308	Year 5 Estimated Milestone Bundle Amount: $91,121
Total Estimated DSRIP Funding for 4 Years :$359,920.00			

Category 2

Pass 3B
Summary Information: **OLD:** *281406301.2.1 New: 281406301.2.2*

- Provider: Comanche County Medical Center is a 25 bed critical access facility with a primary service area of the counties of Comanche, Eastland, Erath, Brown, Mills, and Hamilton Texas.

- Intervention(s): This project will implement a program that will help to increase immunizations for the target populations of kindergarten children and adults 65 years and older.

- Need for the project: As many sources has indicated, improving immunization percentages does have a direct affect on reducing hospitalizations and ER visits and high costs associated with preventable hospitalizations admissions and readmissions is rated at the second most priority (CN.2).

- Medicaid and Uninsured Target population: Comanche County is a poor county economically and the average age is older than the state average. The target population has a high percentage of Medicaid and uninsured/underinsured individuals. The primary targeted population will be school age children, specifically children entering kindergarten or pre-school who need vaccinations to start school and the elderly (age 65 and older) who are more susceptible to pneumonia and the flu. As portrayed above, this program will appeal to everyone in the target population including individuals on Medicaid and the uninsured (charity and indigent).

- Category 1 or 2 expected patient benefits: The project will set a baseline in DY 2 and will strive to improve on that baseline by reaching more individuals in the target population in DY 3, DY 4, and DY5. It is our goal to vaccinate 2,000 individuals annually by the end of DY 5.

- Category 3 outcomes: IT-2.10 Our goal is to Our goal is to reduce the number of admissions with a primary diagnosis of flu and pneumonia. The baseline will be set in DY 2 and it is our goal to reduce the percentage from that baseline 2% each year.

- Provider: Comanche County Medical Center is a 25 bed critical access facility with a primary service area of the counties of Comanche, Eastland, Erath, Brown, Mills, and Hamilton Texas.

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- Category 3 outcomes: IT-2.10 Our goal is to Our goal is to reduce the number of admissions with a primary diagnosis of flu and pneumonia. The baseline will be set in DY 2 and it is our goal to reduce the percentage from that baseline 2% each year.

Pass 3b
Project Title: Community Immunization Program

Category 2: Program Innovation and Redesign

Project Option 2.7.6 Implement evidence-based disease prevention programs to targeted patients who are at high risk - Immunization and Education program.

Unique Project ID: New:281406301.2.2; **OLD:**281406301.2.1

Facility Description: Comanche County Medical Center-281406301

Pass 3b
Project Title: Community Immunization Program

Category 2: Program Innovation and Redesign

Project Option 2.7.6 Implement evidence-based disease prevention programs to targeted patients who are at high risk - Immunization and Education program.

Unique Project ID: New:281406301.2.2; **OLD:**281406301.2.1

Facility Description: Comanche County Medical Center-281406301

Comanche County Medical Center (CCMC) is a 25 bed critical access rural facility located in Comanche County Texas on State highway 16 about halfway between the towns of Comanche and De Leon, TX. CCMC is equipped with diagnostic capabilities rivaled by much larger facilities. Those capabilities include a full-service laboratory, imaging departments (including a 64 slice CT scanner, Nuclear Camera, and MRI) and a rural health clinic which gives patients access to nine different primary care providers and 24 hour emergency services staffed with a physician 24 hours each day.

Project Description:

CCMC proposes to provide immunization programs to both the school age and elderly patients who are at risk for several different diseases.

The project would educate patients on the importance of vaccinations and improve access to the vaccines to the targeted population. This access would occur through Comanche County Medical Center's (CCMC) rural health clinic (Doctors Medical Center), in partnership with Comanche Community Healthcare and is proposed to work with the four different school districts in Comanche County and if possible involve civic clubs and senior citizen centers in area towns to help with this project. The primary targeted population will be school age children, specifically children entering kindergarten or pre-school who need vaccinations to start school

and the elderly (age 65 and older) who are more susceptible to pneumonia and the flu. "Vaccination prevents the spread of infectious diseases. Vaccination for influenza is recommended for children aged 6 months through 18 years of age, adults aged 50 years and older, pregnant women or women who will be pregnant during flu season, persons with certain chronic medical conditions, persons in long-term care facilities, and health care workers and other persons in close contact with those at high risk." (http://mchb.hrsa.gov/whusa10/hsu/pages/306v.html)

Comanche County is has one of the oldest populations in the State of Texas as evidenced by the U.S. Census Bureau's Quick Facts, the median age of the County is 42.2 years as compared to the State average of 33.4 years. This is further evidenced by CCMC's percentage of Medicare patients that it serves. In each of the years that CCMC has been open, patients with Medicare or Medicare Advantage plans constitute more than 50% of the hospital's volumes. Of the patients with Medicare, pneumonia is one of the top diagnoses that are treated. "Across all age groups, there were 119 hospital stays for every 1,000 persons in Texas…..there were 571 stays for every 1,000 elderly ages 85 and over and 308 per 1,000 for ages 65-84." (Facts and Figures, TDH, 2009, page 13). This program will cover all the targeted population including Medicaid and the uninsured (Charity and Indigent).

Currently there no providers in the county provide access to kindergarten students who have insurance coverage and many who do not have insurance cannot afford a physician's office visit to get their children immunized. This program would address kindergarten age children and provide the vaccines and shots for no charge at "shot clinics" held in difference locations in Comanche County. In addition through this proposed program, CCMC would offer flu shots to school age children, individuals in Comanche County age 65 and older, CCMC and Comanche County Consolidated Hospital District employees, volunteers, and board members for no charge. The cost for hospitalizations and emergency room care are the highest cost areas in our facility and during the flu and cold season, the treatment of patients with pneumonia and flu continue to be one of the major reasons for hospital stays. In the State of Texas, the hospital stays of patients age 65 and older average 10%. At CCMC for 2011, the percentage was in excess of 10%. In Texas, "Stays among patients…65-84 years old accounted for larger shares of aggregate charges (….33.1 percent…) relative to other age groups." (Facts and Figures, TDH, 2009, page 30).

It is CCMC's goal to immunize individuals in order to prevent hospitalizations and visits to the emergency room in the targeted population. Further, by DY 5, it is CCMC's goal to vaccinate 2,000 individuals annually. In addition, CCMC will consider future expansion in the program to cover other diseases like shingles. This program will provide services including the vaccination of individuals in the target groups and the education of the importance of vaccinations. As mentioned throughout this document, there have been various studies by TDH and by many others (http://mchb.hrsa.gov/mchirc/chusa_04/pages/0505vc.htm) of how such a program can be effective in reducing costs related to admissions and emergency room visits and to the overall health of the patients in the nation. This project is a new initiative that will be coordinated with all parties involved to address opportunities in our

service area. Previous efforts have been fragmented at best and did not target the areas where the impact would do the most good. According to the RHP 11 Community needs assessment, the high costs associated with preventable hospitalizations admissions and readmissions is rated at the second most priority (CN.2).

Starting Point/Baseline/Goal: The baseline for the patient served will be determined in DY2. Once the baseline is set, the goal will be to increase the percentage of patient serviced by two percent in each year (DY 3, DY4 and DY5). It is our goal to vaccinate 2,000 individuals annually by DY 5.

Milestones/Metric for Category 2 Project:

P-1 Process Milestone: Development of innovative evidence-based project for targeted population.

P-1.1 Metric: Document innovational strategy and plan.

For the school age target population, an initial plan will be developed with a goal to target all four public schools for children in preschool and kindergarten. The totals will be compared to the total enrolled students in those schools to determine a baseline in DY 2 and beyond. Before each school year, CCMC will contact representatives from each school to identify ways to improve the process and to increase the rate of immunization.

For the elderly target population, an initial plan will be developed to target Doctors Medical Clinic patients and Comanche Community Healthcare patients. CCMC also plans to approach the two nursing home facilities in the county for immunization of their residents. Before the flu season each year, CCMC will coordinate with the providers (physicians and mid-level providers) to identify ways to improve the process and to increase the rate of immunization.

c. Data Source: CCMC will track each patient immunized, the location, date, and type of immunization given along with the patient's age.

d. Rationale/Evidence: To identify, develop and test new models of healthcare delivery and disease management to lay the groundwork for widespread adoption of innovative care that can lead to a system that delivers better health, better care at a reduced cost. It is CCMC's goal to use an immunization program in order to prevent or reduce the amount of patients that could potentially acquire flu and pneumonia and the related emergency room and hospitalizations that occur.

P-4. Process Milestone: Execution of evaluation process for project innovation.

P-4.1. Metric: Document evaluative process, tools and analytics.

In DY 2, a log sheet, report or other mechanism will be created which will track the location, the date, the patient, the types of immunizations given, and the targeted age group the patient fell into. Trending reports will also be developed to monitor progress from year to year which will be used to communicate with identified partners to identify ways to improve upon the baseline data. In addition this data will be cross-referenced to hospital records for those patients who were immunized and were later treated in the emergency room or hospitalized for flu and pneumonia.

a. Data Source: The above mentioned log sheet, report or other mechanism.

b. Rationale/Evidence: Evaluation of a systematic way to improve and account for public health actions by involving procedures that are useful, feasible, ethical, and accurate. It is CCMC's goal to develop a process to accurately track, evaluate, and improve the results from the immunization program. CCMC would look to do this without affecting the privacy and dignity of the patients that are served.

I-5. Improvement Milestone: Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model.

I-5.1. Metric: TBD by Performing Provider based on milestone described above

a. Numerator: Number of individual in the target population reached by the innovative project.

1. Pre-school and Kindergarten children in Comanche County immunized

2. Elderly (age 65 and older) in Comanche County immunized

b. Denominator: Number of individuals in the target population

1. Pre-school and Kindergarten children in Comanche County via public schools or U.S. Census Bureau

2. Elderly (age 65 and older) per the U.S. Census Bureau

c. Data Source: Previous mentioned logs and reports for immunizations and the count of students from the public schools and the data obtained via U.S. Census Bureau reports.

d. Rationale/Evidence: Use information to identify methods and procedures to increase compliance and the percentage of the target population in order to drive down costs related to emergency room and hospital admissions for pneumonia and flu.

I-7. Improvement Milestone: Increase access to disease prevention programs using innovative project option.

I-7.1 Metric: Increase the percentage of target population reached.

a. Numerator: Number of individuals of target population reached by the innovative project.

b. Denominator: Number of individuals in the target population.

c. Data Source: Logs and reports of immunizations and corresponding numbers of individuals in the targeted groups from the schools and the U.S. Census Bureau reports.

d. Rationale/Evidence: After setting the baseline in DY 2, increasing the percentage of individuals served in the target populations while comparing the results from the Category 3 project.

Rationale:

The proposed service area is the Comanche County and the public schools in Comanche, De Leon, Gustine, and Sidney, Texas. According to the 2011 estimate from the U.S. Census Bureau, Comanche County has a population of 13,891 with 871 individuals 5-9 years of age and 4,686 individuals age 55 years and older. According to the RHP 11 Community needs assessment, the high costs associated with preventable hospitalizations admissions and readmissions is rated at the second most priority (CN.2).

Related Category 3 Outcome Measures:

OD-2 Potentially Preventable Admissions, IT-2.10 Flu and Pneumonia Admission Rate. The total number of patients admitted to CCMC for ER and as an Inpatient with flu and pneumonia will be benchmarked in DY 2 as compared to total hospital and ER admissions to determine the initial baseline for this measure. With the efforts related to the Category 2 immunization program we expect to see a positive result on the category 3 measure. Cost avoidance is achieved by the prevention of unnecessary ER and Inpatient admissions. According to a May 2011 article as published by the Texas Department of State Health Services, patients with the principal diagnosis of Pneumonia is number 4 of the Top 20 most expensive conditions of hospitalization. (Statistical Brief – The Most Expensive Conditions for Hospitalization by Payor, 2009, DSHS, pg. 3).

Relationships to Other Projects: There are several projects within the RHP that are expected to reduce admissions to the hospital and the emergency department. While this project does not coordinate with other facilities within the region, the end goals are very similar, reduce unnecessary admissions and emergency department visits.

Project Valuation:

The importance of vaccination is well documented. "We vaccinate to protect our future….Our children don't have to get smallpox shots any more because the disease no longer exists. If we keep vaccinating now, parents in the future may be able to trust that diseases like polio and meningitis won't infect, cripple, or kill children. Vaccinations are one of the best ways to put an end to the serious effects of certain diseases." (Why Immunize?, CDC, http://www.cdc.gov/vaccines/vac-gen/why.htm). As the article titled, "Unvaccinated Kids Behind Largest U.S. Measles Outbreak in Years,"(www.everydayhealth.com) states, sometimes misguided fears over vaccine safety can keep individuals from getting vaccinated. It is CCMC's goal with this program to use a well proven method to help drive down costs in the target market for those who do not have access or not aware of vaccines that can reduce their risk. CCMC will use the funds allocated through this program in combination of funds generated

from internal sources to improve the health status of the patients we serve through this program and related education to increase the amount of individuals we reach. CCMC used a funding evaluation worksheet as provided to develop the valuation of the project.

Five Year Expected Outcome (overall goal):
The overall goal of this program is to increase the amount of individuals who are vaccinated in the target market which should reflect a reduction in the cost of care for hospitalizations for the diseases the patients are vaccinated for. We have set a goal to vaccinate 2,000 individuals annually by the end of DY 5.

Quality Improvement:
CCMC as part of this project will assemble a team of individuals who will meet face-to-face at least semi-annually to evaluate the effectiveness of the program, discuss the results of findings and trends, and look for opportunities to expand the reach, the scope and increase the effectiveness of the program overall. An agenda with minutes and materials presented at the meeting will be maintained for reference. While this was not included as a process improvement measure to be evaluated and met for the project, we believe this type of process is inherent to a project like this.

New:281406301.2.2; **OLD:**281406301.2.1	2.7.6		***COMMUNITY IMMUNIZATION PROGRAM***
Comanche County Medical Center		*281406301*	
Related Category 3 Outcome Measure(s): OD-2	New:281406301.3.4 Old:281406301.3.1	IT-2.10	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 Process Milestone: Development of innovative evident-based project for targeted population Metric 1 P-1.1 Metric: Document innovational strategy and plan Baseline/Goal: Develop Baseline and Hire One nurse to oversee the project and coordinate efforts Data Source: Log or report that tracks patients immunized as compared to total target population. Payroll hire records Milestone 1 Estimated Incentive Payment (*maximum amount)*: $ 119,375	**Milestone 2** P-4 Process Milestone: Execution of evaluation process for project innovation Metric 1 I-5.1 Metric: Minutes detailing continuing evaluation process Baseline/Goal: Evaluate previous results and make changes when necessary Data Source: Minutes of meetings and related documentation Milestone 2 Estimated Incentive Payment: $195,347 **Milestone 4** I-7 Improvement Milestone: Increase access to disease prevention programs using innovated project option. Metric 1 I-7.1 Metric: Increase access to	**Milestone 2** P-4 Process Milestone: Execution of evaluation process for project innovation Metric 1 I-5.1 Metric: Minutes detailing continuing evaluation process Baseline/Goal: Evaluate previous results and make changes when necessary Data Source: Minutes of meetings and related documentation Milestone 2 Estimated Incentive Payment: $195,915 **Milestone 4** I-7 Improvement Milestone: Increase access to disease prevention programs using innovated project option. Metric 1 I-7.1 Metric: Increase access to	**Milestone 2** P-4 Process Milestone: Execution of evaluation process for project innovation Metric 1 I-5.1 Metric: Minutes detailing continuing evaluation process Baseline/Goal: Evaluate previous results and make changes when necessary Data Source: Minutes of meetings and related documentation Milestone 2 Estimated Incentive Payment: $161,842 **Milestone 4** I-7 Improvement Milestone: Increase access to disease prevention programs using innovated project option. Metric 1 I-7.1 Metric: Increase access to

New:281406301.2.2; **OLD:**281406301.2.1	2.7.6		***COMMUNITY IMMUNIZATION PROGRAM***
Comanche County Medical Center		*281406301*	
Related Category 3 Outcome Measure(s): OD-2	New:281406301.3.4 Old:281406301.3.1	IT-2.10	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 P-4 Process Milestone: Execution of evaluation process for project innovation Metric 1 I-5.1 Metric: TBD by Performing Provider based on milestone described above Baseline/Goal: Develop documentation process, evaluation process, tools and analytics Data Source: The above mentioned log or report and minutes from meetings Milestone 2 Estimated Incentive Payment (*maximum amount)*: $119,375 **Milestone 3** I-5 Improvement Milestone: Indentify X number or percentage of patients in	disease prevention programs using innovated project option Baseline/Goal: Baseline plus 2% Data Source: Comparison of Year 2 to Year 3 calculation Milestone 4 Estimated Incentive Payment (*maximum amount)*: $195,347	disease prevention programs using innovated project option Baseline/Goal: Baseline plus 4% Data Source: Comparison of Year 2 to Year 4 calculation Milestone 4 Estimated Incentive Payment (*maximum amount)*: $195,915	disease prevention programs using innovated project option Baseline/Goal: Baseline plus 6% Goal to vaccinate 2,000 individuals by the end of DY 5. Data Source: Comparison of Year 2 to Year 5 calculation Milestone 4 Estimated Incentive Payment (*maximum amount)*: $161,843

New:281406301.2.2; **OLD:**281406301.2.1	2.7.6		***COMMUNITY IMMUNIZATION PROGRAM***
Comanche County Medical Center		*281406301*	
Related Category 3 Outcome Measure(s): OD-2	New:281406301.3.4 Old:281406301.3.1	IT-2.10	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)**
defined population receiving innovative intervention consistent with evidence-based model Metric 1 I-1.5 Metric: TBD by Performing Provider based on milestone described above Baseline/Goal: Develop Baseline for percentage of target population serviced under this project Data Source: Calculation worksheet and/or minutes of meeting discussing baseline percentage Milestone 3 Estimated Incentive Payment (*maximum amount)*: $119,374			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $358,124	Year 3 Estimated Milestone Bundle Amount: $390,694	Year 4 Estimated Milestone Bundle Amount: $391,830	Year 5 Estimated Milestone Bundle Amount: $323,685

New:281406301.2.2; **OLD:**281406301.2.1	2.7.6		***COMMUNITY IMMUNIZATION PROGRAM***
Comanche County Medical Center		*281406301*	
Related Category 3 Outcome Measure(s): OD-2	New:281406301.3.4 Old:281406301.3.1	IT-2.10	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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $1,464,333			

Pass 3B

Summary Information
New Unique Project ID: 112692202.2.2
Old Unique Project ID: 112692202.2.1

- Provider: Fisher County Hospital District 112692202 is a 14-bed acute care facility located in Rotan, Texas, **the *only*** healthcare provider for Fisher and Kent Counties, an 1,800 square mile area with a population of approximately 4,569. Annually we serve 66% of the total population, around 3,000 patients. According to our Community Needs Assessment as of 2011 Fisher/Kent Counties are Mental Health Professional, Primary Health Professional, Dental Health Professional Shortage Areas and Medically Underserved Areas. Both Counties are designated Frontier.

- Intervention(s): Our project 112692202.2.2 will redesign the outpatient delivery system to coordinate care for patients with chronic diseases, implementing the core components: 1) develop a specially trained chronic care team, 2) insure patients' easy access to the care team,3) increase patient engagement, 4) empower patients to make lifestyle changes, 5) Conduct quality improvement for project

- Need for the project: **–** Our project addresses priority community need CN.1 – characterized by high rates of chronic disease, including cancer, heart disease, cardiovascular disease, respiratory disease and obesity. 60% of our patient population is diagnosed with one or more chronic diseases, often resulting in several encounters either in the hospital, clinic, or emergency department.

  To enable effective preventive care and improved management of chronic illnesses, patients must have ready access to their primary health care practitioner, and the opportunity for ready exchange of information. By DY5 85% of patients, including uninsured and underinsured patients and Medicare/Medicaid patients will receive timely care, appointments and information, as reported through patient surveys. Our goal is to receive 580 completed patient surveys per year.

- Medicaid and Uninsured Target population: Kent/Fisher Counties low income, Medicaid, indigent, uninsured, and minority populations are disproportionately medically disenfranchised, as is common throughout our region. These individuals often

have multiple chronic conditions which are likely to become acute episodes, putting patients at risk for disability and premature death, without regular primary care. FY 2011, we experienced $500,000 Bad Debt; $174,647, Charity; and $99,423, Indigent care. Additionally our emergency center had 36% users Medicaid, uninsured, charity and indigent; many were non-emergent care.

- Category 2 expected patient benefits FY02 FY03 FY04 FY05 Totals

Chronic Care Program Enrollees	50	50	100	150	350
Including Medicaid/Indigent	20	25	50	55	150
Chronic Care Patients needing further clinical Interventions		50	50	50	150
Relevant Staff Trained	20	30			100% trained
Wagner's assessment of the hospital/health system chronic care treatment	25	25	25	25	100
Patients with one self Management goal					275

Our goal is to identify and enroll chronic care patients in our chronic care program where specially trained health coaches will work with each patient, helping to navigate him/her through our services such as education and training classes, workshops, nutritional evaluation, and our cardiac, respiratory, and wellness programs.

The five-year expected outcomes and patient impact will be increased access to preventive healthcare and management of chronic health conditions, resulting in reduced secondary complications of these chronic conditions. Health status, health outcomes and patient satisfaction will improve. Costly inpatient care and emergent care will be reduced among uninsured, underinsured, Medicaid and Medicare patients. We anticipate 3,000 patient participant encounters in our education, fitness classes, training and workshops.

- Category 3 outcomes:

One of the challenges we currently face is the ability for patients to obtain timely appointments. Accordingly, to help us monitor and focus on quality improvement in this area, we have chosen Patient Satisfaction: OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores as our outcome measure for our Chronic Care Management project which includes milestones:

Develop a comprehensive care management program: Train staff in the Chronic Care Model, Develop program to identify and manage chronic care patients needing further clinical intervention and Improve the percentage of patients with self-management goals. P.1.- Project planning, engage stakeholders and needs assessment; P.2. – Establish baseline survey numbers.

Focusing on the patient satisfaction outcomes, OD-6-IT-6.1: Improvement over baseline of patient satisfaction scores to establish if patients are getting timely care, appointments, and information. By DY5, at least 85% of patients will report timely care, appointments and information. We will receive at least 580 surveys per year in DY4 and DY5.

Category 2: Program Innovation and Redesign

Project Option 2.2.1 –Expand Chronic Care Management Models

Unique Project ID: New ID: 11692202.2.2/ Old ID: 112692202.2.1

Facility Description: Fisher County Hospital District-112692202

Fisher County Hospital District 112692202 is a 14-bed acute care facility located in Rotan, Texas serving Kent/Fisher Counties an area of 1,800 square mile area with a population of approximately 4,569. Both Kent and Fisher Counties are designated as Medically Underserved Areas and Health Provider Shortage Areas. They are also recognized as Frontier Areas.

Fisher County Hospital District, located in Rotan, Texas is the *only* healthcare provider for Fisher and Kent Counties, in this isolated, underserved northwest area of the state, total population, 4,569. Annually we serve 66% of the total population, around 3,000 patients, of which 60% is diagnosed with one or more chronic diseases, often resulting in several encounters either in the hospital, clinic, or emergency department.

As stated in our Community Needs Assessment, our folks are basically old, sick and poor. Per Hospital financials, 2011, we experienced $500,000 Bad Debt; $174,647, Charity; and $99,423, Indigent care. Additionally we had 75% Medicare, 1.3% Medicaid payers. One or more, unmanaged chronic health conditions compromise lifestyle, employment; contribute to behavioral health conditions, particularly depression and anxiety; and weigh heavily on the future financial viability for our Hospital.

Project Description:

Project Option 2.2.1 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases

Our goal 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 especially requiring out-of-area transfer to higher level specialty care, overloading the regional facilities. We will address the Chronic Disease issues prevalent in our community by utilizing the Chronic Care Model, developed by Ed Wagner with the information and resources from the Institute for Healthcare Improvement. The project will include

self-management support, delivery system design, decision support, clinical information systems, organization of health care, and community support. Based on our DY2 assessment data, we will determine the types and numbers of classes and interventions.

We will build a complex multi-faceted chronic care management program from the ground up. Aside from the necessity of hiring a Chronic Care Management project coordinator, we will utilize, for the main part, our existing health care professionals, expanding their roles through chronic disease education, training and certification such as: Diabetic Health Coach; American Association of Diabetic Educators certificate; respiratory care health coach; American Association of Respiratory Care Course verification; patient educators/coaches for heart/stroke patients; American Heart Association certificate; and Health Care Coaches; National Society of Health Coaches certifications. This program is innovative and unique in that it combines traditional patient case management utilizing virtual practice coaches who coordinate and monitor patient care while working with providers to monitor and evaluate patient care outcomes.

We plan to develop a program to identify and manage chronic care patients needing further clinical interventions such as screening tests, preventative tests -- Glucose levels; H-1-AC; metabolic panels; BUN; creatinine levels, electrolyte levels -- or other clinical services. Early detection coupled with enrollment in a chronic care management program, appropriate medications, self-management tools, and therapeutic support has proven to be effective against conditions worsening.

One clear challenge we face is a lack of any space in our facility for group meetings, intervention activities, or one-to-one counseling support time with the health coaches. Presently almost every square foot of space in our Hospital is claimed by fiery-eyed occupants. With DSRIP funding, we intend to renovate an area in our connected assisted-living facility for multi-use adaptation.

The remaining assisted-living floor space will be renovated to meet the needs of our physical therapy department, which is currently located away from the hospital campus. Integrating the physical therapy department into the hospital and adjacent to the group meeting room will allow us to better promote physical activity and training, vital components of our work to improve the health status of patients with chronic medical conditions.

Another problem is that many of our patients with chronic disease diagnoses do not have available transportation for medical appointments; support groups, group meetings, and other intervention activities. We must purchase an appropriate vehicle for this critical element of the chronic care program.

Project Goal:

We will utilize chronic disease management initiatives to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. Program elements include the ability to identify chronic health conditions or co-occurring chronic health conditions, based on an assessment of patients' risk of developing complications, co-morbidites or utilizing acute or emergency services.

The primary goals of the RHP 11 are to: 1) Transform health care among all patient groups and to further advance the goals of the triple aim; and 2) Focus on increasing the capacity of primary care and increasing strategies related to disease prevention and the expansion of mental health services. A successful RHP project will result in improved health outcomes and improved coordination and chronic disease management, the very description of our project

Five-Year Target Outcomes:

This project is consistent with the RHP 11 plan to improve access to provide the right care at the right time in the right setting. The five-year expected outcomes will be increased access to preventive healthcare and management of chronic health conditions, resulting in reduced secondary complications of these chronic conditions. Health status, health outcomes and patient satisfaction will improve. Costly inpatient care and emergent care will be reduced.

To enable effective preventive care and improved management of chronic illnesses, patients must have ready access to their primary health care practitioner, and the opportunity for ready exchange of information. By DY5 80% of patients, including uninsured and underinsured patients and Medicare/Medicaid patients will receive timely care, appointments and information, as reported through patient surveys. Our goal is to receive 580 completed patient surveys per year.

Starting Point/Baseline:

The baseline for this income measure is currently zero. In DY3, a baseline will be established from the first complete year of surveys completed by patients.

Project Options: 2.21 Redesign the outpatient delivery system to coordinate care for patients with chronic diseases, including:

a) We will develop a specially trained chronic care team tailored to our patients' needs, including non-physician health professionals such as certified health coaches, 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, trained educators in disease-specific issues; and health coaches helping patients to navigate the health care system. We plan to "grow our own health coaches/patient educators" by utilizing our current health care professionals, expanding their roles through chronic disease education, training and certification, under the direction and tutelage of our to-be-hired Chronic Care Management project coordinator.

b) Ensure that patients can access their care teams in person or by phone or email ~ - provide some patients with pre-paid cell phones; provide transportation to/from group meetings, appointments; support groups and other intervention activities.

c) We plan to increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources

d) Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions. Examples include the decision to exercise or to eat a healthy, well balanced diet. It is well documented that exercise and weight loss benefit patients with many health conditions, including hypertension, cardiovascular disease and diabetes; there is a high incidence of these diseases in the local and regional area. The implementation of exercise classes and the promotion of increased physical activity are important components of our plan.

e) Conduct quality improvement for project using methods such as rapid cycle improvement. Identify 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.

Related Category 3 Outcome Measure:

One of the challenges we currently face is the ability for patients to obtain timely appointments. Accordingly, the implementation of outcome improvement measure for patient satisfaction, OD-6-IT-6.1 will help us to monitor and focus on quality improvement in this area.

We have selected Patient Satisfaction: OD-6 Patient Satisfaction, IT-6.1 Percent improvement over baseline of patient satisfaction scores as our outcome measure for our Chronic Care Management project which includes milestones: Develop a comprehensive care management program**;** Train staff in the Chronic Care Model, Develop program to identify and manage chronic care patients needing further clinical intervention and Improve the percentage of patients with self-management goals. Focusing on the patient satisfaction outcomes, OD-6-IT-6.1: Percent improvement over baseline of patient satisfaction scores to establish if patients are

getting timely care, appointments, and information. The process milestone for DY2 include project planning and engaging stakeholders. The process milestone for DY3 will be to establish baseline data for visit surveys, to be utilized during outcome improvement. Our annual goal is to receive 580 completed patient surveys per year. Our outcome measure targets are:

DY4 – A minimum of 80% of patients will report timely care, appointments and information.
DY5 – A minimum of 85% of patients will report timely care, appointments and information.

Rationale/Evidence:

Our project addresses priority community need CN.1 – characterized by high rates of chronic disease, including cancer, heart disease, cardiovascular disease, respiratory disease and obesity. We plan to focus on a wide variety of chronic care diagnoses specific to our community and design appropriate approaches/interventions to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. We will assess our current hospital system of taking care of our chronically ill and correct the deficiencies. Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive - responding mainly when a person is sick - to one that is proactive and focused on keeping a person as healthy as possible.
This project promotes effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health care settings, including the clinic, emergency room and outpatient areas. Half of all Americans live with a chronic condition. Among our patients, we have observed that almost 60% of our clinic patients have a chronic ongoing health care need. Furthermore, almost half of all people with chronic illnesses have multiple conditions.

Challenges that further complicate the effective treatment of these patients include: rushed practitioners not following established practice guidelines, lack of care coordination, lack of active follow-up to ensure the best outcomes, and patients inadequately trained to manage their illnesses.

Overcoming these deficiencies will require a transformation of health care to a proactive system, focused on keeping patients as healthy as possible. The Chronic Care Model will provide the basic framework for improving and integrating care in our community health system, and will also strengthen our regional rural network in RHP 11.

Relationship to Other Performing Providers' Projects in the RHP :

Through our Category 1 project, 112692292.1.1, the expansion of primary care, we will recruit an additional practitioner to meet the primary care needs of our Medicare, Medicaid, indigent and underinsured patients. Once we have developed an adequate primary care staff, the implementation of this Category 3B project will provide the framework to effectively and efficiently manage the chronic health needs of our patients. Other hospitals in RHP 11 working to improve chronic care management and/or to improve patient satisfaction include: Anson Hospital, Stamford Hospital, Hendrick Medical Center, Knox County Hospital and Mitchell County Hospital. We have a strong regional collaborative and have worked together extensively to improve regional health care. We do not have other HHSC funding to implement chronic care management.

In many respects, our hospital serves as a safety net for local patients and within our regional health network. The regional transfer hospitals in our area lack sufficient capacity to meet all of the inpatient and outpatient medical needs in the region. Small rural hospitals such as ours, can provide efficient and cost-effective primary care. This frees the regional hospitals to provide care for their urban patients and specialty care for more complex regional patient needs. And can you imagine the detrimental impact on patient mortality and morbidity without our rural hospital to provide front line health care for this 1,800 square mile area, an area about the size of Delaware?

Plan for Learning Collaborative:

We will participate in collaborative learning projects planned by Palo Pinto Hospital and will coordinate with other hospitals in our region to maximize the effectiveness of this comprehensive improvement program. We will share our lessons learned during conference calls and meetings.

Project Valuation/Patient Benefit: We valued the project at $1,012,710 based on the following:

A. Size Factor: FY2011 Fisher County Hospital treated the following chronic care encounters:

FY2011:	Clinic	Hospital/ED
Diabetes	333	273
Hypertension	365	147
CHF	47	92
COPD	41	92

Asthma	62	93
Arthritis	64	42
Depression	66	128

B. Project Scope: Our project will redesign the outpatient delivery system to coordinate care for patients with chronic diseases in our hospital outpatient settings and clinic. We will implement the Chronic Care model and develop a trained chronic care team to improve the management of chronic conditions. The assisted living space will be renovated to provide space for the therapy department, physical fitness instruction and a classroom. We will also address the need for local medical transportation.

C. Populations Served: Our target population includes uninsured, underinsured and Medicaid patients, as well as Medicare patients who have one or more chronic diseases. By DY5, a minimum of 350 patients will be enrolled in our chronic care program. Of these, 275 patients will have one self management goal, and 150 patients will be identified for further clinical intervention. We anticipate 3,000 patient encounters participating in our training and workshop classes. At least 580 patient surveys will be completed during DY5.

D. Community Benefit: Patients will receive more preventive healthcare, access to primary care, and improved management of chronic illness. Health status, health outcomes and patient satisfaction will improve. There will be reduced secondary complications, and costly inpatient and emergent care will be reduced. By DY5, through surveys, at least 85% of patients will report that they receive timely care, appointments and information.

E. Cost Avoidance: Approximate annual costs of care: Diabetes with no complications, ranges from $6 - $10,000 with no complications; Diabetes, Out of control, end-stage renal, dialysis, $100,000; COPD, ranges from $5,000 to $75,000, depending on inpatient acuity; CHF, $7,000 to $75,000 per hospital stay; Hypertension- $1,000 and up, depending on complication; Asthma, $1,800 to $10,000; Depression, $1,500 -$10,000. A quick estimate of the chronic health care costs for our patients is over $3.4 million annually/$13,600,000 for the 4 year project. Early diagnosis, treatment and appropriate interventions save medical hardships for the patients and avoid needless costs for the healthcare system.

F. Community Need: CN.1: 60% of our patients have one or more chronic illnesses. In our rural area underserved Hospital, health care practitioners are scarce, required to cover clinics, hospital, and the emergency center, almost simultaneously. Additionally, the advent of the electronic medical record system has further encroached on the day of the busy physician/mid-level, reducing the time spent in patient's clinic visits. Our Chronic Care Management program will offer a cost avoidance aspect and will provide increased access to preventive care and health information, and improve management of chronic health conditions. Health outcomes and patient satisfaction will improve.

G. Our hospital will provide $408,348 in local funding for Category 2 activities.

2.2.1	New 112692202.2.2 Old 112692202.2.1	2.2.1. A, B, C, D, E	2.2 Expand Chronic Care Management
112692202	Fisher County Hospital District		
New 112692202.3.5 Old 112692202.3.1	Related Category 3 Outcome Measure(s):	IT-6.1	Percent improvement over baseline of patient satisfaction

Year 3 (10/1/2013 – 9/30/2014)	Year 2 (10/1/2012 – 9/30/2013)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
P-3. Milestone 1: Develop a comprehensive care management program. P-3.2. Metric : Increase the number of patients enrolled in care program a. number of patients enrolled by 50 (total 100) b. data source: program enrollment records Milestone 1 Estimated Incentive Payment (*maximum amount)*: $90,066 **P-9. Milestone 3: Develop program to identify and manage chronic care patients needing further clinical intervention** P-9.1. Metric: Increase the	**P-3. Milestone 1: Develop a comprehensive care management program** P-3.1. Metric: Documentation of the Wagner Chronic Care Model a. Data Source: Program materials b. Rationale/Evidence: Review Wagner Chronic Care model and conduct an assessment of the hospital/health system to guide quality improvement efforts and evaluate changes in chronic illness care P-3.2. Metric: Increase the number of patients enrolled in our care management **program over baseline (0)**	**P-3. Milestone 1: Develop a comprehensive care management program** P-3.2. Metric : Increase the number of patients enrolled in care program by 100 a. number of patients enrolled- **200** b. data source: program enrollment records p-3 Milestone 1 Estimated Incentive Payment: $90,327 **P-9. Milestone 3: Develop program to identify and manage chronic care patients needing further clinical intervention** P-9.1. Metric: Increase the number of patients identified	**I-18. Milestone1**: Improve the percentage of patients with self-management goals I-18.1. Metric: Patients with self-management goals a. Numerator: The number of patients with the specified chronic condition/MCC in the registry with at least one recorded self management goal**: 275** b. Denominator: Total number of patients with the specified chronic condition/MCC in the registry**: 350** c. Data Source: Registry d. Rationale/Evidence: Self Management education complements traditional patient education in

2.2.1	New 112692202.2.2 Old 112692202.2.1	2.2.1. A, B, C, D, E	2.2 Expand Chronic Care Management
112692202	Fisher County Hospital District		
New 112692202.3.5 Old 112692202.3.1	Related Category 3 Outcome Measure(s):	IT-6.1	Percent improvement over baseline of patient satisfaction

Year 3 (10/1/2013 – 9/30/2014)	Year 2 (10/1/2012 – 9/30/2013)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
number of patients identified as needing screening test, preventative tests, or other clinical services a. Numerator: Number of patients identified and subsequently receiving needed tests or other clinical services: to 25 b. Denominator: Number of patients identified as needing screening tests, preventative tests, or other clinical services: **50** c. Data source: EHR, patient registry p-9 Milestone 3 Estimated Incentive Payment: $90,066	a. Number of patients enrolled in a care management program to 50 b. Data source: Program enrollment records Milestone 1 Estimated Incentive Payment (*maximum amount)*: $123,836 **P-2. Milestone 2**: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic program materials a. Numerator: Number of relevant staff trained in the Chronic Care Model: **30** b. Denominator: Total number	as needing screening tests, preventative tests, or other clinical services. a. Numerator: Number of patients identified and subsequently receiving needed tests or other clinical –by additional **25** b. Denominator: Number of patients identified as needing screening test, preventative tests, or other clinical services **–by additional 50** c. Data Source: EHR, patient registry p-9 Milestone 3 Estimated Incentive Payment: $90,328	supporting patients to live the best possible quality of life with their chronic condition. **I-18. Milestone1** Estimated Incentive Payment: $74,618 **P-3. Milestone 1: Develop a comprehensive care management program.** P-3.2. Metric : Increase the number of patients enrolled in care program **by 150** a. number of patients enrolled—**total 350** b. data source: program enrollment records p-3 Milestone 1 Estimated Incentive Payment: $74,619 **P-9. Milestone 3: Develop**

2.2.1	New 112692202.2.2 Old 112692202.2.1	2.2.1. A, B, C, D, E	2.2 Expand Chronic Care Management
112692202	Fisher County Hospital District		
New 112692202.3.5 Old 112692202.3.1	Related Category 3 Outcome Measure(s):	IT-6.1	Percent improvement over baseline of patient satisfaction

Year 3 (10/1/2013 – 9/30/2014)	Year 2 (10/1/2012 – 9/30/2013)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
P-2. Milestone 2: a. Numerator: Number of relevant staff trained in the Chronic Care Model: **20** b. Denominator: Total number of relevant staff: **30** c. Data Source: HR, training program materials p-2 Milestone 2 Estimated Incentive Payment (*maximum amount)*: $90,066	of relevant staff: **30** c. Data Source: HR, training program materials p-2 Milestone 2 Estimated Incentive Payment (*maximum amount)*: $123,837	**P-10. Milestone 4**: 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 P-10.1. Metric: Increase the number of group visits and/or telephone visits and/or other interaction types a. Numerator: Number of group visits/telephone visits/other interaction types: **120** b. Data source: EHR, billing records p-10 Milestone 4 Estimated	**program to identify and manage chronic care patients needing further clinical intervention** P-9.1. Metric: Increase the number of patients identified as needing screening test, preventative tests, or other clinical services: a. Numerator: Number of patients identified and subsequently receiving needed tests or other clinical services- by additional **50** **(total 150)** b. Denominator: Number of patients identified as needing screening test, preventative tests, or other clinical services 75—

2.2.1	New 112692202.2.2 Old 112692202.2.1	2.2.1. A, B, C, D, E	2.2 Expand Chronic Care Management	
112692202	Fisher County Hospital District			
New 112692202.3.5 Old 112692202.3.1	Related Category 3 Outcome Measure(s):	IT-6.1	Percent improvement over baseline of patient satisfaction	
Year 3 (10/1/2013 – 9/30/2014)	**Year 2 (10/1/2012 – 9/30/2013)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Incentive Payment: $90,328	total 175 c. Data Source: Data source: EHR, patient registry p-9 Milestone 3 Estimated Incentive Payment: $74,619
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $247,673	Year 3 Estimated Milestone Bundle Amount: $270,198		Year 4 Estimated Milestone Bundle Amount: $270,983	Year 5 Estimated Milestone Bundle Amount: $223,856
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,012,710				

Pass 3B
Summary Information: New 112702904.2.2
Old *112702904.2.1*

- Provider: Haskell Memorial Hospital is a 25 bed critical access hospital serving a population of approximately 5900 people. The community has a population of approximately 25% over 65 years old and 22.6% below the federal poverty level and is designated as a primary care health provider shortage area.

- Intervention(s): The project purposes to purchase a CT scanner to improve access and reduce cost due to the need to transport patients to other facilities for scanning and improve care created by accurate and timely diagnosis. The addition of a CT scanner to our services will provide emergent care patients with appropriate and time sensitive quality care that will lower overall cost for the patient's treatment.

- Need for the project: Haskell Hospital is qualified to treat emergent needs of our patients if the right equipment is available to properly diagnose the patient. We will transform and improve access to specialty care by enhancing access points and increase capacity for appropriate care and be able to reduce the cost of care by doing CT scans locally. Currently patients must be transported 120 miles roundtrip through an ambulance service at a cost of $600 per trip add approximately $72,000 annually to the cost of CT scans. Ambulance services are utilized for this purpose and thus are not available for times of true emergencies. The cost and inconvenience created causes the patients and family additional anxiety. The diagnosis process is delayed in critical circumstances due to the lack of this service.

- Medicaid and Uninsured Target population: With 24.7 % of the population older than 65 and 22.6 % of the population below poverty level, the Medicaid and uninsured population will benefit from the additional access to care at the inpatient, outpatient and emergency department setting increasing access and improving care for a more satisfied patient. The target populations will be emergent patients and those Medicaid and indigent patients unable to travel elsewhere for CT scans due to inadequate financial resources.

- Category 1 or 2 expected patient benefits: The project will give the community better access to care for patients and assist in the region wide goal of right care, right place, right time. Patients will not have to be transported or experience delays in critical care when CT is indicated which will improve patient outcomes. Non emergent patients without financial resources will be able to have the CT scan done locally without having to travel 120 miles round trip which creates a financial burden on the patient. The project would benefit in DY 4 the **240** current patients that were sent out for CT scans this past year and numerous others that are unidentified and unknown at this time. The DY 5 projected benefit would be an increase of 2% or an estimated 245 patients.

- Category 3 outcomes: IT-5.1-Our goal is to have improved cost savings by cost minimization to show less costly among alternatives that produce equivalent outcomes.

Pass 3B

Category 2: Program Innovation and Redesign

Project Option 2.5- Redesign for Cost Containment

Unique Project ID: New 112702904.2.2
Old 112702904.2.1

Facility Description: Haskell Memorial Hospital-112702904

Project Description:

Haskell Memorial Hospital, as a Critical Access Hospital, serves a rural area of uninsured, Medicaid, and Medicare households. Based on the 2010 Census quick facts, 22.6% of the population live below the federal poverty level, 24.7% of the County population is 65 year of age or older, and within 10 years, an additional 15% of the county population will be of retirement age. As a provider within a county designated as a Primary Care Health Provider Shortage Area, Haskell Memorial Hospital is the primary source of care within a 60 mile radius. As such we seek to direct non emergent needs to the local clinics and keep only those patients with emergency and/or inpatient needs. In order to provide emergent care patients with appropriate and time sensitive quality care, HMH purposes to add a CT scan to our services. CT has become a basic diagnostic tool that most physicians now deem as a necessary to diagnose conditions such as strokes, pulmonary embolisms, aorta dissections, cardiac conditions, motor vehicle accident traumas and other life threatening conditions appropriately. This project has the potential to reduce transfers and EMS costs related to unnecessary transports to the next nearest facility which is 60 miles in distance one direction. The addition of a CT scanner to our facility will improve overall healthcare outcomes and increase our capacity to diagnose and treat conditions such as those mentioned above that would otherwise be costly or deadly if left untreated.

HMH is qualified to treat many emergent needs and a CT scanner will add a safeguard to properly diagnose and treat emergent needs without prolonging diagnosis and thus decreasing the risks of increased morbidity and mortality if the right equipment is available to properly diagnose the patient. Patient experience and patient outcomes will also improve with more readily available access to appropriate care. HMH will educate and train staff to operate the CT scan and to further improve efficiencies and timely access to specialty care for patients.

Based on the availability of a CT scan we will transform and improve access to specialty and preventive care by enhancing access points and increasing capacity for the growing need for appropriate care while reducing the cost of care by doing the CT scan locally. This will also improve access for the uninsured and Medicaid populations. Patient care and patient outcomes will improve with more readily available access to care by DY 5 through the availability of proper diagnostic tools such as the CT scanner. We believe this project will also advance the

RHP 11 regional goals of the Triple Aim: right care, right place, and right time and reduce the burden on Emergency Departments across the region.

Starting Point/Baseline:

Currently the cost to transport a patient for a CT scans adds approximately $600 to the cost of the scan which is estimated to be within the range of $1200 to $1400. This additional cost is a burden to Medicare, Medicaid and especially the unfunded clients that reside in our service area. There is not an effective methodology in place to measure the cost of time, money and anxiety for the patient and their family members who have to make this 120 mile trip for proper diagnosis. Unfortunately, we have not been able to measure the cost associated with prolonged diagnosis and the detrimental effects that may have had on someone suffering from a stroke or a cardiac event. DY 2 will be spent on negotiations for the best price of a scanner and the logistics involved in preparing a space to house the machine. Requests for proposals will be prepared and bids from vendors will be accepted in order to get the best price for both the machine and the renovations that will be necessary. In DY 3, we will prepare policies and procedures, provide training to our providers and staff, forge relationships with Abilene Radiology who will be reading the CT scan results and prepare for full implementation of CT scanner in DY 4 with a first year usage anticipated to be **240 patients** with an anticipated 2% increase in usage to **245 patients** in DY 5. We will implement a system to monitor the usage for outcomes/diagnosis and medical necessity to determine cost effectiveness and proper use of the cat scan. We anticipate an immediate utilization of the service for those that currently have to drive elsewhere and also for the Emergency Room visits that are currently being transported 120 miles round trip for CT scans.

Rationale:

Access to quality care is a priority for our community and our region. Based on a community survey performed in January of 2011 by the Texas A&M Public Policy Research Institute, access to specialty care was a major concern among many community members. A limitation to specialty care in the ED at HMH has reduced our scope and size as a public safety net provider. We have identified a gap related to proper diagnosis in emergency situations and a high cost related to EMS transfers. With this project we expect to better be able to address critical issues in a timely fashion in the appropriate emergency setting. We expect to reduce potentially preventable transfers ED to ED and improve outcomes for patients. Upon completion we expect to provide patients with quality care in the appropriate environment at a lower cost. Patients will not have to be transported nor experience delays in critical care which will improve patient outcomes and patient satisfaction.

This project falls under the RHP 11 Community needs Identification Number CN.5-Need to overcome patient access to care barriers.

Required core components:

a. 2.5.4 –Other project option: Implement other evidence based project that will impact cost efficiency in an innovative manner not described in the project options above.

By providing additional access to specialty care, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction in costs associated with unnecessary transports of patients for CT scans to other providers. Currently approximately **16 inpatients, 104 ED patients and 120 outpatients** must go elsewhere for a CT scan. The cost of the CT scanner ranges from approximately $225,000 to $250,000. Currently patients pay from $1200 to $1400 plus $600 for transportation for a scan for a total cost of $434,400 a year for **240 patients**. In one year the CT scanner will pay for itself and generate funds for its operation thus providing sustainability for the investment. In addition, a savings of $72,000 per year will be saved on transportation plus an unaccountable amount generated from early diagnosis. This will be especially beneficial to Medicaid and indigent patients who do not have the financial means to travel for these services and many times do not get the service because of lack of transportation and money.

Related Category 3 Outcome Measure(s):

OD-5 Cost of Care
IT-5.1 Improved Cost Savings: Demonstrate cost saving in care delivery

Rationale/Evidence: Haskell Memorial Hospital believes by providing local access to a CT scanner we can reduce the overall cost of an episode of care for those patients who are being transported elsewhere for those services. If there was a local option, it would reduce the cost of care and provide faster results and if in the emergency department, it would stop/reduce the burden on EMS for potential emergent transfers for our rural hospital to the urban hospital for CT scans that result in minor treatments that could have been done at our facility if we had the needed imaging equipment. In a recent study of the number of patients transported out of our ED for a cat scan, we have found an average of two per week go by ambulance with an average cost of $600 for the trip to Abilene which equates to **104** patients per year times $600 equal $62400 for just the transportation of ED patients. Some of these patients may have to be sent by air which is an even greater cost. This does not take into account the delay of care for the patient and cost to the family to drive to where the patient is going. We have transported approximately 16 patients in the last year that were inpatients in our facility to another facility for CT scan at an estimated transportation cost of $9600. Most of these patients are elderly and the transport is very difficult on them. An estimate from HMH physicians' offices of 10 per month or **120** per year patients are sent to Abilene for CT scans which cause the patient to incur cost for gas and the inconvenience of travel 120 miles round trip. Again, many of these patients are elderly and/or poor and this poses a hardship on them to travel elsewhere for the scan that is needed.

Relationship to other Projects:

By providing additional specialty care in the form of a CT scan, patients and families will receive better access to care which will result in better health outcomes, patient satisfaction, appropriate utilization of services, and a reduction in costs associated with non-emergent care treatment in the other ED in our region.

Many of the projects within our region are related to expanding specialty care within the community or region. Many of our rural hospitals face similar needs and similar difficulty in services to provide our communities with the services they need. The RHP 11 goals to transform health care in the total population and advance the goals of right care, right place and right time are goals we are working toward with our expansion of services and a goal that will greatly improve health outcomes and appropriate utilization of services in our region.

Relationship to Other Performing Providers' Projects in the RHP:

RHP 11 goals are to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. RHP 11 has chosen to focus on increasing the capacity of primary care, increasing strategies related to disease prevention, and expanding behavioral health services. We anticipate that all the projects will reduce the burden on Emergency Departments and improve health outcomes across the region. RHP 11 has a number of collaborations which invests resources into our rural communities where sole providers face burnout and fatigue. The selected DSRIP projects will begin to build the infrastructure needed in our primary care system to be the backbone for improved care coordination, chronic disease management and care transitions, projects of the future. In increasing the capacity of primary care, the cost of care will be impacted. The ED is the highest cost setting for care. When patients over utilize or unnecessarily utilize the ED for primary and preventive care, the cost burden is wasteful. RHP 11, again, has identified projects that seek to bend the cost curve, which is foundational to the transformation of the healthcare system for patients and for providers.

Haskell Memorial Hospital's project to redesign for cost containment through the expansion of specialty care with the addition of a CT scanner coincides with other projects within the region that are expanding their access to specialty care through various programs and decreasing the cost of care by allowing patients to receive services they need in their local communities. Because of the distance between our communities, we do not see any duplication of these needs and services as being an issue.

Plan for Learning Collaborative: N/A

Project Valuation:

I have valued our project based on the cost savings that will be incurred due to patients receiving the specialty service they need at the local provider rather than traveling a long distance for that service. This saves on transportation cost via ambulance, air and private vehicle. The value is also based on patient's ability to be treated locally when the CT scan they received show a diagnosis that can be treated locally rather than being sent to a tertiary

hospital that will typically be more costly. It is also valued on the ability to make a faster diagnosis for those with critical needs so that appropriate care can be provided more timely and effectively than having to be sent elsewhere before a condition can be diagnosed. We anticipate services to at least 240 patients in DY 4 and 245 patients in DY 5 based on the current number of patients being sent elsewhere for CT scans.

We are choosing to do only one project in Category 2 due to the limited amount of funds allocated to our facility so we are putting all of our value in the project to redesign for cost containment through the expansion of services by adding a CT scanner. This was an identified need in a local community assessment done in January of 2011 and is also an identified need in our RHP community assessment CN.5. This service will help serve the county population of 5900 people and improve their access to care and provide a valuable community benefit. We anticipate it will save cost in our emergency room and other areas by not having to transport patients and to have more availability of services for diagnosis of patients in critical and time sensitive cases.

NEW 112702904.2.2 OLD 112702901.2.1	***2.5.4 PROJECT OPTION: OTHER PROJECT OPTION***	***2.5.4 OTHER PROJECT OPTION***	***REDESIGN FOR COST CONTAINMENT***	
Haskell Memorial Hospital				*112702904*
OD-5	NEW 112702904.3.4 OLD 112702904.3.2	*IT-5.1*	*IMPROVED COST SAVINGS: DEMONSTRATE COST SAVING 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-X*] Implement and monitor a system to track cat scans performed, outcomes/diagnosis, and medical necessity to determine cost effectiveness and proper use. **Metric 1: (P-X.1)** Establish a process and plan for evaluating cat scans performed and reviewing for outcomes/diagnosis and medical necessity with monthly reporting to hospital QA on results and recommendations **Data source: EMR, radiology reports, medical necessity guidelines**	**Milestone 2 (I-X)** Improved access to specialty care at a lower cost while monitoring medical necessity through quality improvement program **Metric: (I-X.1)** Demonstrate cost savings in care delivery by contracting with the most cost-effective contractor for remodeling and purchase of scanner **Data source**: Request for proposals submitted by contractors **Metric: (I-X.2)** Develop measures that will identify medical necessity,		**Milestone 2 (I-X)** Improved access to specialty care at a lower cost while monitoring medical necessity through quality improvement program **Metric: (I-X.2)** Monitor measures developed for medical necessity, patient diagnosis, outcomes and cost saving related to local access**.** Demonstrate improved access in care delivery by decreasing the number of people who go out of town for scans and increasing the availability of CT services to the 1980 ED patients seen per year, to inpatient services and to the other 5900 patients seen for	**Milestone 2 (I-X)** Improved access to specialty care at a lower cost while monitoring medical necessity through quality improvement program. (Improved cost savings at least $72,000) **Metric: (I-X.2)** Monitor measures developed for medical necessity, patient diagnosis, outcomes and cost saving related to local access Demonstrate improved care delivery capturing data on CT scanner usage over the year and comparing CT cost to previous year and improved medical necessity usage based on diagnosis

NEW 112702904.2.2 OLD 112702901.2.1	***2.5.4 PROJECT OPTION: OTHER PROJECT OPTION***	***2.5.4 OTHER PROJECT OPTION***	***REDESIGN FOR COST CONTAINMENT***	
Haskell Memorial Hospital				*112702904*
OD-5	NEW 112702904.3.4 OLD 112702904.3.2	*IT-5.1*	*IMPROVED COST SAVINGS: DEMONSTRATE COST SAVING 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)**
Rationale/Evidence: As health care costs rise- regulators, policymakers and industry leaders are interested in developing accurate ways to measure and try to reduce health care costs for individuals as well a society. By providing a measure and process to track the cat scans performed at our facility rather than having to transport them and monitoring for medical necessity, we can better provide the access to care needed (at a lower cost) by our community and especially for those that are financially unable to drive elsewhere for	patient diagnosis , and outcomes while saving cost for the services Data source: EMR, radiology reports, medical necessity guidelines		outpatient services. Baseline: number of CT performed (**estimate 240** based on current year sent out), Number found to be medically necessary based on diagnosis Goal: Estimate 90% of the **240** CT's performed will be determined to be medically necessary based on diagnosis **Data source**: EMR, radiology reports, medical necessity guidelines, financial statements **Rationale/evidence**: Access to quality care is a priority for our community and our region. A	Baseline: number of CT performed estimated at a 2% increase (**245),** Number found to be medically necessary based on diagnosis Goal: Estimate 92% of the **245** CT's performed will be determined to be medically necessary based on diagnosis **Data source**: EMR, radiology reports, medical necessity guidelines, financial statements

NEW 112702904.2.2 OLD 112702901.2.1	***2.5.4 PROJECT OPTION: OTHER PROJECT OPTION***	***2.5.4 OTHER PROJECT OPTION***	***REDESIGN FOR COST CONTAINMENT***	
Haskell Memorial Hospital				*112702904*
OD-5	NEW 112702904.3.4 OLD 112702904.3.2	*IT-5.1*	*IMPROVED COST SAVINGS: DEMONSTRATE COST SAVING 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)**
test such as Medicaid and indigent patients			limitation to specialty care in the ED at HMH has reduced our scope and size as a public safety net provider. We have identified a gap related to proper diagnosis in emergency situations and a high cost related to EMS transfers. With this project we expect to better be able to address critical issues in a timely fashion in the appropriate emergency setting. We expect to reduce potentially preventable transfers ED to ED and improve outcomes for patients. Upon completion we expect to provide patients with quality care in the appropriate environment at a lower cost. Patients will not have to be	

NEW 112702904.2.2 OLD 112702901.2.1	***2.5.4 PROJECT OPTION: OTHER PROJECT OPTION***	***2.5.4 OTHER PROJECT OPTION***	***REDESIGN FOR COST CONTAINMENT***	
Haskell Memorial Hospital				*112702904*
OD-5	NEW 112702904.3.4 OLD 112702904.3.2	*IT-5.1*	*IMPROVED COST SAVINGS: DEMONSTRATE COST SAVING 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)**
Estimated Incentive Payment *(maximum amount): $* $144,759	Estimated Incentive Payment *(maximum amount): $* 158,111		transported nor experience delays in critical care which will improve patient outcomes and patient satisfaction Estimated Incentive Payment *(maximum amount):* $159,396	Estimated Incentive Payment *(maximum amount):* $130,296
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $ $144,759	Year 3 Estimated Milestone Bundle Amount: $ 158,111		Year 4 Estimated Milestone Bundle Amount: $ 159,396	Year 5 Estimated Milestone Bundle Amount: $ 130,296
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $592,562				

Hendrick Medical Center
Category 2 – Enhance/Expand Medical Homes
138644310.2.1
Pass 1

Summary Information:
Provider: Hendrick Medical Center is a 522 bed hospital in Abilene Texas serving a 105 square mile area and a population of approximately 117,000.
Intervention(s): This project will help to expand the Medical Care Mission by giving them additional funding to expand their services to be able to serve an even greater population of the Indigent population.
Need for the Project: Because the Medical Care Mission serves such an expansive area of 22 surrounding counties they are always in need of resources to be able to handle this very large population.
Medicaid and Uninsured Target Population: Any patient needing primary care services is the target population. All of the patients seen by the Medical Care Mission are categorized as indigent and uninsured so we expect all of the population served by the Medical Care Mission to benefit greatly from this expansion of care.
Category 1 or 2 Expected Patient Benefits: The Medical Care Mission currently sees an estimated 9500 patients per year. The goal in DY 4 will be to see an additional 2%, which is expected to be an estimated 190 over the baseline. The goal in DY 5 will be to see an additional 3%, which is expected to be 285 over the baseline. At the end of DY 5 the goal will be to see an additional 475 patients over the baseline. The total amount of patients seen at the end of DY 5 is estimated to be around 38,475. This total is factoring in 9500 patients seen in DY 2, 9500 patients seen in DY 3, 9690 patients seen in DY 4 and 9785 seen in DY 5.
Category 3 Outcomes: IT-9.2. The goal is to decrease emergency department visits for diabetes by 1% in DY4 over the baseline established in DY2 and by 2% in DY5 over the baseline established in DY2.

Category 2: Program Innovation and Redesign

Project Option 2.1.2 **Enhance/Expand Medical Homes**

Unique Project ID: 138644310.2.1

Facility Description: Hendrick Medical Center-138644310

- The Medical Care Mission currently provides a medical home for patients from the 22 county area surrounding Abilene. The specific patient population is individuals and families at or below 200% of the federal poverty level who do not have Medicaid, Medicare, or commercial insurance. Specific services include primary care, chronic disease management, acute care, counseling, referral to support services, specialty referrals, treatment for HIV/AIDS and dental care. Eligibility is based on household income, and patients are charged according to a sliding scale. Patients are not turned away for an inability to pay. The Mission serves as an effective alternative for uninsured patients who would traditionally seek care in the local trauma centers as well as greatly reducing avoidable admissions due to neglected chronic disease. In addition to patients who have no other means of access to care. The Mission works closely with the Indigent Healthcare system of Taylor County to provide medical homes for clients enrolled in their system. Increased funding would allow the Mission to recruit and hire additional provider and support staff, increase public awareness of services, and design a tracking system to measure trauma center impact, coordinate additional specialty care and assist with the added lab fees involved with the increased numbers making the Medical Care Mission their medical home. This project is based on the community need of expansion of care and being able to support a larger indigent population.

Project Description:

- Currently there is a Medical Care Mission which provides primary and preventive care to the uninsured in Taylor County. The Medical Care Mission currently sees an estimated 9500 patients per year. The goal in DY 4 will be to see an additional 2%, which is expected to be an estimated 190 over the baseline. The goal in DY 5 will be to see an additional 3%, which is expected to be 285 over the baseline. At the end of DY 5 the goal will be to see an additional 475 patients over the baseline. The total amount of patients seen at the end of DY 5 is estimated to be around 38,475. This total is factoring in 9500 patients seen in DY 2, 9500 patients seen in DY 3, 9690 patients seen in DY 4 and 9785 seen in DY 5. Challenges and issues currently faced are the ability to hire an administratively competent registered nurse and a full time physician's assistant. Another goal of the Medical Care Mission is to be able to also allow more time per patients visit in order to provide a better overall health prospective for the patient. Currently most of the Medical Care Missions' patients are chronically ill and have multiple issues, which require, in many cases, two to five times the amount of clinical and pharmacological investigation as an otherwise healthy patient. The implementation

of this project will aid in these goals. The services provided by the mission are primary care services and other services include primary care, chronic disease management, acute care, counseling, referral to support services, specialty referrals, treatment for HIV/AIDS and dental care. Enhancing and expanding medical homes in the Medical Care Mission would expand capacity for these services as well as provide better care coordination and reduce potentially preventable ED visits by this population of patients. The goal of projects under this heading is to expand or enhance the delivery of care provided through the Patient-Centered Medical Home (PCMH) model. The PCMH provides a primary care "home base" for patients. Under this model, patients are assigned a health care team who tailors services to a patient's unique health care needs, effectively coordinates the patient's care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care. Through the enhancement of the Medical Home we are able to serve more indigent patients over the 5 year period. Giving access to more indigent care individuals in the community is a regional goal and this will support that.

Starting Point/Baseline:

- Baseline data will be established in DY 3 based on the enhanced access to the medical home. The baseline is estimated to be 9500. The Medical Care Mission currently provides a medical home for indigent patients from the 22 county area surrounding Abilene but through the implementation of the program we will help to expand their services to a larger population throughout the community. In DY 2 the goal is to train additional staff on the PCMH change concepts. In DY 3 the goal is to enhance patient access to the medical home. In DY 4 the goal is to increase the percent of enrolled patients based on the established baseline by 2%. In DY 5 the goal is to Increase the percent of enrolled patients based on the established baseline by 3%.

Rationale:

- The project option and components have been selected to better allow the patient centered medical home to attract and accommodate a higher amount of high-risk patients as well as collaborate and coordinate with other hospitals in the county. This project will help expand the data exchange between hospitals and the affiliated medical home sites by allowing us to increase the amount of data that we exchange. Through the implementation of this project additional training will occur to accommodate the high-risk patients. Implementation of a comprehensive, multidisciplinary intervention will be established in order to accommodate the high-risk patients. Because the medical home will be able to take care of more patients and will be able to set them up with the services that they need, the ED department visits should decrease. This is something that will be monitored by our category 3 domain in DY 4 & 5. The identification of potential project improvements and the identification of key challenges associated with an expansion of the project will be assessed through learning collaborative that will occur on a semi-annual basis between Hendrick Medical Center and Medical Care Mission. Also through the learning collaborative, best practices will be identified and shared between the two entities. The milestones and metrics are relevant to the population and circumstances because they directly address the need to provide services to indigent care and low income families within our community. Because we

have a high population that is considered indigent and low income these milestones and metrics will allow the medical home the ability to expand and take care of more of these types of patients. This project significantly enhances an existing initiative because it will allow the medical home to expand its current services to serve a larger patient population. Federal, state, and health care providers share goals to promote more patient-centered care focused on wellness and coordinated care. In addition, the PCMH model is viewed as a foundation for the ability to accept alternative payment models under payment reform. PCMH development is a multi-year transformational effort and is viewed as a foundational way to deliver care aligned with payment reform models and the Triple Aim goals of better health, better patient experience of care, and ultimately better cost-effectiveness. By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction. These projects all are focused on the concepts of the PCMH model; yet, they take different shapes for different providers. The patient/family is the focal point of this model, and the medical home is built around this center. Another key factor is that the focus of the medical home has shifted to include all children and adults, not just children with special health care needs. In the 2002 revision (PDF - 45KB) of its 1992 statement (PDF - 32KB) on the medical home, the AAP reiterated and enhanced its explanation of the medical home's crucial characteristics. These guidelines stress that care under the medical home model must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. In 2007, the AAP joined with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) to form the Joint Principles of the Patient Centered Medical Home. Under this collaborative effort, the characteristics of the medical home have been defined within these 7 principles: Personal physician, physician directed medical practice, whole person orientation, care is coordinated and/or integrated, quality and safety are hallmarks of the medical home, enhanced access to care and patient focused payment system. (HRSA (http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html))

- This project addresses community need number CN.5.

Related Category 3 Outcome Measure(s):

- OD-9: Appropriate Utilization
- IT-9.2: ED appropriate utilization
- Category 3 outcome measures include in DY4 & DY5 the ED appropriate utilization. We chose the third option and chose diabetes to be the ED visit that we will report on for the population that is seen in the Medical Care Mission which consists mostly if not entirely of indigent care. This is a priority for the RHP because our community and region have such a large population of diabetes patients and low income families and individuals. So our improvement target will be measuring the reduction in emergency department visits for target conditions (Diabetes). Reducing emergency department visits is extremely important because they are very costly. By reducing these visits we will save the patients

and the insurance companies' money. The category 2 project will help achieve the category 3 outcome measures by expanding services in the Medical Care Mission and this will help reduce the inappropriate ED utilization because more care will be available. The expansion of care will be able to support and take care of a larger population. This will also improve the health of low-income populations by giving them the ability to have an alternative healthcare option that can meet their needs. Appropriate ED utilization is extremely important to our region because it cuts down on costs dramatically both for the patient and for the insurance companies. Through the expansion of the current medical home in this project, they will be able to support a larger percentage of indigent care patients, which in turn will decrease the inappropriate utilization of ED visits. This will improve the health of low-income or indigent care populations because it will give them greater access to the care that they need, when they need it.

Relationship to other Projects:

- This project relates to RHP project identification numbers 138644310.1.1 by also increasing the capacity of care available to the community. By expanding the medical care mission more primary care physicians will have the ability to direct referrals accordingly to patients who need this type of care. This also relates to PPA's, PPR's, PPC's, Patient Centered Healthcare & Emergency Department Category 4 measures.

Relationship to Other Performing Providers' Projects in the RHP:

- This project achieves the goals of the region which is to reduce costs to patients, provides them with the healthcare that they need, when they need it and also relieves the ED of inappropriate visits. This project also relates to the other primary care projects in the region because this project is also an avenue for primary care. Providers with related primary care projects include: Anson, Hamlin Memorial Hospital, Haskell memorial Hospital, Mitchell County Hospital and Palo Pinto General Hospital.

Plan for Learning Collaborative:

- Learning collaborative will occur between Hendrick Medical Center and Medical Care Mission on a semi-annual basis.

Project Valuation:

- This project achieves waiver goals because it is expanding the capacity for indigent patients and gives the Medical Care Mission the ability to see more of those patients. It also will decrease inappropriate use of high cost services and facilities. Improve patient education to seek appropriate levels of care, Increase public health measures like vaccination rates. We have also used the fact that the Medical Care Mission will be alleviating ED visits from Hendrick and Abilene Regional and will also be able to accommodate more people. The Medical Care Mission will see additional indigent care patients that have not always had a PCP in the past. The project investment will be allowing additional funding to flow through the Medical Care Mission in order to support additional staffing and training to be able to handle a larger indigent care population. The total amount of patients seen at the end of DY 5 is estimated to be around 38,475. This total is factoring in 9500 patients seen in DY 2, 9500 patients seen in DY 3, 9690 patients seen in DY 4 and 9785 seen in DY 5. These factors combined

together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and addressing priority community need. Based on the criteria mentioned above we were able to come up with the valuation.

138644310.2.1	***2.1.2***	***2.1.2.A., 2.1.2.B, 2.1.2.C, 2.1.2.D, 2.1.2.E, 2.1.2.F***	***ENHANCE/EXPAND MEDICAL HOMES***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.4*	*IT-9.2*	*Reduce Emergency Department visits for target conditions (Diabetes)*	
Year 2 (10/1/2012 – 9/30/2013)	**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: Baseline will be established in DY3 based on the enhanced patient access to the medical home. The goal is to train staff on the PCMH change concepts. Data Source: Training records and HR documents. Milestone 1 Estimated Incentive Payment (*maximum amount)*: $959,259	**Milestone 2** [P-2]: Put in place policies and systems to enhance patient access to the medical home. Metric 1 [P-2.1]: Performing Provider policies on medical home. Baseline/Goal: Baseline will be established in DY3 based on enhanced patient access to the medical home. The baseline is estimated to be about 9500 total patient visits. The goal is to enhance patient access to the medical home. Data Source: Performing Provider's "Policies and Procedures" documents Milestone 2 Estimated Incentive Payment: $981,094		**Milestone 3** [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. Goal: The goal is to increase the percent of enrolled patients based on the established baseline by 2%. The goal is to see an estimated 9690 patients in DY 4. Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider Milestone 3 Estimated	**Milestone 4** [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. Goal: The goal is to increase the percent of enrolled patients based on the established baseline by 3%. The goal is to see an estimated 9785 patients in DY 5. Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider

138644310.2.1	***2.1.2***	***2.1.2.A., 2.1.2.B, 2.1.2.C, 2.1.2.D, 2.1.2.E, 2.1.2.F***	***ENHANCE/EXPAND MEDICAL HOMES***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.4*	*IT-9.2*	*Reduce Emergency Department visits for target conditions (Diabetes)*	
Year 2 (10/1/2012 – 9/30/2013)	**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: $979,573	Milestone 4 Estimated Incentive Payment: $790,959
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $959,259	Year 3 Estimated Milestone Bundle Amount: $981,094		Year 4 Estimated Milestone Bundle Amount: $979,573	Year 5 Estimated Milestone Bundle Amount: $790,959
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $3,710,885				

Hendrick Medical Center
Category 2 – Cellulitis Treatment
138644310.2.2
Pass 1

Summary Information:
Provider: Hendrick Medical Center is a 522 bed hospital in Abilene Texas serving a 105 square mile area and a population of approximately 117,000.
Intervention(s): This project will help care for Cellulitis patients in an outpatient environment instead of a traditional inpatient environment, saving the patients money.
Need for the Project: Because we can't currently care for Cellulitis patients in an outpatient setting this project will allow us to accommodate this set up, which will benefit the patients greatly.
Medicaid and Uninsured Target Population: Any patient needing treatment for Cellulitis is our target population. Approximately 22% of our patients are either Medicaid, indigent, or uninsured so we expect about a quarter of the population served to benefit greatly from this expansion of services.
Category 1 or 2 Expected Patient Benefits: The goal is for 20 patients to receive care under this model in DY4 and for 25 patients to receive care under this model in DY5. Each patient that is treated under this project will have an estimated cost savings of $2,100. If you take the goal of 20 patients and multiply that by $2,100 you get a total DY cost savings of $42,000. When you take the 25 patients in DY 5 and multiply that by $2,100 you get a total DY cost savings of $52,500. If you add up the cost savings in both DY 4 & 5 you get an estimated total project cost savings of $94,500. If we are able to continually increase the amount of patients we can see in future years, the cost savings will increase incrementally.
Category 3 Outcomes: IT2.13. The goal is to decrease cellulitis admission rate by 1% compared to baseline in DY 4 and by 2% compared to baseline in DY 5.

Category 2: Program Innovation and Redesign

Project Title: Cellulitis Treatment

Project Option 2.2.2 Expand Chronic Care Management

Unique Project ID: 138644310.2.2

Facility Description: Hendrick Medical Center-138644310

Project Description:

- Hendrick Medical Center is piloting a program where patients with cellulitis can be aggressively treated on an outpatient basis. We treat about 200 patients a year with Cellulitis. Historically, these patients were admitted for 3-5 days for IV antibiotics and bed rest. By treating them in the ED with a newer antibiotic that can be given over 2 minutes by IV push and a second IM antibiotic, we can improve patient experience and efficiencies in the ED. The newer antibiotic reaches therapeutic levels in the bloodstream in 30 minutes while the older inpatient antibiotic could take 24 hours. Patients will be sent to the infusion clinic the next day and a wound care physician will evaluate their response to treatment. If they are improving, the physician has the option of giving a second dose of the IV antibiotic or changing therapy to oral antibiotics. We feel that by treating these patients aggressively as outpatient we will see improved outcomes. This will result in less cost to the patient, shorter treatment time, less exposure to complications in the hospital and higher patient satisfaction by letting them heal faster and at home. This project is based on the community need that cellulitis patients need a better way to be treated.

Project Description:

- Infusion services will be expanded to treat cellulitis. Patients with cellulitis are being admitted through the ED and receiving treatment in an inpatient setting. Evidence based protocols, support patients being treated in the ED and then admitted to the infusion center to be treated on an outpatient basis. 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. Chronic disease management initiatives use population-based approaches to create practical, supportive, evidence-based interactions between patients and providers to improve the management of chronic conditions and identify

symptoms earlier, with the goal of preventing complications and managing utilization of acute and emergency care. Program elements may include the ability to identify one or more chronic health conditions or co-occurring chronic health conditions that merit intervention across a patient population, based on an assessment of patients' risk of developing complications, co morbidities or utilizing acute or emergency services. These chronic health conditions may include diabetes, congestive heart failure, chronic obstructive pulmonary disease, among others, all of which are prone to co-occurring health conditions and risks. The challenges we face in relation to treating cellulitis patients is the fact that they occupy beds that other patients with more severe conditions desperately need. Although, most of the time the patients that are treated for cellulitis also have another high-risk health care need, their cellulitis could also be severe enough to be considered high-risk. Often time's cellulitis leads to other severe complications if not cared for in a proper manner. By implementing this care model to treat cellulitis in an outpatient setting we will decrease costs for the patient and the insurance companies and we will open up more acute inpatient beds for other patients in the community. The five year expected outcome for this project will focus on cellulitis patients and their treatment options. Over the five years we expect to serve more of those cellulitis patients in an outpatient setting while also identifying patients that need further clinical interventions. One of our regional goals is to lower the cost of healthcare for the patients and provide alternative, more efficient and effective methods of caring for their needs, and this addresses those areas. It will provide an environment to the patient that will allow them to better manage their condition and potential co-occurring high-risk health care needs.

Starting Point/Baseline:

- During calendar Year 2011 we treated a total of 209 patients in an inpatient setting. We expect to identify and treat a portion of this population in an outpatient setting after implementing our evidence-based clinical protocols for Cellulitis. In DY 2 we will develop a comprehensive care management program to treat our patients with Cellulitis. In DY 3 the goal is to identify at least 10% of the total Cellulitis population that needs further clinical intervention. In DY 4 the goal is to treat 20 patients using the care model. In DY 5 the goal is to treat 25 patients using the care model.

Rationale:

- The reason for selecting this project option is because this project directly changes the way that we can care for Cellulitis patients through our outpatient clinic to be cost saving to the patient and more convenient for their recovery. It also provides a way to better identify those patients with other high-risk health care needs that often need further clinical intervention. The outpatient clinic will have the equipment and staff to care for the patient's health care needs. Once these patients have had their treatment and are released to go home they will receive a follow up call or appointment to assess the progress of the treatment. The implementation of this project will also better help the patient manage their condition at home because it will treat them in an outpatient setting and then they will be released to their home with instructions of care until their follow up appointment. The impacts, lessons learned and opportunities of this project will be assessed through internal

meetings conducted semi-annually; thus fulfilling the CQI component. The milestones and metrics chosen are relevant to the population and circumstances because there are currently around 200 patients that are treated for Cellulitis. These patients need a better way to be treated in a less costly more patient centered way. This project will accomplish this. This project represents a new initiative because there is currently not a program of this nature in existence to treat these patients. There are many definitions of "chronic condition", some more expansive than others. We characterize it as any condition that requires ongoing adjustments by the affected person and interactions with the health care system. The most recent data show that more than 145 million people, or almost half of all Americans, live with a chronic condition. That number is projected to increase by more than one percent per year by 2030, resulting in an estimated chronically ill population of 171 million. Almost half of all people with chronic illness have multiple conditions. As a result, many managed care and integrated delivery systems have taken a great interest in correcting the many deficiencies in current management of diseases such as diabetes, heart disease, depression, asthma and others. Those deficiencies include:

1. Rushed practitioners not following established practice guidelines
2. Lack of care coordination
3. Lack of active follow-up to ensure the best outcomes
4. Patients inadequately trained to manage their illnesses

Overcoming these deficiencies will require nothing less than a transformation of health care, from a system that is essentially reactive - responding mainly when a person is sick - to one that is proactive and focused on keeping a person as healthy as possible. To speed the transition, Improving Chronic Illness Care created the Chronic Care Model, which summarizes the basic elements for improving care in health systems at the community, organization, practice and patient levels. Evidence on the effectiveness of the Chronic Care Model has recently been summarized. Misdiagnosis of non-infections conditions as cellulitis is a common error and can result in unnecessary hospitalization and antibiotic use. Cellulitis is a common infectious process effecting the skin and subcutaneous tissues. Along with other skin and soft tissue infections, it results in significant morbidity and exacts considerable healthcare costs. More than $3.7 billion were spent on approximately 240,000 adult inpatient admissions for cellulitis in the United States in 2004 [5]. Outpatient and Emergency Department (ED) visits for skin and soft tissue infections add to this impressive cost. In 2005, approximately 14.5 million persons visited physician offices, hospital outpatient departments, and EDs for skin infections in the United States. This number represents an approximately 50 percent increase over that in 1997 [6]. Dermatology Online Journal (Volume 17 Number 3 March 2011). (http://dermatology.cdlib.org/1703/1_originals/1_10-00308/article.html)

- This project addresses community need number CN.1.

Related Category 3 Outcome Measure(s):

  - OD-2: Potentially Preventable Admissions

- IT-2.13: Other Admissions Rate - Cellulitis
- Category 3 outcome measure looks at admission rates for Cellulitis. These admission rates are the total number of outpatient visits for Cellulitis conditions under age 75 years over the total year's population. This will exclude individuals 75 years of age and older and death before discharge. There is a growing population of cellulitis patients and allowing them to be treated in an outpatient setting is not only cost saving, but it gives them a much more efficient and effective way of treating their condition. The category 2 project will help achieve the category 3 outcome measure by giving cellulitis patients better care in an outpatient setting reducing the chance for an admission. A large indigent population exists here in Taylor County and by implementing this project and achieving these related category 3 measures we will be helping that portion of Cellulitis patients that do fall within the low income population.

Relationship to other Projects:

- This project relates to RHP project identification number 138644310.1.1 because primary care physicians will have a huge help in making this project successful. This project also relates to PPA's, PPR's, PPC's, Patient Centered Healthcare & Emergency Department Category 4 measures. Because patients will be seen in an outpatient setting and will be followed up with in our wound care facility or by their primary care physician, it will help to greatly decrease PPA's, PPR's, PPC's and inappropriate emergency department visits and will also establish more of a patient centered healthcare approach by changing the way patients are treated to serve their needs.

Relationship to Other Performing Providers' Projects in the RHP:

- This project is related to several other projects in the RHP that plan to expand outpatient services to treat chronic care patients. Providers with similar projects include: Eastland Memorial Hospital. This project will address and serve the regional goal of trying to lower costs and provide better patient centered healthcare by giving patients a more efficient and effective way of being treated.

Plan for Learning Collaborative:

- At this time there are no plans for learning collaborative in relation to this project.

Project Valuation:

- This project achieves waiver goals because it is lowering costs for patients with Cellulitis. It is essentially giving them an option of being treated as an outpatient instead of an inpatient. The community will benefit from this project because the cost to treat cellulitis will decline and the availability to treat cellulitis in an outpatient setting will increase. This will lower the cost to the patient and allow them to be treated on an outpatient basis which will allow them to recover and heal at home. We treat a growing population of 200 patients per year with Cellulitis and this would give them the opportunity to lower their costs by being treated in an outpatient setting instead of an inpatient setting. The goal would be to first identify the

patients that would qualify for the outpatient treatments. We estimate that at least 10% of the estimated 200 patients per DY would be identified and eligible to be treated in an outpatient setting. Staff and equipment will add to the cost of implementing this project. These two factors alone are costly. The patients have to be referred by a physician in order to be eligible for the service; that is why only certain patients will be able to utilize the facilities. The hope would be to eventually be able to treat more and more cellulitis patients with this method. The services provided will occur as follows; identified patients will be treated in the ED with a newer antibiotic that can be given over 2 minutes by IV push and a second IM antibiotic. The next day the patient will have a follow up visit in the infusion center for a second dose of the antibiotic. If progress is noted on day 2, the wound care physician will make the decision as appropriate for patient to continue with oral antibiotics at home. During this time, if a wound is present, the patient might be seen by a wound care specialist for dressing and check up. Due to this ability we can improve patient experience and efficiencies in the ED. The newer antibiotic reaches therapeutic levels in the bloodstream in 30 minutes while the older inpatient antibiotic could take 24 hours. The project investment would be the equipment, antibiotic, and staff that we would use to equip our outpatient infusion clinic, and ED, in order to serve this patient population. Acute care costs will be avoided with these identified patients because these patients would not need to be admitted as an inpatient. The cost difference between an inpatient visit and an outpatient visit is significant. When you take that reduction in cost and you multiply it by the estimated 20 to 30 patients, the potential of cost savings is very good. By the end of DY 5 the goal would be to see between a total of 40 and 50 patients under this scenario. Each patient that is treated under this project will have a cost savings of $2,100. If you take the goal of 20 patients and multiply that by $2,100 you get a total DY cost savings of $42,000. When you take the 25 patients in DY 5 and multiply that by $2,100 you get a total DY cost savings of $52,500. If you add up the cost savings in both DY 4 & 5 you get a total project cost savings of $94,500. If we are able to continually increase the amount of patients we can see in future years, the cost savings will increase incrementally. These factors combined together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and addresses the priority community need and based on the criteria mentioned above we were able to come up with the valuation.

138644310.2.2	***2.2.2***	***2.2.2***	***CELLULITIS TREATMENT***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.5*	*IT-2.13*	*Other Admissions Rate - Cellulitis*	
Year 2 (10/1/2012 – 9/30/2013)	**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: A baseline was established of 209 cellulitis patients that were treated in an inpatient setting in calendar year 2011. The goal is to develop a comprehensive care management program to treat our patients with Cellulitis. Data Source: Program materials	**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, preventative tests, or other clinical services. Numerator: Number of patients identified and subsequently receiving needed tests or other clinical services. Denominator: Number of patients identified as needing screening test, preventative tests, or other clinical services. Baseline/Goal: The goal is to identify at least 10% of the total Cellulitis population that needs further clinical intervention. Data Source: EHR, Patient		**Milestone 3** [I-17]: Apply the Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]: 20 patients receive care under the Care Model for a chronic disease or for MCC Goal: The goal is to treat 20 patients using the care model. Data Source: Registry, EHR Milestone 3 Estimated Incentive Payment: $979,573	**Milestone 4** [I-17]: Apply the Care Model to targeted chronic diseases, which are prevalent locally Metric 1 [I-17.1]: 25 patients receive care under the Care Model for a chronic disease or for MCC Goal: The goal is to treat 25 patients using the care model. Data Source: Registry, EHR Milestone 4 Estimated Incentive Payment: $790,959

138644310.2.2	***2.2.2***	***2.2.2***	***CELLULITIS TREATMENT***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.5*	*IT-2.13*	*Other Admissions Rate - Cellulitis*	
Year 2 (10/1/2012 – 9/30/2013)	**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)*: $959,259	Registry Milestone 2 Estimated Incentive Payment: $981,094			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $959,259	Year 3 Estimated Milestone Bundle Amount: $981,094		Year 4 Estimated Milestone Bundle Amount: $979,573	Year 5 Estimated Milestone Bundle Amount: $790,959
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:*** $3,710,885				

Hendrick Medical Center
Category 2 – Palliative Care
138644310.2.3
Pass 1

Summary Information:
Provider: Hendrick Medical Center is a 522 bed hospital in Abilene Texas serving a 105 square mile area and a population of approximately 117,000.
Intervention(s): This project will treat patients facing serious illness by giving them smooth transitions across settings.
Need for the Project: Currently we do not have a palliative care program and by providing one we are able to increase patient centered care by giving patients the option of being cared for in the way that the palliative care program can provide.
Medicaid and Uninsured Target Population: Any patient in the end stages of life needing a palliative care program is our target population. Approximately 22% of our patients are either Medicaid, indigent, or uninsured so we expect about a quarter of the population served to benefit greatly from this expansion of services.
Category 1 or 2 Expected Patient Benefits: In DY's 3, 4 & 5, the goal is to see a minimum of 800 patients per year. In DY 3 our baseline is expected to be an estimated 800 patients. In DY 4 our goal is expected to be an estimated 816 patients and then in DY 5 the goal is expected to be an estimated 824 patients. If you add up 800 in DY 3, 816 in DY 4 and 824 in DY 5 you get a total estimated patient volume at the end of DY 5 of 2,440 patients. The goal is to increase the number of palliative care consults by 2% in DY4 over the established baseline and to also implement a survey to gather quality of care information, and in DY5 the goal is to increase the number of palliative care consults by 3% and also to implement a survey to gather quality of care information in order to see the change in satisfaction over the years.
Category 3 Outcomes: IT-13.4. The goal is to decrease admissions to ICU in the last 30 days of life by 1% in DY4 under the baseline established in DY3 and by 2% in DY5 under the baseline established in DY3.

Category 2: Program Innovation and Redesign

Project Title: Palliative Care Programs

Project Option 2.10.1 **Use of Palliative Care Programs**

Unique Project ID: 138644310.2.3

Facility Description: Hendrick Medical Center-138644310

- Palliative care is care for patients and families facing serious illness, alleviation of suffering (anticipating, preventing, treating), communication about treatments and care goals, alignment of plan preferences, smooth transitions across settings. It is recognized as a core service on AHA survey, criterion in US News and World Report ratings of America's Best Hospitals, recommended by ASCO as requirement for cancer center certification, recognized by The Joint Commission Advanced Certification Program – as of September 2011. The services that our palliative care program will provide are: communication about treatment options with patients and families, defining care goals for the patients' future and the families' future, alignment of plan preferences as well as offering smooth transitions across care settings. Palliative Care has been proven to lower costs, shorten length of stay, thereby helping to improve throughput and increase capacity for admissions, reduce readmission to ED, and reduce low-margin admissions (long stays for exacerbations of chronic illness), emergency department interventions, and timely discussions about ICU therapies. Our community does not currently have a program of this nature that they could benefit from so providing one would really fill a needed gap in the community. This project is based on the community need that the community needs access to the care that they need when they need it.

Project Description:

- Palliative care will care for patients and families facing serious illness and will allow for a smooth transition across settings. The goal is to provide palliative care services to improve patient outcomes and quality of life. A challenge that we have is that we currently can't offer this type of care to patients who desperately need it. Several challenges that will occur during implementation are getting a dedicated physician as well as the space that the dedicated physician will need, Also the time it will take to implement the program. In DY's 3, 4 & 5, the goal is to see a minimum of 800 patients per year. In DY 3 our baseline is expected to be an estimated 800 patients. In DY 4 our goal is expected to be an estimated 816 patients and then in DY 5 the goal is expected to be an estimated 824 patients. If you add up 800 in DY 3, 816 in DY 4 and 824 in DY 5 you get a total estimated patient volume at the end of DY 5 of 2,440 patients. This project will allow us to serve those patients that are in desperate need of this type of care. Palliative medicine represents a different model of care, focusing not on cure at any cost but on relief and prevention of suffering. Here the priority is supporting the

best possible quality of life for the patient and family, regardless of prognosis. Ideally, the principles of palliative care can be applied as far upstream as diagnosis, in tandem with cure-directed treatment, although it's still associated in most people's minds with end-of-life care. There is an economic incentive for hospitals to support palliative care -- research shows significant reductions in pharmacy, laboratory, and intensive care costs -- though there's understandable reluctance to tout such benefits. After all, accusations of "death panels" effectively shut out government funding for palliative care as national debates about health care reform took shape. Palliative care has emerged in the past decade. It takes an interdisciplinary approach – doctors, nurses, social workers and often chaplains – and blends it with curative care for seriously ill people. While palliative care is for people who are very sick, they don't have to have a six-month life expectancy. Some palliative care programs operate in hospitals; others treat people living at home. Growing numbers of community-based hospices also have palliative care services now. Pediatric palliative care is not available everywhere, although it's becoming more common at the major children's hospitals, In addition, hospices nationwide, which traditionally were often unwilling to treat dying children, have also become more open to pediatric care. The new health reform law allows dying children on Medicaid or the state Children's Health Insurance Program to get hospice or palliative care without halting other treatment. Health care reform has the potential to improve palliative care by implementing care coordination (in hospitals and community) evidence-based programs that are already proven to be working. Within palliative care, patients receive dignified and culturally appropriate end-of-life care, which is provided for patients with terminal illnesses in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences.

Palliative care is medical care focused on establishing achievable goals for medical care, support in attaining those goals, expert management of symptom distress including pain, and support for the people holding the bag- the family caregivers. It is delivered to patients and families based on need and not prognosis- and at the same time as all other effective life prolonging or disease modifying therapies. That is, it is appropriate for any patient with multiple chronic illnesses, functional decline, symptoms, and or overwhelmed family systems. Palliative care programs are increasingly widely available, now found in over 50% of U.S. hospitals, and in more than 80% of hospitals with more than 300 beds (where most seriously ill Americans receive their care). A study of variability in access to palliative care on a state-by-state analysis has been completed by. Of course, once patients are in an identifiable terminal phase of illness they should be referred for hospice care, a form of palliative care designed specifically for the dying (prognosis must be under 6 months to be eligible for hospice). The problem is that people with multiple chronic illnesses and/or serious illness, often live for many years with their disease(s), and their prognosis is not at all predictable often until very late in the course of illness. More than 75% die of something other than cancer, things like heart disease, emphysema, kidney and liver disease, frailty and debility, strokes and dementia- all categories of illness in which it is difficult if not impossible to predict the timing of death. For these patients and their families, improving access to non hospice palliative care is a key strategy both to improve quality and, in multiple studies, to

reduce costs. Our 5 year outcome includes the implementation of the program in our facility and the continual increase of patients that we can serve in that area. The 5 year expected outcome will be to see approximately 2,440 patients in this program at the end of DY 5. We plan to help at least 800 patients every year that will need this type of care. This project is related to regional goals because it will give hospice patients an alternative route of care that will serve that population better than just hospice can. This gives those patients access to levels of care that they would not have had before the palliative program and regionally we are trying to expand access to the care that our patients need and this project supports that. This will also relieve hospital beds in our hospice unit which will allow us to serve more hospice patients, thus increasing patient access to the care that they need.

Starting Point/Baseline:

- Our first year annual visits are expected to be approximately 800 visits based on demographics and current patient volume in our hospice program. We plan to see a minimum of 800 patients in following years. In DY 2 the goal will be to establish a business write up or plan to prepare for the implementation of a palliative care program. In DY 3 we plan to establish baseline data based on implementation of palliative care program. The goal is to implement the program and begin serving patients with this program. In DY 4 the goal will be to increase the number of palliative care consults over the established baseline by 2%.. Also in DY 4 the goal will be to implement a survey and record the results of the survey. In DY 5 the goal will be to implement a survey and record the result of the survey and then compare the results to DY 4. Also in DY 5 the goal will be to increase the number of palliative care consults over the established baseline by 3%.

Rationale:

- The project option of implementing a palliative care program was chosen because our facility would like to implement this program to serve patients with end-of-life decisions and care needs that they don't currently have the option of using. In DY2 we will develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program. The next step will be to transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility. One of our milestones is to implement a patient and family experience survey regarding the quality of care. Quality improvement and key challenges will be assessed through internal semi-annual meetings that will discuss the lessons learned and impacts of the program. The milestones and metrics chosen aid the need of palliative care because we currently do not have a palliative care program and the community and the region are in desperate need of this type of care. Because the milestones and metrics directly address the establishment of a palliative care program it is relevant to the population and circumstances within it. This project represents a new initiative because this type of program does not exist in this community and we are in desperate need of one. While end-of-life care was once associated almost exclusively with terminal cancer, today people receive end-of-life care for a number of other conditions, such as congestive heart failure, other circulatory conditions, COPD, and dementia86. Further, some experts have suggested that palliative and hospice care

could be more widely embraced for many dying patients. However, these experts say that overly rigid quality standards and poorly aligned reimbursement incentives discourage appropriate end-of-life care and foster incentives to provide inappropriate restorative care and technologically intensive treatments. These experts note that hospitals, nursing homes, and home health agencies need stronger incentives to provide better access to palliative care and care coordination either directly, themselves, or by contract with outside suppliers of hospice services87. It seems clear that improving care coordination near the end of life can improve care for patients with chronic conditions; however, in addition to the elderly with multiple chronic conditions and terminal illnesses, palliative care should also allow children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness. Often the most persuasive argument for hospital support is demonstrated cost savings resulting from formal palliative care services. While the program can generate revenue derived from delivery of palliative care, it typically will be modest compared to the larger number of dollars saved through shorter LOS or lower costs per day once the patient has been referred to palliative care. Center to Advance Palliative Care (http://www.capc.org/building-a-hospital-based-palliative-care-program/financing/cost-savings/index_html/view?searchterm=quality%20and%20cost%20savings)

- This project addresses community need number CN.2.

Related Category 3 Outcome Measure(s):

  - OD-13: Palliative Care
  - IT-13.4 Proportion admitted to the ICU in the last 30 days of life
  - Category 3 outcome measures used in DY 4 & 5 are the Palliative Care measures used to look at the proportion admitted to the ICU in the last 30 days of life. The assessment tool will look at the patient satisfaction of the program and will help give feedback for aspects of the program that could be improved to better serve the patients and their families. This outcome measure was chosen because the implementation of this project directly affects the proportion admitted to the ICU in the last 30 days of life. These outcomes are a priority because right now we currently do not have a palliative care program to care for patients with the type of care that they need. This category 2 project will help achieve the category 3 outcome measure because if a palliative care program is implemented then the proportion admitted to the ICU in the last 30 days of life will be affected. A portion of the population is indigent and low income and this program will also serve those patients.

Relationship to other Projects:

- This project relates to 138644310.1.1 and PPA's, PPR's, PPC's, Patient Centered Healthcare & Emergency Department Category 4 measures. Through the implementation of the palliative care program, these category 4 measures will be addressed and improved because this program has the potential to reduce these measures, especially the patient centered healthcare measure.

Relationship to Other Performing Providers' Projects in the RHP:

- This project relates to specialty care and primary care projects in the region because this project will specifically give those providers a good place to send the patients that qualify for palliative care and that need this type of care. Providers with similar projects include: Anson General Hospital, Betty Hardwick Center, Hamlin Memorial Hospital, Haskell Memorial Hospital, Helen Farabee Center, Mitchell County Hospital District, Palo Pinto General Hospital, Pecan Valley Centers, Rolling Plains Memorial Hospital and Stamford Memorial Hospital.

Plan for Learning Collaborative:

- At this time there are no plans for learning collaborative in relation to this project.

Project Valuation:

- This project will achieve waiver goals because it will provide palliative care services to improve patient outcomes and quality of life. The community will benefit from this project in several different ways. Patients will be able to move through units much quicker in turn reducing their LOS while also reducing their cost. This will not only provide better care for the patient but it will also open up beds at other places in the hospital for others in the community to use if needed. This will cover a large population and is expected to serve about 800 patients the first year it is implemented based on our facilities current volume of hospice care patients. In DY's 3, 4 & 5, the goal is to see a minimum of 800 patients per year. In DY 3 our baseline is expected to be an estimated 800 patients. In DY 4 our goal is expected to be an estimated 816 patients and then in DY 5 the goal is expected to be an estimated 824 patients. If you add up 800 in DY 3, 816 in DY 4 and 824 in DY 5 you get a total estimated patient volume at the end of DY 5 of 2,440 patients. This project will be a fairly large investment and will serve many people that desperately need palliative care that can't get it anywhere else in the community. These factors combined together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and addressing priority community need. Based on the criteria mentioned above we were able to come up with the valuation.

138644310.2.3	***2.10.1***	***2.10.1.A, 2.10.1.B, 2.10.1.C, 2.10.1.D***	***PALLIATIVE CARE***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.6*	*IT-13.4*	*Palliative 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-1]: Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program Metric 1 [P-1.1]: Business case. Submission of business case. Baseline/Goal: The goal will be to establish a business write up or plan to prepare for the implementation of a palliative care program. Data Source: Business case write-up; documentation of planning activities. Milestone 1 Estimated Incentive Payment (*maximum amount)*: $2,877,776	**Milestone 2** [P-5]: Implement/expand a palliative care program Metric 1 [P-5.1]: Implement comprehensive palliative care program. Documentation: Charter for Palliative care program. Baseline/Goal: Establish Baseline Data in DY3 based on implementation of palliative care program. The program is expected to see an estimate of 800 patients this year. The goal is to implement the program and begin serving patients with this program. Data Source: Palliative care program. Milestone 2 Estimated		**Milestone 3** [P-6]: Increase the number of palliative care consults Metric 1 [P-6.1]: Palliative care consults meet targets established by the program. Numerator: Number of palliative care consults. Denominator: Target number of palliative care consults. Goal: The goal is to increase the number of palliative care consults over the established baseline by 2%.The goal is to see an estimated 816 patients.. Data Source: EHR, palliative care database Milestone 3 Estimated Incentive Payment: $1,469,359	**Milestone 5** [P-6]: Increase the number of palliative care consults Metric 1 [P-6.1]: Palliative care consults meet targets established by the program. Numerator: Number of palliative care consults. Denominator: Target number of palliative care consults. Goal: The goal is to increase the number of palliative care consults over the established baseline by 3%.The goal is to see an estimated 824 patients.. Data Source: EHR, palliative care database Milestone 3 Estimated Incentive Payment: $1,186,439

138644310.2.3	***2.10.1***	***2.10.1.A, 2.10.1.B, 2.10.1.C, 2.10.1.D***	***PALLIATIVE CARE***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.6*	*IT-13.4*	*Palliative 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: $2,943,281		• **Milestone 4** [I-12]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time • Metric 1 [I-12.1]: Survey developed and implemented; scores increased over time. Result of survey scores. • Goal: The goal will be to implement a survey and record the result of the survey. • Data Source: Patient/family	**Milestone 6** [I-12]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time Metric 1 [I-12.1]: Survey developed and implemented; scores increased over time. Result of survey scores. Goal: The goal will be to implement a survey and record the result of the survey and to compare the results of the survey to the survey in DY 4 to make sure the scores increased over time. Data Source: Patient/family experience survey

138644310.2.3	***2.10.1***	***2.10.1.A, 2.10.1.B, 2.10.1.C, 2.10.1.D***	***PALLIATIVE CARE***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.6*	*IT-13.4*	*Palliative 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)**
			experience survey Milestone 5 Estimated Incentive Payment: $1,469,359	Milestone 6 Estimated Incentive Payment: $1,186,439
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $2,877,776	Year 3 Estimated Milestone Bundle Amount: $2,943,281		Year 4 Estimated Milestone Bundle Amount: $2,938,718	Year 5 Estimated Milestone Bundle Amount: $2,372,878
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $11,132,653				

Hendrick Medical Center
Category 2 – Diabetes Health Promotion
138644310.2.4
Pass 1

Summary Information:
Provider: Hendrick Medical Center is a 522 bed hospital in Abilene Texas serving a 105 square mile area and a population of approximately 117,000.
Intervention(s): Diabetes is the 6th leading cause of death in Texas and through the implementation of this program more of the community will be educated and will have access to classes and materials that will help them better manage their diabetes.
Need for the Project: Regional data indicates that type 2 diabetes is becoming more common among children and adolescents. With this data and the knowledge that on a daily basis Hendrick Medical Center has one third to one half of all the in-patients have a diagnosis of diabetes; the need for educating patients is vital.
Medicaid and Uninsured Target Population: Any patient with diabetes is our target population. Approximately 22% of our patients are either Medicaid, indigent, or uninsured so we expect about a quarter of the population served to benefit greatly from this expansion of services.
Category 1 or 2 Expected Patient Benefits: The goal is to increase the access to the health promotion programs and activities by 1% in DY4 and then to increase the access to the health promotion programs and activities by 2% in DY5. The Hendrick Diabetes Education program saw about 443 patients in 2011. This is expected to continually grow each year. DY 3 is expected to see about 443 patients. DY 4 is expected to see about 448 people and in DY 5 the expectation is to educate around 452 people. The goal when you add up DY's 3, 4 & 5 is to educate a total of approximately 1000 to 1,300 people under the newly developed plan by DY 5. About 1 out of every 4 of our patients is considered Medicaid or Indigent care so close to 100 patients that attend these classes will be in that category.
Category 3 Outcomes: IT-2.7. The goal is to decrease diabetes short term complication admission rate by 1% in DY4 under the baseline established in DY3 and by 2% in DY5 under the baseline established in DY3.

Category 2: Program Innovation and Redesign

Project Title: Diabetes Health Promotion

Project Option 2.6: Implement Evidenced-based Health Promotion Program

Unique Project ID: 138644310.2.4

Facility Description: Hendrick Medical Center-138644310

Project Description:

The goal is to increase education related to diabetes and health promotion and disease prevention through the continuation and expansion of promotional materials and classes. Hendrick, as a provider faces the challenge of being able to help patients better manage their conditions at home reducing the costs for patients and providing better quality of care. This project will help overcome that by giving patients within the community the ability to have the education and material to better manage their condition. We plan to implement innovative evidence based health promotion strategies such as use of community health workers, innovations in social media and messaging for targeted populations. The 5 year expected outcome is to continually increase our class sizes over the next 5 years in order to educate more patients in the community. As a region, it is a goal to reduce healthcare costs and one way of doing that is to educate the community on ways to be healthy and manage their health appropriately.

Diabetes remains one of the most serious health problems in Texas as well as nationally. Approximately 1.8 million adults in Texas have diagnosed diabetes and another 460,040 more are estimated to have undiagnosed diabetes. It is the sixth leading cause of death in Texas. Diabetes continues to be one of the most costly health problems, leading to complications such as blindness, cardiovascular disease, amputations and complications of pregnancy. A big concern is now children are the new face of diabetes. Regional data indicates that type 2 diabetes is becoming more common among children and adolescents. With this data and the knowledge that on a daily basis Hendrick Medical Center has one third to one half of all the in-patients has a diagnosis of diabetes, the need for educating patients is vital. Hendrick Medical Center is committed to providing quality comprehensive diabetes self-management education. It is the belief that education is the key to empowering the person with diabetes to better manage his or her disease and avoid the complications of diabetes and achieve an optimum health status. Hendrick Medical Center provides

diabetes self-management education in accordance with National Standards for Diabetes Self-Management Education. The Hendrick Diabetes Education program saw about 443 patients in 2011. This is expected to continually grow each year. DY 3 is expected to see about 443 people and DY 4 is expected to see about 448 people and in DY 5 the expectation is to educate around 452 people. The goal when you add up DY's 3, 4 & 5 is to educate a total of approximately 1000 to 1,300 people under the newly developed plan.. Hendrick Diabetes Program reaches out to the community by providing a monthly support group, yearly workshop, health fairs, and speaking at special groups upon their individual request. Recently the Hendrick Diabetes Center was relocated outside the hospital. It is more visible and easier for the community to access education and on-going support. These things will be helpful when it is time to expand the current outreach and target a much large area with the resources that will come from this project. This project is based on the community need that is evident within our community in regards to the large population of diabetes patients. Patients with diabetes are increasing each year and educating them on how to better manage their condition on their own is a priority for the community.

Starting Point/Baseline:

The total class volume for 2011 was 443 patients. We hope to increase our classes and promotional efforts to serve an approximate number between 425 and 500 patients in the community within DY3 and to also offer more outreach and additional materials and trainings to the community. The goal in DY 2 will be to develop an evidence based project to reach the diabetes population in the community. The goal in DY 3 will be to implement, document and test the evidence-based project for the diabetes population in our community. The goal in DY 4 will be to increase the percentage of the defined diabetes population reached by 1%. The goal in DY 5 will be to increase the percentage of the defined diabetes population reached by this project by 2%.

Rationale:

The reason for selecting the project option is because this projects aims to promote healthy lifestyles by using an evidence-based methodology. Through this project we will be able to help a larger population in our community that need help managing and caring for their diabetes. Since the population that are diagnosed with some form of diabetes increases every year, these milestones and metrics are very important. The milestones and metrics are relevant to the RHP's population and circumstances because they specifically address the development and implementation of an evidence based program to help improve the community population with diabetes. This project will significantly enhance an existing initiative because it will allow us to reach out to a larger defined population with more options and materials to better help them manage their chronic conditions. The required project component with this project option is CQI. A meeting will be conducted semi-annually to discuss the lessons learned, opportunities and key

challenges associated with the project. The current prevention and treatment system is an unconnected, silo-based approach, which reduces the effectiveness and increases the cost of health care. As the US health care system strives to deliver better health, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals. Delivery Mechanisms: Community health workers can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, detection, and basic emergency care; and improve quality by contributing to patient-provider communication, continuity of care, and consumer protection. Information sharing, program support, program evaluation, and continuing education are needed to expand the use of community health workers and better integrate them into the health care delivery system. Self-Management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers information and technical skills, self-management education teaches problem-solving skills. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients; and in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.

The Centers for Disease Control and Prevention use the following objectives: Increase awareness and knowledge of the seriousness of diabetes, its risk factors, and effective strategies for preventing complications associated with diabetes and preventing type 2 diabetes. Increase the number of people who live well with diabetes and effectively manage their disease to prevent or delay complications and improve quality of life. Decrease the number of Americans with undiagnosed diabetes. Among people at risk for type 2 diabetes, increase the number who make and sustain effective lifestyle changes to prevent diabetes. Facilitate efforts to improve diabetes-related health care and education, as well as systems for delivering care. Reduce health disparities in populations disproportionately burdened by diabetes. Facilitate the incorporation of evidenced-based research findings into health care practices. These objectives are implemented to serve the purpose of reducing the burden of diabetes and pre-diabetes by facilitating the adoption of proven approaches to prevent or delay the onset of diabetes and its complications. (http://www.cdc.gov/diabetes/ndep/index.htm)

This project addresses community need number CN.1.

Related Category 3 Outcome Measure(s):

OD-2: Potentially Preventable Admissions
IT-2.7: Diabetes Short Term Complication Rate

Category 3 outcome measures include in DY4 & DY5 the Diabetes Short Term Complication Admission Rate. This will measure the non-maternal/non-neonatal discharges of age 18 years and older with a principal diagnosis code for short-term complications compared to the entire population of 18 years and older. Through the increase in promotional material and classes for the diabetic population we will be able to hopefully decrease the diabetes short term complication admission rate. The reason for choosing this outcome measure is to measure the diabetes short term complication admission rate because diabetes is such a huge issue within our community and the region. By implementing this project we will be able to directly address patients with diabetes, thus addressing the diabetes short term complication admission rate. The related category 2 project will help achieve the category 3 outcome measure by educating diabetes patients within the community. This will give patients in the community with diabetes the knowledge that they need in order to better manage their condition, thus alleviating the diabetes short term complication rate. Much of our population in Taylor County is indigent or low income and many of those patients have diabetes, and so by implementing this project we will be taking care of this population.

Relationship to other Projects:

This project relates to RHP project identification number 138644310.1.1 because primary care physicians can help introduce this type of program to patients that desperately need the care and training that this program can offer. This also relates to PPA's, PPR's, PPC's, Patient Centered Healthcare & Emergency Department Category 4 measures. The education and training that is offered by this program will help reduce PPA's, PPR's PPC's and inappropriate emergency department visits. These educational materials and classes are designed around the patient, thus achieving patient centered healthcare.

Relationship to Other Performing Providers' Projects in the RHP:

This project is related to another evidence based disease prevention program in the region. Providers with similar projects include: Fisher County Hospital and Rolling Plains Memorial Hospital. The regional goal for these projects is to educate and train the patients in the region to better manage their disease at home which will allow for saved costs from hospital visits and will also help them obtain a better quality of life.

Plan for Learning Collaborative:

At this time there are no plans for learning collaborative in relation to this project.

Project Valuation:

We are going to expand/enhance our current Diabetes program by offering more training classes on health and exercise as well as offering it to more patients in the community through additional outreach. The community will become more educated in health promotion and disease prevention regarding diabetes and this could potentially save them money and increase their health and standard of living. This project will serve the diabetic community and will help train and educate them on healthy eating habits as well as exercise. The Hendrick Diabetes Education program saw about 443 patients in 2011. This is expected to continually grow each year. DY 3 is expected to see about 443 patients. DY 4 is expected to see about 448 people and in DY 5 the expectation is to educate around 452 people. The goal when you add up DY's 3, 4 & 5 is to educate a total of approximately 1000 to 1,300 people under the newly developed plan by DY 5. The investment will mostly be in training materials and training staff for the patients. These factors combined together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and addresses priority community need. Based on the criteria mentioned above we were able to come up with the valuation.

138644310.2.4	***2.6.1***	***2.6.1.***	***DIABETES HEALTH PROMOTION***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.7*	*IT-2.7*	*Diabetes Short Term Complication 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-2]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community (Diet & Exercise etc…) Metric 1 [P-2.1]: Document innovational strategy and plan. Baseline/Goal: Our baseline data was established in calendar year 2011 with 443 patients attending diabetes classes. The goal in this metric will be to develop an evidence based project to reach the diabetes population in the community. Data Source: Performing Provider evidence of	**Milestone 2** [P-3]: Implement, document and test an evidence-based innovational project for targeted population Metric 1 [P-3.1]: Document implementation strategy and testing outcomes. Baseline/Goal: The goal will be to implement, document and test the evidence-based project for the diabetes population in our community. The goal will also be to see about 443 patients that attend the diabetes classes. Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider		**Milestone 3** [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: The goal will be to increase the percentage of the defined diabetes population reached by this project by 1% compared to baseline. The goal is to educate an estimated 448 patients. Data Source: Documentation of target population reached, as designated in the project plan. EHR, Diabetes center documentation Milestone 3 Estimated	**Milestone 4** [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: The goal will be to increase the percentage of the defined diabetes population reached by this project by 2% compared to baseline. The goal is to educate an estimated 452 patients. Data Source: Documentation of target population reached, as designated in the project plan. EHR, Diabetes center documentation Milestone 4 Estimated Incentive Payment: $1,468,924

138644310.2.4	***2.6.1***	***2.6.1.***	***DIABETES HEALTH PROMOTION***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.7*	*IT-2.7*	*Diabetes Short Term Complication 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)**
innovational plan Milestone 1 Estimated Incentive Payment (*maximum amount)*: $1,781,481	Milestone 2 Estimated Incentive Payment: $1,822,031		Incentive Payment: $1,819,206	
Year 2 Estimated Milestone Bundle Amount: $1,781,481	Year 3 Estimated Milestone Bundle Amount: $1,822,031		Year 4 Estimated Milestone Bundle Amount: $1,819,206	Year 5 Estimated Milestone Bundle Amount: $1,468,924
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $6,891,642				

Hendrick Medical Center
Category 1 – Cardiac Health Promotion
138644310.2.5
Pass 2

Summary Information:
Provider: Hendrick Medical Center is a 522 bed hospital in Abilene Texas serving a 105 square mile area and a population of approximately 117,000.
Intervention(s): It is evident that heart disease is an increasing condition and it is important to fill that gap by providing more education and more resources to the community. This will hopefully help decrease admissions and readmissions related to heart conditions to the facility.
Need for the Project: The community and our patient population need to be able to have access to more educational resources in order to sustain heart health. By implementing this project this will greatly improve the population that we are able to reach. This project is funded through the collaboration option. This project is transformative to the region because everyone from the region and the communities within the region will have access to this class or classes that are offered. This will give those individuals educational material and knowledge that will help them better understand the importance of maintaining cardiac health as well as best practices and techniques to achieve that. Hendrick Medical Center will be the only entity that is implementing this project.
Medicaid and Uninsured Target Population: Any patient that is in need of cardiac health education is our target population. Approximately 22% of our patients are either Medicaid, indigent, or uninsured so we expect about a quarter of the population served to benefit greatly from this expansion of services.
Category 1 or 2 Expected Patient Benefits:. In DY 3 we estimate to have a baseline of 150. In DY 4 we estimate that we will see about 155 & by DY 5 we estimate to see about 158 patients. If you add DY 3 of 150, DY 4 of 155 and DY 5 of 158, the total at the end of DY 5 would be an estimated 463 patients served. 22% of our patient population is either Medicaid or indigent care, so about 1 out of every 4 patients will be Medicaid or indigent care.
Category 3 Outcomes: IT-3.5. The goal is to decrease the acute myocardial infarction 30 day readmission rate by 1% in DY4 under the baseline established in DY3 and by 2% in DY5 under the baseline established in DY3.

Pass 2

Category 2: Program Innovation and Redesign

Project Title: Cardiac Health Promotion

Project Option 2.6: Implement Evidenced-based Health Promotion Program

Unique Project ID: 138644310.2.5

Facility Description: Hendrick Medical Center-138644310

Project Description:

The project goal is to expand services in the Chest Pain Center to include disease prevention education and self management guides for patients and people in the community. Currently a class or several classes are given every year with an attendance of approximately 150. This class helps educate the community on heart health, diet techniques, exercise techniques and other important ways to monitor and maintain your heart health, but also covers other topics and health issues. Our goal with this project is to expand that class and maybe even add an additional class that just focuses on heart health. We hope to expand the amount of promotional materials and hope to reach a larger population through the implementation of this project. Implement innovative evidence based health promotion strategies such as use of community health workers, innovations in social media and messaging for targeted populations. The challenge that we are facing is the fact that patients are not receiving the education and training that they need in order to take better care of themselves. This project will overcome that challenge by educating those people and helping them to better manage their conditions at home. The goal will be to establish a baseline in DY 3 based on the number of patients and people in the community that we are able to educate through our enhanced class. The amount of people that we expect to reach in DY 3 will be around 150. These patients will receive cardiac health promotion materials such as guides, best practices and other types of literature that outlines the importance of cardiac health. The 5 year expected outcome for the project will be an increase in disease prevention education in regards to heart health and also a decrease in hospital admissions. In DY 3 we estimate to have a baseline of 150. In DY 4 we estimate that we will see about 155 & by DY 5 we estimate to see about 158 patients. If you add DY 3 of 150, DY 4 of 155 and DY 5 of 158, the total at the end of DY 5 would be an estimated 463 patients served. One regional goal that this relates to is the decrease in healthcare costs and if this program can decrease potentially preventable admissions then we are accomplishing regional goals.

Heart disease is becoming more and more prevalent in the US. There has been a major shift in the focus on the treatment of heart disease and heart attacks toward preventive measures and early detection as well as prompt intervention in the event of a heart attack. HMC achieved their Chest Pain Center Certification in 2011 by demonstrating excellent care and compliance with evidence-based guidelines in the care of our heart attack patients. The Chest Pain Center Accreditation, through the Society of Chest Pain Centers (SCPC), is largely community based. It not only involves the facility that achieves the accreditation but also the EMS and referring facilities that are involved in the care of these patients. There are 15 referring facilities that send their patients to Hendrick and 24 EMS services that are involved with this process. Incorporating these facilities and care providers in the process of caring for these patients has widened the lines of communication and bolstered education to better serve our patients. It also serves to inform the community in Abilene and the surrounding areas, of the care that can be provided and the necessary steps to receive that care. One of the goals of this program is to ensure that our community receives education about the risk factors and warning signs of heart disease, as well as information about available preventative options and services, that are all incorporated in the effort to control the rising incidence in heart disease. With increased education for our community as well as our physicians, nurses, and EMS, we can deliver prompt and efficient care as we strive to decrease the damage done to the heart. This project is based on the community need of health based promotion and education. Because education and knowledge about ones condition is so important it is vital to the community that this type of project be implemented.

Starting Point/Baseline:

Baseline data would be established in DY 3 based off of class size and attendance. This is estimated to be around 150 attendees.

Rationale:

The project option was selected because through the implementation of this project we will be able to educate more patients and people throughout the community. The milestones and metrics chosen relate directly to the RHP's population and circumstances by addressing the need of the community in the area of cardiac health promotion. Although we currently offer a class on health and education for different diseases and health concerns, our goal will be to increase our class size to reach a larger population and be able to supply additional materials to aid in cardiac health of the community. This project represents a new initiative because we are able to promote cardiac health with the utilization of new techniques, classes and materials, but will also enhance our current class that is offered every year. The required project component with this project option is CQI. A meeting will be conducted semi-annually to discuss the lessons learned, opportunities and key challenges associated with the project. The

current prevention and treatment system is an unconnected, silo-based approach, which reduces the effectiveness and increases the cost of health care. 1 As the US health care system strives to deliver better health, improved care and lower costs, the potential exists for innovative evidenced based health promotion strategies to further these goals. Delivery Mechanisms: Community health workers can increase access to care and facilitate appropriate use of health resources by providing outreach and cultural linkages between communities and delivery systems; reduce costs by providing health education, screening, detection, and basic emergency care; and improve quality by contributing to patient-provider communication, continuity of care, and consumer protection. Information sharing, program support, program evaluation, and continuing education are needed to expand the use of community health workers and better integrate them into the health care delivery system. Self-Management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Whereas traditional patient education offers information and technical skills, self-management education teaches problem-solving skills. A central concept in self-management is self-efficacy—confidence to carry out a behavior necessary to reach a desired goal. Self-efficacy is enhanced when patients succeed in solving patient-identified problems. Evidence from controlled clinical trials suggests that64 (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients65; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.

Heart disease is a broad term used to describe a range of diseases that affect your heart. The various diseases that fall under the umbrella of heart disease include diseases of your blood vessels, such as coronary artery disease; heart rhythm problems (arrhythmias); heart infections; and heart defects you're born with (congenital heart defects). The term "heart disease" is often used interchangeably with "cardiovascular disease." Cardiovascular disease generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke. Other heart conditions, such as infections and conditions that affect your heart's muscle, valves or beating rhythm, also are considered forms of heart disease. Many forms of heart disease can be prevented or treated with healthy lifestyle choices. (http://www.mayoclinic.com/health/heart-disease/DS01120)

This project addresses community need number CN.1.

Related Category 3 Outcome Measure(s):

OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs)
IT-3.5: Acute Myocardial Infarction 30 day readmission rate

The reason we chose the category 3 outcome measures included in DY4 & DY5 is because they address potentially preventable admissions. This outcome is a priority for the RHP because there is always a high presence of acute myocardial infarction 30 day readmission rate and we are always working to try and lower that rate significantly. Through the measurement of congestive heart failure we will look at all non-maternal discharges of age 18 years and older with a principal diagnosis code for CHF compared to the population in our county of age 18 years and older. Developing an evidence-based program to help educate patients in the community on the importance of heart health and ways to prevent the disease is a great way to help decrease potentially preventable admissions in relation to congestive heart failure because it will provide the education and knowledge that our patients need in order to better manage their condition on their own. This category 2 project will help achieve the category 3 outcome measure because it will educate the community on how to better take care of themselves and this will in turn prevent re-admissions. This will also help low-income and indigent households manage their heart health at home without having to utilize costly services.

Relationship to other Projects:

This project relates to RHP project identification number 138644310.2.4 because it is an implementation of an evidence-based health promotion program. This also relates to PPA's, PPR's, PPC's, Patient Centered Healthcare & Emergency Department Category 4 measures. By implementing this cardiac health program we will be educating more of the community on the necessary steps to taking care of their heart conditions. This is important because it will potentially help reduce the PPA's, PPR's and PPC's. By focusing primarily on the community and the needs of the patients in the community we will be practicing patient centered healthcare.

Relationship to Other Performing Providers' Projects in the RHP:

This project is related to several other projects in the region. A provider with a similar project is Rolling Plains Memorial Hospital. The goal for the region with regard to these projects is to increase the educational and preventative services to help the communities within the region understand the knowledge that is required to stay healthy and disease free.

Plan for Learning Collaborative:

Currently there is not a plan for learning collaborative.

Project Valuation:

The project valuation is based on the expansion of services in the Chest Pain Center to include disease prevention education and self management guides and classes for patients and people in the community. In DY 3 we estimate to have a baseline of 150. In DY 4 we estimate that we will see about 155 & by DY 5 we estimate to see about 158 patients. If you add DY 3 of 150, DY 4 of 155 and DY 5 of 158, the total at the end of DY 5 would be an estimated 463 patients served. This project will reduce readmissions saving the patients money, thus reducing costs, and will also help reduce the cost to the insurance companies. Also the evidence-based care coordination model will help to educate the community and will increase awareness. The scope of this project is not large, but it will help educate patients with and without previous heart health issues. The project investment will be moderate because it will allow us to educate the community on heart health through the implementation of promotional materials. These factors combined together are the reasoning behind our project valuation. Each one of these factors addresses the project scope, populations served, community benefit, cost avoidance and addressing priority community need. Based on the criteria mentioned above we were able to come up with the valuation.

138644310.2.5	***2.6.1***	***2.6.1***	***CARDIAC HEALTH PROMOTION***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.9*	*IT-3.5*	*Acute Myocardial Infarction (AMI) 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]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community (Diet or Exercise etc…) Metric 1 [P-2.1]: Document innovational strategy and plan. Baseline/Goal: The goal is to develop an innovational strategy and plan and to show documentation of that plan. Data Source: Performing Provider evidence of innovational plan Milestone 1 Estimated Incentive Payment (*maximum amount)*: $1,193,347	**Milestone 2** [P-3]: Implement, document and test an evidence-based innovational project for targeted population Metric 1 [P-3.1]: Document implementation strategy and testing outcomes. Baseline/Goal: The baseline will be established in DY 3. This baseline will be based on our class size and is estimated to be around 150 patients that attend. The goal is to simply implement an evidence based innovational project and document that implementation of that project. Data Source: Performing Provider contract or other documentation of		**Milestone 3** [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: The goal is to increase the overall access to the health promotion programs and activities by 3% over the baseline. The goal is to serve an estimated 155 patients. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 3 Estimated Incentive Payment: $1,226,415	**Milestone 4** [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: The goal is to increase the overall access to the health promotion programs and activities by 5% over the baseline. The goal is to serve an estimated 158 patients. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 4 Estimated Incentive Payment: $979,901

138644310.2.5	***2.6.1***	***2.6.1***	***CARDIAC HEALTH PROMOTION***	
Hendrick Medical Center				*138644310*
Related Category 3 Outcome Measure(s):	*138644310.3.9*	*IT-3.5*	*Acute Myocardial Infarction (AMI) 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)**
	implementation TBD by Performing Provider Milestone 2 Estimated Incentive Payment: $1,221,956			
Year 2 Estimated Milestone Bundle Amount: $1,193,347	Year 3 Estimated Milestone Bundle Amount: $1,221,956		Year 4 Estimated Milestone Bundle Amount: $1,226,415	Year 5 Estimated Milestone Bundle Amount: $979,901
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $4,621,619				

Summary Information: 121053602.2.1

- Provider: Knox County Hospital District is a 14-bed hospital in Knox City, Knox County, Texas serving a population of 3,758. The District currently experiences approximately 33,000 patient encounters per year which includes over 100 inpatient admission.

- Intervention(s): This project will ensure that a cultural change takes place in order to transform patient experience.

- Need for the project: HCAHPS survey results indicate that our patients have the perception that our staff is not actively engaged in providing them with a patient experience that either meets or exceeds expectation.

- Medicaid and Uninsured Target population:Approximately 20% of our patient encounters are Medicaid eligible or uninsured.

- Category 1 or 2 expected patient benefits: Our population benefits from improved customer experience by becoming more engaged in their healthcare. Cultural changes within an organization to ensure care is patient centered coupled with continuous teaching and instruction result in patients who are enabled to better manage their conditions.

- Category 3 outcomes: Percent improvement of hospital HCAHPS scores over baseline.

Category 2: Redesign and Improve Patient Experience

Project Option 2.4: Improve Process to Redesign to Improve Patient Experience

Unique Project ID: 121053602.2.1

Facility Description: Knox County Hospital District-121053602

Project Description

Transformation of a healthcare organization from the mindset of simply offering quality care to the shared expectation of outstanding patient experience requires a cultural shift to ignite the motivation of front line staff members as well as those in the executive suite. Areas for improvement have been identified though the accumulation of data from the HCAHPS survey and include indicators relating to "Your Experiences in This Hospital", "When You Left The Hospital", and "Overall Rating of Hospital". Improvement in these areas will engage patients in their healthcare and will encourage them to take ownership of treatment decisions.

Rural healthcare consistently faces the challenge of staffing insufficiencies in areas that could successfully blaze the path to an explosion of success in the improvement of patient experience. To accommodate staffing insufficiencies without further compromising the almost non-existent profit margin, a shift in priorities has to take place. This shift must involve everyone and not just the providers of medical services. Our project involves the creation of one organization-wide culture focusing strictly on the patient and will be accomplished by the reengagement of executives, management, and front-line staff. The 5-year expected outcome is to engage our patients in their healthcare by encouraging them to take ownership in disease management and treatment. Ultimately improved HCAHPS scores will reflect improvements in patient experience and patient engagement which will improve community health, decrease inpatient admissions and readmissions and will drive down the costs of healthcare. This project relates to regional goals of transformation of the culture of our facility.

The structure of our project encompasses every level of staff member and targets each employee as a champion of patient experience. The initiative has garnered the financial support of our Board of Directors as well as their commitment to a successful ongoing effort to improve patient experience and employee satisfaction. The initiative will be led by an Executive Council consisting of a senior group of decision makers. A Service Excellence Council will provide on-going leadership to improving customer satisfaction and will ensure the processes take place effectively. Designated as the "best of the best" frontline employees within each department, the Service Excellence Advisors will take special training to teach Service Excellence to the entire organization over a 6 week period. Operationally Advanced Service Improvement Systems (OASIS) projects are selected and designed to have a positive impact on organization-wide needs.

Starting Point / Baseline

Knox County is home to approximately 3,758 individuals and the District currently experiences approximately 33,000 patient encounters per year which includes over 100 inpatient admissions. With each encounter multiple employees are presented with opportunities to exceed customer expectations. A baseline has been identified through the industry standard HCAHPS survey model. Twelve months worth of HCAHPS data has identified various target areas including:

1) How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted? Result: 88% (Always)
2) During this hospital stay, how often was your pain well controlled? Result: 79% (Always)
3) During this hospital stay, how often did the hospital staff do everything they could to help you with your pain? Result: 93% (Always)
4) Before giving you any new medicine, how often did hospital staff tell you what the medicine was for? Result: 84% (Always)
5) Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? Result: 72% (Always)
6) During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? Result: 78% (Always)
7) During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? Result: 86%
8) What number would you use to rate this hospital during your stay? Result: 68% (10)
9) Would you recommend this hospital to your friends and family? Result: 80% (Definitely yes)

Rationale

Redesigning to Improve Patient Experience was chosen because a need has been identified in our client population for patient engagement of their healthcare and to ensure they have a strong understanding of disease processes and treatments. It is our responsibility, as their primary healthcare providers, to ensure that a cultural change take place so that our providers and staff actively seek avenues to transform patient experience.

Through the HCAHPS Survey tool, our patients have spoken and the expectation of high percentages in the “top box” was deflated in several areas. Targeted areas indicate that our patients have the perception that our staff is not actively engaged in providing them with a patient experience that either meets or exceeds their expectations.

The project will include an integration and prioritization of patient experience throughout the organization. Data and performance measures from HCAHPS will continue to be monitored and the survey process for physician clinics will transition to the CG-CAHPS. Processes will be implemented to improve the patient experience and will encompass each employee from executives to housekeeping and groundskeeper. Though Knox County Hospital District’s primary focus has always been on patient care, the project is a new initiative and will enhance patient experience on every level.

Knox County Hospital is located in rural north-central Texas and is the sole provider of healthcare and serves an estimated county population of 3,758. Almost 21% are over the age of 65 and 16% live below the poverty level. Rural Texans expect and deserve services vital to their health and wellbeing. The District strives to offer services based on community need. Travel to other healthcare facilities is often difficult for the sick and elderly and financially prohibited by the economically disadvantaged. The District envisions a future of providing services that meet not only the basic healthcare needs of our area, but provides an experience exceeding all expectation to each and every patient. Ultimately, the culture of the organization will shift to focus on patient experience and result in patients who are actively engaged in their healthcare. Our project addresses the following Community Needs: CN.1 and CN.2.

Related Category 3 Outcome Measures

The Category 3 Outcome Measure selected for our project is IT-6.2 – Other Outcome Improvement Target: Percent improvement of hospital HCAHPS scores over baseline.

Numerator: Percent improvement in targeted patient satisfaction domain.
Denominator: Number of patients who were administered the survey
Data Source: HCAHPS Survey

This outcome measure was selected as a result of needs identified in current HCAHPS data. The District utilized 12 months of data to identify areas for improvement. Evaluation of data strongly suggests that an organizational-wide culture change is needed to improve patient experience and patient engagement.

Relationship to Other Projects

Our project relates to other projects and interventions within the RHP plan as successful implementation will ensure that patients are engaged in their healthcare and lifestyle choices. The RHP plan references high rates of chronic disease and high costs associated with preventable hospitalization admissions and readmissions. As our patients begin to take responsibility for their health, the incidents of hospitalizations will decrease and community health will improve. It is important for patients to understand management of chronic conditions fully relies on their compliance in lifestyle changes and compliance with regular medications, testing, etc. Our project will provide a platform for cultural changes within the organization to equip providers with the necessary tools for success.

Project Valuation

Knox County Hospital serves an estimated population of 3,758. Our population benefits from improved customer experience by becoming more engaged in their healthcare. Patients who are provided with opportunities to understand health issues and treatments are enabled to take responsibility for their health. Non-compliance is an issue with many patients who have chronic conditions. Ongoing efforts to ensure their compliance will successfully result in cost avoidance through lower utilization of inpatient services. Many conditions can be identified

and treated before they require the more intensive and costly inpatient setting. Knox County has a higher than average diabetic and congestive heart failure populations. Both of these conditions require ongoing maintenance and compliance. Cultural changes within an organization to ensure care is patient centered coupled with continuous teaching and instruction result in patients who are enabled to better manage conditions. Valuation will rely on continuous HCAHPS survey results.

121053602.2.1	***2.4.1 IMPLEMENT PROCESS TO MEASURE AND IMPROVE PATIENT EXPERIENCE***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	***2.4 REDESIGN TO IMPROVE PATIENT EXPERIENCE***	
Knox County Hospital				*121053602*
Related Category 3 Outcome Measure(s):OD-6	*IT – 6.2*	*CN.1*	*Percent Improvement of HCAHPS Scores over 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-1 Appoint an executive accountable for patient experience. Metric: P-1-1 Documentation of an Executive assigned responsibility for patient experience. Goal: Appoint executive responsible for patient experience Milestone 1 Estimated Incentive Payment – $47,550.00 **Milestone 2** P-3 Establish a steering committee Metric: P-3-1 Documentation of Committee proceedings and list of committee members. Goal: Appoint committee Milestone 2 Estimated Incentive Payment - $47,550.00	**Milestone 3** P-4 Integrate patient experience into employee training. Metric P-4-1 Percent of new employees receiving patient experience training. Data Source: Human Resources records Goal: 100% of new employees receive patient experience training. Milestone 3 Estimated Incentive Payment - $103,749.00		**Milestone 4** P-6 Include specific patient and/or employee experience objectives in their job descriptions. Metric: P-6-1 Percent of employees who have specific patient and/or employee objectives in their job descriptions. Goal: 90% of all Hospital employees will have specific patient/or employee objectives in their job descriptions. Milestone 3 Estimated Incentive Payment - $104,051.00	**Outcome Improvement Target 1** IT-6.2 Improvement Target: HCAHPS Scores Goal: Increase by 5% for scores under 90% baseline and increase by 2% for scores over 90% baseline. IT-6.2 Estimated Incentive Payment - $85,955.00

121053602.2.1	***2.4.1 IMPLEMENT PROCESS TO MEASURE AND IMPROVE PATIENT EXPERIENCE***	***2.4.1.A*** ***2.4.1.B*** ***2.4.1.C*** ***2.4.1.D***	***2.4 REDESIGN TO IMPROVE PATIENT EXPERIENCE***	
Knox County Hospital				*121053602*
Related Category 3 Outcome Measure(s):OD-6	*IT – 6.2*	*CN.1*	*Percent Improvement of HCAHPS Scores over 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: $ 95,100.00	Year 3 Estimated Milestone Bundle Amount: $103,749.00		Year 4 Estimated Milestone Bundle Amount: $104,051.00	Year 5 Estimated Milestone Bundle Amount: $85,955.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:*** $388,855.00				

Summary Information: 121053602.2.2

- Provider: Knox County Hospital District is a 14-bed hospital in Knox City, Knox County, Texas. The District owns and operates two rural health clinics, averaging approximately 7,500 patient encounters annually.

- Intervention(s): This project will ensure that patients have rapid access to primary care providers.

- Need for the project: This project was selected to integrate a patient based clinic program to enhance primary care access. Processes have been identified for improvement that will ultimately will improve patient care and outcome.

- Medicaid and Uninsured Target population: The target population are the approximately 7,500 patients annually who are evaluated in our two rural health clinics. Approximately 35% of these visits are Medicaid eligible or uninsured.

- Category 1 or 2 expected patient benefits: The project will enable patients to be evaluated by their provider of choice at a time that is convenient with them and before a potentially small health issue becomes a major crisis requiring emergency or inpatient intervention. By enhancing access patients and their families will align themselves with a primary care system for improved health outcomes and reduced costs of services.

- Category 3 outcomes: The project will improve patient satisfaction scores.

Pass 2

Knox County Hospital District
Category 2

- **Identify Project and Provider Information**

  Project: Redesign Primary Care
  RPH Project ID #: 121053602.2.2
  TPI #: 121053602
  Provider: Knox County Hospital District

- **Project Description**

  Quality healthcare begins with efficient processes to ensure that patients have rapid access to primary care providers. A redesign in primary care will improve efficiency, access, continuity of care, and patient experience and will decrease costs. Most importantly, a redesign will positively impact health outcomes.

  A redesign of primary care will include a review of current data in order to target areas for improvement. Evaluations will include no-show rates, days to third-next available appointment, and primary visit care visit cycle times. Patient-centered scheduling will be implemented in both primary care clinics.

  The five year goal of this project is to ensure patients are able to see their physician when they want to thereby increasing the continuity of care and decreasing the number of patient no-shows and decrease days to third-next available appointment.

  As with any change, challenges are anticipated and include a shift in culture of staff members who are responsible for scheduling. This shift will include staff members performing as much pre-work as possible. Patients will be called and reminded of appointments. Pre-registration of patients, updating insurance and demographic information and finding out what prescriptions need to be refilled, will be handled prior to the visit. Appointments will be rescheduled to a patient's preference when appropriate.

- **Starting Point / Baseline**

  Knox County Hospital District operates two rural health clinics. The clinics average approximately 7,500 patient encounters per year. Three physicians and two nurse practitioners are supported by four licensed vocational nurses and four office staff members.

- **Rationale**

  This project was selected to integrate a patient based clinic program to enhance primary care access. Processes have been identified for improvement that ultimately will

improve patient care and outcome. Knox County Hospital District operates two rural health clinics and average approximately 7,500 patient encounters per year. Each clinic visit brings an opportunity to improve efficiency, access, continuity of care and patient experience. This project relates to regional goals of transformation of the culture of our primary care clinics. Our community benefits with this increased efficiency with fewer no-show rates, improved wait times and improved time spent with clinician. This project addresses Community Need CN.2. When patients are offered opportunities to be evaluated in a clinic setting that is consistent with their choice of provider, at a time that is convenient to them, in an efficient manner, high costs associated with preventable hospitalizations admissions and readmissions are reduced. Further, emergency room visits are also decreased.

Core components of the project will include:
Implementation of patient-centered scheduling model in both primary care clinics. Efficiency in scheduling will improve with this model. Patients will be able to schedule a time of their preference and pre-work will be performed. Staff members will confirm appointments.

Implementation of patient visit redesign. Patients scheduling at their convenience will be called to confirm appointments. All possible pre-work will be performed prior to the visit. Wait times will be decreased and time spent with clinician will be improved. No-show rates will be decreased.

Conduction of Quality Improvement. Data will be tracked to include no-show rates, days to third-next available appointment, and primary care visit cycle times. Data will be tract daily with a monthly submission of results. Actions will be taken immediately to identify and resolve percentages falling out of the expected results.

Milestones will include:

<u>Year 1</u>
P-1 Establish baseline data for each: patient appointment 'no-show' rates, days to third-next available appointment, and primary care visit cycle times.
P-1.1 Metric: Baseline patient 'no-show' rates.
P-1.2 Metric: Baseline days to third next available appointment for each clinic.
P-1.3 Metric: Baseline average patient cycle time.

<u>Year 2</u>
P-2 Milestone: Implement the patient centered scheduling model in primary care clinics.
Metric: Complete three phases of redesign project:

1. Record, document, and examine random patient calls so that staff are able to experience the process of trying to make an appointment from the patient's perspective,
2. Implement open access scheduling in primary care so patients can make same-day or next-day appointments when indicates,
3. Call patients in advance to confirm appointments, pre-register patients, update insurance and demographic information, determine what prescriptions need to be filled and reschedule to patient's preference if applicable.

Year 3
P-3 Milestone: Implement open access scheduling in primary care clinics
Metric: Open access scheduling.

Year 4
I-14 Milestone: Improve the patient experience of the primary care visit by reducing the time a patient waits while in the primary care office without reducing the time a patient spends with his/her provider, as measured by reducing average visit cycle time for primary care clinics to 30 minutes or 1.5 times the actual time spent with clinician – without reducing the time a patient spends with his/her provider.
Metric: Visit cycle time.

- **Related Category 3 Outcome Measure**
  The Category 3 Outcome Measure selected for our project is IT-6.1 Percent improvement over baseline of patient satisfaction scores.

  This outcome measure was selected because it provides feedback from a patient's perspective regarding access to care. Management of 7,500 patient encounters with a limited staff provides ample opportunity for unintentional errors to be made while scheduling and managing patient care. The Measure will provide an avenue to obtain reliable data focusing on the efficiency of patient management in primary care.

- **Relationship to Other Projects**

  Our project relates to other projects and interventions within the RHP plan as successful implementation will ensure that patients have improved access to primary care with improvements to efficiency and continuity of care. These improvements will enable patients to be evaluated by their provider of choice at a time that is convenient with them and before a potentially small health issue becomes a major crisis requiring emergency or inpatient intervention. By enhancing access patients and their families

will align themselves with a primary care system for improved health outcomes and reduced costs of services.

- **Project Valuation**
  Knox County Hospital District serves an estimated county population of 3,758 and records approximately 7,500 primary clinic care visits annually. Our populations benefit from redesigning primary care when scheduling is patient centered and designed to efficiently process as much pre-work as possible. Actions taken will ensure that patients are seen by the physician of their choice at a time that is convenient to them without extended wait times.

121053602.2.2	***RHP PP -2.3***	***RHP PP - 2.3.1***	***REDESIGN PRIMARY CARE***
Knox County Hospital District			*121053602*
Related Category 3 Outcome Measure(s):	*121053602.3.2*	*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]: Establish baseline data for patient appointment no show rates, days to third-next available appointment, and primary care visit cycle times. Metric 1 [*RHP PP Metric* – P-1.1 [Baseline/Goal: Patient no-show rates Data Source: Scheduling system Metric 2 *RHP PP Metric P.1.2* Baseline/Goal: Baseline days to third next available appointment for each clinic Data Source: Scheduling System Metric 3 RHP PP Metric P.1.3 Baseline/Goal: Baseline average patient cycle time. Data Source: Scheduling	**Milestone 2** [P-2]: Implement the patient-centered scheduling model in primary care clinics. Metric 1 [P-2.1]: Baseline/Goal: Completion of 3 phases of redesign project. 1)Examine random patient calls 2)Implement open access scheduling 3)Call patients in advance to confirm, pre-register, determine medication refills Data Source: Program materials, Scheduling system Milestone 2 Estimated Incentive Payment: $28,766.00	**Milestone 3**[P-9]: Implement open access scheduling in primary care clinics. Metric 1 [P-9.1]: Goal: Open access scheduling in both clinics. Data Source: Scheduling system Milestone 3 Estimated Incentive Payment: $30,933.00	**Milestone 4** [I-14]:Improve patient experience in primary care office without reducing time patient spends with provider, as measured by reducing average visit cycle time. Metric 1 [I-14.1]:Visit cycle time Goal: Reduce average to 30 minutes or 1.5 times the actual time spent with provider. Data Source: Scheduling System Milestone 4 Estimated Incentive Payment: $33,270.00

System Milestone 1 Estimated Incentive Payment (*maximum amount)*: $24,787.00			
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $117,756.00			

Add additional projects using same format above

Summary Information: 136325111.2.1

- Provider: Mitchell County Hospital is a 25 bed critical access hospital serving a population of over 10,000 people. The population we serve is every aging with 22.95 % between the ages of 55-64, 14.91 % between the ages of 65-74,19.5 % over 75 with 19 % below the federal poverty level.

- Intervention(s): The plan is to redesign our outpatient delivery system to assist us with the appropriate placement of patients by adding an urgent/chronic care clinic adjacent to our emergency department. We are also looking to expand the hours that the new clinic will be open to allow greater access to Primary Care Providers verses the emergency department.

- Need for the project: We currently have three (3) Primary Care Physicians in our Rural Health Clinic. One (1) has submitted his resignation which will put us in a position to provide a setting immediately for patients to seek primary and chronic care visits. We also are expecting a possible major expansion of our population with the oil find in Mitchell and the surrounding counties along with our current utilization of our emergency department of 450 to 500 patients a month we feel it necessary to be proactive in offering a setting for the new and current population that will and do need Primary Care without having to seek that care in a more costly setting like the emergency department.

- Medicaid and Uninsured Target population: The target population will be those patients that are not able to get the same day visit with our Primary Care Providers and are going to our Emergency Department to be seen. This would be all patient financial classes including our Medicaid and uninsured population.

- Category 1 or 2 expected patient benefits: Patients that currently have to visit our emergency department due to not being able to schedule a same day visit with our Rural Health Clinic will be able to have greater access to a Primary/Chronic Care Provider with the addition of the Urgent/Chronic Care Clinic. This will reduce costs to our patients as the cost for the Urgent/Chronic Clinic visit is less than an emergency room visit.

- Category 3 outcomes: IT-6 .1 The goal of this plan/project is to provide an additional setting for our patients to receive primary/chronic care by increasing access to patient appointment times. We will monitor our patient satisfaction scores in DY 3 and set our baseline and then strive to improve our scores by 5% in DY 4 and DY 5 over the baseline.

Pass 2
Category 2: Expand Access

Project Option 2.2: Expand Chronic Care Management Models

Unique Project ID: 136325111.2.1

Facility Description: Mitchell County Hospital District-136325111

Project Description:

Our goal is to appropriately place all patients in both the correct location and level of care needed to move our method of care from acute towards preventive and maintenance of chronic disease processes. Redesigning how we see patient's is expected to streamline RHC visits, reduce Emergency Department visits and place greater focus on the treatment of chronic disease processes.

Mitchel County Hospital District is organized as a Special District under the Texas Constitution as an independent taxing entity located in Colorado City. Geographically we are 70 miles from Abilene, 85 miles from San Angelo, 79 miles from Midland and 90 miles from Lubbock. The counties primary industry is cotton agriculture. Approximately 10,000 people reside in the county (primary area of responsibility). Our catchment area includes Mitchell and Nolan counties in RHP-11; Scurry County in RHP-12; Coke County in RHP-13 and Howard County in RHP-14 encompassing about 12000 people.

Mitchell County Hospital provides emergency room services 24-7-365. Currently the Emergency Department is staffed by and on-call physician and in-house mid-level practitioner. All payors are questioning the inappropriate use of Emergency Rooms and Medicaid has started retrospectively reducing payments for patients being seen in the Emergency Room that do not meet their criteria. In an effort to remedy this issue; we are going to up-date the specialty clinic spaces to be utilized by 2.1 additional mid-level practitioners as an after routine working hours/urgent care clinic.

A systems approach including examination of the input, process and output of our Emergency Department would demonstrate significant weaknesses in our ability to meet future demand. Annual Emergency Department visits have ranged from 5296 visits to is fy 2008 to 5578 in fy 2012. Demographically, Mitchell County is 25.4% under age 18; 63.3% over age 64 and 11.3% over age 65. Ethnicity is demonstrated at 52.1% white non-Hispanic, 32.6% Hispanic, 14.3% Black and 1.2% other. The distribution of age shows the largest ten- year grouping to be between 15-24 years old. The next largest grouping is 65 years of age and older. Either due to non-availability of routine clinic appointments or fear of job loss by oil field and/or agricultural workers; the addition of 275 Emergency Department Visits and changes in reimbursement dictate that we develop a place to appropriately provide for the needs of patients that may not be emergent but still seek care after routine business hours.

As stated in our community needs assessment; five areas of concern within Mitchel County are, Access to Healthcare Services, Cancer and Respiratory care and screening, Heart Disease, Stroke and Diabetic Care, Mental Health issues and Nutrition and Obesity Care. Our focus on Urgent and Chronic Care is based in the community needs assessment finding that 65.83 % of respondents are concerned with obesity; 50.69% report a need for more diabetic care; 54.82% feel need for greater heart screening and treatment; 57.34% need more cardiac screening and rehabilitations services and 73.62 % express concern over needing more cancer screening and treatment options.

We will be initiating the chronic care clinic as we expand the availability of after-hours urgent care services. Initially we will provide enhanced training t current staff members in the areas of diabetes, Heart Disease and Stroke. We will be obtaining formalized training in chronic care management while hiring a Certified Diabetic Educator (CDE), Health Coaches and support staff to enable long term management of these disease processes. In fy 2012 Mitchell County Hospital provided "chronic care services" during 2172 visits to our emergency room, rural health clinic and inpatient services on a primary diagnosis basis. As co-morbidities we are limited in our ability to track these conditions which is at the least a quality and expense issue.

We will be redesigning spaces to facilitate group meetings, intervention activities, one-to-one counseling support and interactions with health coaches. DSRP funding will enable us to renovate a space near the hospital emergency room that will provide private and group space for delivering urgent and coordinated chronic care during and after normal working hours for those who work inside and out of their homes.

Core Components:

a. We will develop a specially trained chronic care team capable of addressing our patients chronic care needs. The team will be made up of non-physician healthcare professionals e.g., certified health coaches, nutritionists offering culturally and linguistically relevant, trained educators in disease specific issues and health coached to assist patients in getting to the best placed to receive necessary services. We will utilize current staff to meet many of these needs as one benefit in being small and rural we already know our patients and under the direction of a to-be-hired Chronic Care Management Coordinator, we will be able to ramp up more efficiently.

b. Our Health Coaches will develop communications systems that enable access to the care team by phone, e-mail or in person to attend group meetings, make appointments, and participate in support groups and other interventional activities.

c. We plan to increase patient engagement, through patient education, group visits, self-management support, improved communication techniques and coordination with community resources.

d. Implement activities to empower patients to make life-style changes to stay healthy and manage their chronic conditions.

e. Conduct quality improvement for project using basic health assessments, reduced sick visits and self-assessments.

Relationship to other Performing Providers' Project in RHPs:

Rationale/Evidence:

When considering our "Top 100 Diagnoses", the need to address access to chronic disease management beginning with the affect nutrition has on diabetes, heart disease and stroke, COPD, CHF, Hypertension it is very apparent that interventions aimed at altering healthy choices and monitoring their effects is and appropriate place to begin. We will focus on chronic care diagnosis specific to our community and design approaches that are practical, supportive, evidence based interactions with providers at varying services. We will assess our current delivery system for taking care of our chronically ill patients and modify deficiencies. These modifications will assist in moving from curative/reactive care modes to preventive models that enhance health status.

Community Needs:

Our project addresses four of the eight major issues identified in our Community Needs Assessment. Based on the results of the 2011 Community Health Assessment for Mitchell County, the following represent the leading community concerns; Access to Healthcare, Cancer & Respiratory, Heart Disease, Stroke & Diabetic Care, Mental Health, Nutrition & Obesity, Need for Public Healthcare Education relating to Health Education Services, Assisted Living and general Community Issues.

Related Category 3 Outcome Measure

We have chosen patient satisfaction: OD-6 Patient Satisfaction, IT-6.1 Percent Improvemet over baseline of patient satisfaction scores as the outcome measure for this project including milestones: Develop a comprehensive care management program: train staff in the Chronic Care Model; Develop program to identify and manage patients needing further clinical interventions and improve the percentage of patients with self-management goals and basic skill sets. OD-6-IT6.1: Percent improvement over baseline patient satisfaction scores to establish if patients are getting timely care, appointment, and information.

Project Valuation:

We valued the project at $503,910 based on the following:
FY2011 Mitchell County Hospital treated the following chronic care patients:

	Clinic	Hospital/ED
Diabetes	562	49

Hypertension	616	67
CHF	117	112
COPD	140	175

Estimated costs for Uncomplicated Diabetes is $5500-$9500.00; Complicated Diabetes, ESRD and Dialysis maybe $100,000.00; COPD ranges from $7000.00 to $70,000.00 depending on acuity; CHF $7000.00 to $70,000.00 per hospital stay. A quick estimate of chronic care costs for our patients is over $4,000,000.00 annually or $16,000,000.00 for the four years of the project. Early diagnosis, treatment and multiple interventions will reduce medical expenses to our patients and avoid excessive costs to the healthcare system.

A growing body of research documenting problems in nutrition and activity in rural areas have found that rural residents are generally worse off than their urban counterparts in regards to obesity, which is opposite to the situation that existed prior to 1980. No one explanation appears satisfactory for why our problems with nutrition, activity and weight are so prominent in Mitchell County and rural America. Perhaps the most important reasons working against rural areas in regards to obesity and general health concern demography. Our residents are older, less educated and poorer than their urban counterparts. All of these demographic factors increase the risk for obesity and chronic disease.

Mitchell County Hospital District will provide local funding.

136325111.2.1	***2.2.1***	***2.2.1***	**Expand Chronic Care Management Models**
Mitchell County Hospital District			**136325111**
Related Category 3 Outcome Measure(s):	*136325111.3.6*	*IT- 6.1*	**Percent improvement over baseline of patient satisfaction scores**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1 Establish additional/expand existing/relocate primary care clinics Metric 1 [P-1.1.]: Number of additional clinics or expanded hours or space Data Source: Documentation of meeting minutes for planning of new or expanded hours of current clinics Milestone 1 Estimated Incentive Payment (*maximum amount)*: $95,464 *Add more milestones and metrics as applicable*	**Milestone 2** [P-1]: Begin implementation of plan to develop an urgent/chronic care clinic Metric 1 [P-1.1]: Baseline/Goal: begin process to hire 1 mid-level provider and support staff to convert one of our specialty clinic exam rooms into a urgent/chronic care clinic Data Source: Documentation of implementation of plan Milestone 2 Estimated Incentive Payment: $55,393 **Milestone 3** [P-1]: Hire one mid-level provider and support staff for clinic Metric 1 [P-1.1]: Baseline/Goal: 0 mid-levels	**Milestone 4** [P-1]: Begin scheduling of patients in our urgent care/chronic care clinic Metric 1 [P-1.1]: Goal: 5 patients a week scheduled to our urgent/chronic care clinic Data Source: Daily/weekly schedule that will be stored and updated on our EHR system Milestone 4 Estimated Incentive Payment: $56,258 **Milestone 5** [P-1.1]: Increase the number of patients scheduled to our urgent/chronic care clinic Metric 1 [P-1.1]: Goal: 5% increase in	**Milestone 6** [P-1]: Increase access to primary care services and chronic clinic services through the expansion of service offered at our urgent/chronic care clinic Metric 1 [P-1.1]: Increase the number of scheduled patients for urgent care and chronic care needs Goal: TBD Data Source: EHR scheduling system Milestone 6 Estimated Incentive Payment: $95,390

136325111.2.1	***2.2.1***	***2.2.1***	**Expand Chronic Care Management Models**	
Mitchell County Hospital District				**136325111**
Related Category 3 Outcome Measure(s):	*136325111.3.6*	*IT- 6.1*	**Percent improvement over baseline of patient satisfaction scores**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	currently to support this area/1 mid-level and support staff to support expanded services Data Source: Documentation of new mid-level and support staff hired for new urgent care/chronic care clinic Milestone 3 Estimated Incentive Payment: $55,393		scheduled patients from clinic start up baseline Data Source: EHR scheduling system Milestone 5 Estimated Incentive Payment: $56,257	
Year 2 Estimated Milestone Bundle Amount: $95,464	Year 3 Estimated Milestone Bundle Amount: $110,786		Year 4 Estimated Milestone Bundle Amount: $112,515	Year 5 Estimated Milestone Bundle Amount: $95,390
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $414,155				

Palo Pinto General Hospital District

Category 2 – Establish/Expand a Patient Navigation Program
Pass 3B, New: 138950412.2.2 (OLD: 138950412.2.1)

Summary Information

- Provider: Palo Pinto General Hospital District is a 99 bed hospital in Mineral Wells, Texas (Region 11) serving a 951.8 square mile area and a population of approximately 28,115.

- Intervention(s): This project will implement care and education to expectant mothers who will be at most risk of not receiving prenatal care, i.e. Medicaid and the uninsured population. Particular attention will be paid to teenagers.

- Need for the project: The hospital currently delivers 475 babies per year. Of those deliveries, 22% or 105 deliveries are to mothers between the ages of 13-19 years and 23% of those deliveries were to Hispanic mothers on Medicaid with limited or no understanding of English.

- Medicaid and Uninsured Target population: The target population is the Medicaid and uninsured patients and teenagers in need of education and assistance if they are already pregnant.

- Category 3 outcomes: IT-8.2 Reduce Low Birth Weight Babies. Our goal is to reduce the number of expectant mothers delivering babies under 2,500 grams at birth.

Facility Description: Palo Pinto General Hospital-138950412

Category 2: Program Innovation and Design
Project Option 2.9: Establish/Expand a Patient Navigation Program
Unique Project ID: 138950412.2.1

Project Description:

Palo Pinto General Hospital District is located in Mineral Wells, Texas. Palo Pinto County is an impoverished rural county with a very high teenage pregnancy rate.

The hospital has approximately 475 obstetrical deliveries a year. Of those deliveries, 22% or 105 deliveries were between the ages of 13-19 years and 23% of those deliveries were to Hispanic mothers on Medicaid with limited or no understanding of English. Many of these babies are of low birth weight. The teens are in need of prenatal care in the 1st trimester. According to the latest State of Texas information and the Community Needs Assessment (CN.8), Palo Pinto has a teen birth rate of 7.9% compared to the state average of 6.2%. These deliveries were to teenage mothers with limited English proficiency or have no insurance and become Medicaid dependent when they become pregnant.

The hospital has the ability, with the assistance from a female OB/GYN, (2.9.1 (c)) to connect patients to primary and preventive care and (2.9.1.(d)) increase access to care management. Innovative healthcare and community professionals (2.9.1 (b)) will also be assisting with the education of the students and the parents.

An OB/GYN physician will start education classes at the 5th grade level with girls of the 10-11 year old age group. For the 12-19 year old age group, the physician will counsel the patient about pregnancy, provide initial exams, and set-up follow-up visits. It is estimated these classes can eventually reach as many as 1,500 high risk girls in the next 3 years.

By DY 5, we expect to reduce the number of babies born weighing less than 2,500 grams by 10%. These babies spend up to 10 days in the hospital or if more critical, must be transported to a higher level of care. This improvement in delivery of care by targeting prenatal care supports both the Triple Aim principles and the economic goals established by RHP 11. Through educational awareness and prenatal care, appropriate care in low costs settings such as a clinic, will reduce the likelihood of a low birth weight baby who might be delivered through a preventable c-section and then need NICU days and increased lengths of stay in the inpatient setting as well as increased monitoring post discharge.

Starting Point/Baseline:

The hospital has approximately 475 obstetrical deliveries a year. Of those deliveries, 22% or 105 deliveries were between the ages of 13-19 years and 23% of those deliveries were to Hispanic mothers on Medicaid with limited or no understanding of English. In DY 2, the starting point/baseline will be the average number of babies weighing less than 2,500 grams at birth, born in the hospital, in the last 3 years. Then a focus will be placed on the age of the mothers and any identifying contributing factors with the births. This data will be collected from the

EHR. In Category 3, IT – 8.2, an average of 30 babies per year are born weighing less than 2,500 grams. Our focus is to reduce low birth weight babies by 5% each of the DY.

Rationale:

As identified by CN.8, Palo Pinto County has an exceedingly high teen pregnancy rate along with a large number of teen Hispanic women giving birth at Palo Pinto General Hospital who do not get prenatal care until the second or third trimester. More than 80% of the births at Palo Pinto General Hospital are Medicaid. To reduce the number of women needing education and prenatal care to decrease the number of birth to low weight babies, a focus group will begin with education in the schools by a local female OB/GYN. The local OB/GYN has agreed to assist the hospital, along with other healthcare professionals for education, counseling, and prenatal care.

Other navigators, to insure a successful program, for the education process will be workers from the hospital who have indicated their willingness and passion to work on this program, i.e., dietician, social worker, educators, in addition of the OB/GYN physician. As identified in the table below, milestones and metric will monitor the progress we make in this project toward educational push and enrolling girls in it,

Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions. Evidence shows that interventions with education and prenatal care that a mother will deliver a healthier baby. Increased patient engagement in such activities can empower patients with the knowledge, information and confidence to better self-manage their conditions, helping the patients to stay healthy. Through project option 2.9.1, we plan (2.9.1 (c)) to connect patients to primary and preventive care and (2.9.1.(d)) increase access to care management. Innovative healthcare and community professionals (2.9.1 (b)) will also be assisting with the education of the students and the parents.

Required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency, counseling of pregnant women and identifying those in need of education.

b) Deploy innovative health care personnel, such as case managers/workers, community health 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. Community Health Workers and other health professionals will be the patient navigators.

c) Connect patients to primary and preventive care.

d) Increase access to care for the uninsured, underinsured and Medicaid patients

Related Category 3 Outcome Measure(s):

OD-8 Perinatal Outcomes

a. Numerator: The number of babies born weighing <2,500 grams at birth
b. Denominator: All births
c. Data source: HER, claims

This Quality improvement supports Project 2.9 in that when mothers are not educated about early intervention when they are pregnant, the outcome is usually preterm births, low birth weight babies and most of these babies are Medicaid or uninsured. Hispanic births account for 22% and 21% are teenagers. If we can educate the students from the 5 – 12 grades about prenatal care, we can reduce the number of low birth weight babies.

Relationship to other Projects:

In *Project 1*, (Pass 3B, New: 138950412.1.3 (OLD: 138950412.1.1)) the hospital will be focusing on High Blood Pressure due to the number of cardiovascular related illnesses, the high obesity population within the county and how the clinic can avoid hospital admissions for this population and reduce the number of ED visits.

In *Category3*, (Pass 3B, New: 138950412.3.5 (OLD: 138950412.3.2)) the hospital will be focusing on the low birth weights of newborns due to the lack of prenatal care. In addition, due to the higher than state average for teen pregnancies and the high school dropout rate, the clinic will be focusing on educating teens on the importance of early prenatal care. A focus on care in low cost settings which aim to reduce higher acuity episodes of care in the hospital or ED. We expect these projects to have direct correlation to the PPAs, PPRs and ED measures in Category 4.

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

Plan for Learning Collaborative: N/A

Project Valuation:

The project valuation was determined by the number of mothers not receiving prenatal care in the 1st trimester, the number of teenage pregnancies in the county. Medicaid and indigent pregnant women, births and children are the focus. Pregnancies and deliveries are a major cost driver. Healthy baby initiatives seek to encourage pregnant women to carry their baby to full term and seek proper prenatal care, which will reduce costs associated with an emergency delivery. The funds will be used to educate teenagers and pregnant women on the importance of early prenatal care. Because most of these mothers are Medicaid or indigent, funding will go to the provider to encourage them to take care of these pregnant women. Funds will also be used to education to identify those most at risk for not receiving early prenatal care.

PASS 3B, NEW: 138950412.2.2 (OLD: 138950412.2.1)	***2.9.1***	***2.9.1.B, C, D***	***2.9 ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
		Palo Pinto General Hospital		*138950412*
Related Category 3 Outcome Measure(s):	*Pass 3B, New: 138950412.3.5 (OLD: 138950412.3.2)*	*IT-8.2*	*OD-8 Perinatal 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)**	
Milestone 1 [*RHP PP Milestone* – P-2]: Establish a health care navigation program to provide support to patient population (1,500 girls over 2 years) 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 [*RHP PP Metric* – P-2.1]: Number of people trained as patient navigators, number of navigation procedures or number of continuing education sessions	**Milestone 2** [P-4]: Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources. Metric [P-4.1]:Number of classes and/or initiations offered or number or percent of patients enroll in the program. a. Numerator: Number of patients enrolled in patient engagement programs. b. Denominator: Number	**Milestone 3** [P-4]: Increase patient engagement, such as through patient education, self-management support, improved patient-provider communication techniques, and/or coordination with community resources. Metric [P-4.1]:Number of classes and/or initiations offered or number or percent of patients enroll in the program. a. Numerator: Number of patients enrolled in patient engagement programs. b. Denominator: Number	**Milestone 5** [I-X]: Increase the number of teens (patients) reached by the navigators. Metric 1 [I-X.1]: Increase the number of teens (patients) reached by the navigators. Data Source: EHR, hospital data inquiries. School records. Baseline/Goal: Continue education programs and reduce low birth weight babies by another 5% over DY 4.	

PASS 3B, NEW: 138950412.2.2 (OLD: 138950412.2.1)	***2.9.1***	***2.9.1.B, C, D***	***2.9 ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
Palo Pinto General Hospital				*138950412*
Related Category 3 Outcome Measure(s):	*Pass 3B, New: 138950412.3.5 (OLD: 138950412.3.2)*	*IT-8.2*	*OD-8 Perinatal 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)**
for patient navigators. Metric [*RHP PP Metric* – P-2.3]: Frequency of contact with care navigators for high risk patients. a. Numerator: Number of care navigation encounters. b. Denominator: Number of unique patients enrolled in patient navigation program. c. Data Source: Class participants lists. Students enrolled in schools, referrals from schools, student counselors, healthcare providers and OB/GYN doctors.	of patients eligible to participate in engagement programs, as determined by provider. c. Data Source: Class participants lists. Students enrolled. Baseline/Goal: DY 3, Education programs will be developed for the age of the mother and early prenatal care		of patients eligible to participate in engagement programs, as determined by provider. c. Data Source: Class participant lists. Students enrolled. Continue education programs and red babies by 2% over DY 3. Milestone 3 Estimated Incentive Payment: $97,054	

PASS 3B, NEW: 138950412.2.2 (OLD: 138950412.2.1)	***2.9.1***	***2.9.1.B, C, D***	***2.9 ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
Palo Pinto General Hospital				*138950412*
Related Category 3 Outcome Measure(s):	*Pass 3B, New: 138950412.3.5 (OLD: 138950412.3.2)*	*IT-8.2*	*OD-8 Perinatal 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)**
Baseline/Goal: DY 2 Forming a committee to put together a program to determine the focus and direction to begin the process. Milestone 1 Estimated Incentive Payment: $177,411	will be initiated. Approximately 20% of the 475 (90) births a year do not get prenatal care in the 1st trimester and most of those are teenager. It is anticipated that a reduction of 6% can be obtained by the end of DY 3.		**Milestone 4** [I-X]: Increase the number of teens (patients) reached by the navigators. <u>Metric 1</u> [I-X.1]: Increase the number of teens (patients) reached by the navigators. Data Source: EHR, hospital data inquiries, healthcare providers, teachers, counselors, and other physicians. Baseline/Goal: Continue education programs Baseline/Goal: Continue to educate teenager and other	

PASS 3B, NEW: 138950412.2.2 (OLD: 138950412.2.1)	***2.9.1***	***2.9.1.B, C, D***	***2.9 ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
Palo Pinto General Hospital				*138950412*
Related Category 3 Outcome Measure(s):	*Pass 3B, New: 138950412.3.5 (OLD: 138950412.3.2)*	*IT-8.2*	*OD-8 Perinatal 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)**
	Milestone 2 Estimated Incentive Payment: $193,546		mothers to be to seek prenatal care and to reduce the risk of babies born prematurely. The goal is another 5% over DY 3. Milestone 4 Estimated Incentive Payment: $97,055	Milestone 5 Estimated Incentive Payment: $160,351

PASS 3B, NEW: 138950412.2.2 (OLD: 138950412.2.1)	***2.9.1***	***2.9.1.B, C, D***	***2.9 ESTABLISH/EXPAND A PATIENT CARE NAVIGATION PROGRAM***	
Palo Pinto General Hospital				*138950412*
Related Category 3 Outcome Measure(s):	*Pass 3B, New: 138950412.3.5 (OLD: 138950412.3.2)*	*IT-8.2*	*OD-8 Perinatal 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)**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $177,411	Year 3 Estimated Milestone Bundle Amount: $193,546		Year 4 Estimated Milestone Bundle Amount: $194,109	Year 5 Estimated Milestone Bundle Amount: $160,351
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $725,417				

Summary Information: 133244705.2.1

- Provider: Rolling Plains Memorial Hospital is a 42 bed hospital in Sweetwater, TX serving 912 square mile area and a population of approximately 15,000.

- Intervention(s): This project will implement evidence based protocols to screen people in our community for immunizations, breast cancer, and colorectal cancer. We plan to increase our local immunization rates and to refer people to specialty and primary care services when needed.

- Need for the project: Supporting case studies have proven immunizations for flu and bacterial pneumonia have reduced potentially preventable admissions. In our local community needs assessment, the community of Sweetwater specifically requested increased screenings for breast cancer and colon cancer.

- Medicaid and Uninsured Target population: The target population includes all populations that meet the screening elements. Approximately 25% of our population is Medicaid/Indigent and Uninsured.

- Category 1 or 2 expected patient benefits: In 2011, we had 137 Pneumonia, and 108 Influenza vaccinations. 447 mammogram screenings, 83 Colonoscopy Screenings. We plan to increase each of these vaccinations/screenings by 10% by DY5, resulting in significant health savings to our patient population. This would result in 14 more pneumonia vaccinations, 11 more influenza vaccinations, 45 more mammograms, and 8 more colonoscopy screenings

- Category 3 outcomes: IT-2.10 Our goal is to reduce the flu and pneumonia admission rate by 16% from baseline year, or 25 less admissions.

M. Category 2: Program Innovation and Redesign

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

Narrative for each Category 2 Project shall include:

- The narrative for each Category 2 Project is limited to 6 pages.
  Identifying Project and Provider Information: 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens,colonoscopiese, etc.) 133244705.2.1, Rolling Plains Memorial Hospital/133244705

  Project Description: Rolling Plains Memorial Hospital currently screens upon discharge for immunizations as required by CMS and the Joint Commission. This is the first step in implementing evidence based disease prevention strategies to reduce admissions, improve health outcomes, and ensure quality care is provided to the patient. However, as evidenced in our RHP 11 community needs assessment CN#4 and our local survey, gaps in prevention remain, specifically for immunizations, mammography, and colorectal cancer. RPMH performed almost 300 colonoscopies in 2011, of which 83 were screening. This is over 25% of our total procedures hospital wide. With this patient load and a higher percentage of persons over 65 year of age, we know patients and residents in Nolan County need these services.
  Through this initiative, RPMH plans to implement evidence based protocols to screen people in our community for immunizations, breast cancer, and colorectal cancer. We plan to increase our local immunization rates and to refer people to specialty and primary care services when needed. Through these preventive measures we expect to prevent hospitalizations and complications related to communicable diseases and cancer, which will improve patient outcomes and reduce costs associated with potentially preventable events. We believe this is in line with the national transformation of care focuses on preventive services and more cost effective treatments in order to reduce more expensive acute and emergent care. We will implement an evidence based prevention program which targets:
  - Patients who come into the Emergency Department, as they are not currently screened for these preventive services. In 2011, we had 10,700 Emergency Room visits, meaning 10,700 additional screenings. If only 10% of those had not received the flu vaccination and consented to, this could result in potentially 1070 vaccinations. For pneumonia vaccinations, we plan to screen patients 65 and older. In 2011, we saw 1,534 patients in that age group. If 10% had not received and consented to receive the vaccination, that would be potentially 153 vaccinations. For mammogram screening

and colorectal screening, we plan to question women over 40 for mammograms, and all patients over 50 regarding colorectal screening. Education documents will be provided to any in the target group who have not had a screening. For FYE 2011, we had 2400 women over the age of 40 seen in the Emergency Room and 2800 of all patients over the age of 50. If 25% of these had not had a screening, we could educate 600 women on mammogram screening, and 700 patients on colorectal screening. A success rate of 20% of these (people who followed up with a screening), results in 140 mammogram screenings, and 170 colorectal screenings.

- Employees and their families. We currently provide flu vaccinations to our employees and their families. This new initiative will also provide the pneumonia vaccination to our employees and their families. We have 300 employees, with approximately 20 over age 65. Including their spouse, this could result in 40 more vaccinations.
- Other community wide groups like school aged children and nursing home residents. Flu/pneumonia vaccinations could potentially be offered to 2500 school age children. Approximately 65 nursing home residents could be offered the vaccinations, as well as education on mammogram and colorectal screenings,

Education about and access to preventive services is our goal. As with all health initiatives, there will be a heavy educational push to promote health and preventive care. In addition to our staff doing face to face counseling and education, we will use public service announcements, ads, banners, posters and other notices to get out the message. By DY 5, we anticipate a 10% increase in people screened for breast and colorectal cancers as well as 10% increase in people screened for immunizations, including Pneumococcal, Flu, Pertussis, and any emergent disease such as Swine Flu.

RHP 11 goals are to transform health care in the total population and to further advance the goals of the Triple Aim: right care, right place, and right time. RHP 11 has chosen one of its' focuses as increasing strategies related to disease prevention. This project supports the RHP goal of disease prevention. This project also seeks to bend the cost curve, which is foundational to the transformation of the healthcare system for patients and for providers.

A study by A. Lindsay Frazier, MD, MSc; Graham A. Colditz, MD, DrPH; Charles S. Fuchs, MD, MPH; Karen M. Kuntz, ScD sited a cost savings of $92,900 per year of life gained for early detection of colon cancer. A 10% increase in colorectal screenings by DY5 could result in over $700,000 in savings per year of life gained. (Cost-effectiveness of Screening for Colorectal Cancer in the General Population) A study in the International Journal of Cancer, Volume 49, Issue 4 sites a cost savings of $35,000 per year of life gained. A 10% increase in mammogram screenings by DY5 could result in over $1,000,000 in health cost savings per life year gained.

Starting Point/Baseline: RPMH currently provides immunization screenings, upon discharge from the hospital, for flu and pneumonia, and T-DAP in the OB unit. In FY

2011, we administered 95 T-DAP, 137 Pneumonia, and 108 Influenza vaccinations. We co-host and participate in about 3 different health screenings and health fairs per year. These screenings include blood glucose, cholesterol, and PSA screenings (for a fee). In 2011, we provided 447 mammogram screenings and 83 Colonoscopy Screenings. This project will enhance our disease prevention services for children and the elderly and expand our screening services for all immunizations and breast and colorectal cancer.

Rationale: As evidenced by CN.4, hospital charges related to pneumonia are a heavy cost to our region and our hospital. Because of this and supporting case studies where immunizations for flu and bacterial pneumonia have reduced potentially preventable admissions, RPMH will implement an immunizations screening project. Additionally in our local community needs assessment, the community of Sweetwater specifically requested increased screenings for breast cancer and colon cancer. Since we currently do not have services targeting the prevention of these diseases in our community, we have identified this as a top priority project. We plan to improve immunization and preemptive health screenings rates across our county, for both children and the elderly. Increasing immunizations and screenings can prevent death and major illnesses. By concentrating on the causes of chronic disease, the community moves from a focus on sickness and disease to one based on wellness and prevention.

Required QI: The Hospital plans to develop a new methodology, or refine an existing one, based on learnings from the additional screenings and vaccinations.

Related Category 3 Outcome Measure(s): Flu and pneumonia Admission Rate**:** IT-2.10 *(Standalone measure)*
Our goal is to reduce our flu and pneumonia admission rate by 16% from the baseline. Providing the Flu vaccinations for all populations and the Pneumonia vaccination for older adults has proven to reduce potentially preventable admissions which results in healthcare savings. This area was shown to be a need in our Community Needs Assessment. Hospitalizations for the Bacterial Pneumonia are considered "potentially preventable," because if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred. The methodology used to identify "potentially preventable hospitalizations" was developed by the Agency for Healthcare Research and Quality (AHRQ). AHRQ is the lead federal agency responsible for research on healthcare quality costs, outcomes and patient safety.

Relationship to other Projects: [A narrative describing how this project supports, reinforces, enables, and is related to other projects and interventions within the RHP plan. Please list the related Category 1 and 2 projects with the unique RHP project identification number and related Category 4 Population-focused measures.

- **Relationship to Other Performing Providers' Projects in the RHP:** If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.

- **Plan for Learning Collaborative:** If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.

- **Project Valuation:** We valued the project at $2,199,204 based on the following:

  Project Size-As a proxy for the size and reach of this project, we have used the 900 visits per month in our ED and our 260 employees with a multiplier of two to estimate family size and then to capture how many additional screening and preventive services will be accessed. Additionally, there will be others reached through health fairs and health promotion activities.

  Project Scope-We selected the most costly cancers, breast and colon. We have also selected communicable diseases. Immunizations can often prevent disease, hospitalization and complications. Therefore, we have included most of the regular and ongoing vaccinations all patients need.

  Population Served-We will serve both patients and employees of our hospital as well as all of Nolan County through specific outreach initiatives like the health fairs and school outreach. In 2011, we had 137 Pneumonia, and 108 Influenza vaccinations. 447 mammogram screenings, 83 Colonoscopy Screenings. We plan to increase each of these vaccinations/screenings by 10% by DY5, resulting in significant health savings to our patient population. This would result in 14 more pneumonia vaccinations, 11 more influenza vaccinations, 45 more mammograms, and 8 more colonoscopy screenings

  Community Benefit-Disease prevention activities will improve our immunization access and rates as well as early detection and treatment of potentially fatal illnesses.

  Cost Avoidance: For cost avoidance, we have looked at the case studies by DSHS and other evidence based public health initiatives and know that immunizations for children and the elderly can prevent potentially preventable hospitalizations. DSHS estimated hospital charges in Nolan County related to Bacterial Pneumonia to be $2,170,797 from 2005 - 2010. In 2011, we had 211 admissions, or 17%, related to Pneumonia. Approximately 75% were Medicare patients and roughly 10% were Medicaid. To project cost avoidance for all payors, which is the basis for DSHS database, we anticipate preventing at least 50 hospitalizations over the next 4 years at an average cost of $10,000 to $12,000 per hospitalization to save at least $500,000 to $600,000 in health care costs. This doesn't include payer costs related to discharge, such as swing bed costs, rehab or home health follow-up costs, nor does it include other ancillary costs such as pharmacy. Hospitalizations and treatment regimes for cancer were estimated by the National Cancer Institute to be around $124.6 billion in 2010, which was before our more advanced and specialized treatments came on the scene. For patients with a

cancer diagnosis, there are also out of pocket expenses, doctors visits, multiple medications, lost wages and often travel to urban hubs for advanced specialty and clinical trial treatments. The National Institute of Health estimated that colorectal cancer in 2007 cost about $8.4 billion and breast cancer close to $7 billion. As noted by the Centers for Disease Control, screenings save lives and advance warnings can save the system and patient's financial loss and medical hardship through early treatment and intervention.

Priority Community Need: In our most recent community survey, breast and colorectal cancer screenings were identified as a top priority.

Estimated Local Funding: Local funding is through our Hospital District.

133244705.2.1	***2.7***	***2.7.1***	Implement Evidence-based Disease Prevention Programs	
Rolling Plains Memorial Hospital				*132244705*
Related Category 3 Outcome Measure(s):	*133244705.3.2*	IT-2.10	Flu and pneumonia Admission Rate **:** *(Standalone measure)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1. Milestone: Development of innovative evidence-based project for targeted population Metric 1 P-1.1. Metric: Document innovational strategy and Baseline/Goal 95 T-DAP, 137 Pneumonia, and 108 Influenza vaccinations. 447 mammogram screenings, 83 Colonoscopy Screenings Data Source: Performing Provider evidence of innovational plan Rationale/Evidence: To identify, develop and test new models of healthcare delivery and disease management lays the ground work for widespread adoption	**Milestone 2** P-2. Milestone: Implement evidence-based innovational project for targeted population Metric 1 P-2.1. Metric: Document implementation strategy and testing outcomes Data Source: Documentation of plan implementation Rationale/Evidence: To identify, develop and test new models of healthcare delivery and disease management lays the ground work for widespread adoption of innovative care that can lead to a system that delivers better health, better care at reduced costs. Milestone 2 Estimated		**Milestone 3** I-7. Milestone: Increase access to disease prevention programs using innovative project option resulting in potential health cost savings of $1.7 mil per life year gained Metric 1 I-7.2. Metric: Increased number of encounters as defined by intervention [P-9.1]: Goal: Increase designated vaccinations and screening by 5% over baseline. This would result in 7 more pneumonia vaccinations, 5 more influenza vaccinations, 22 more mammograms, and 4 more colonoscopy screenings. Data Source: E.H.R.; Claims	**M Milestone 4** I-7. Milestone: Increase access to disease prevention programs using innovative project option resulting in potential savings of $1.7 mil per life year gained. Metric 1 I-7.2. Metric: Increased number of encounters as defined by intervention [P-9.1]: Goal: Increase designated vaccinations and screening by 10% over baseline. This would result in 14 more pneumonia vaccinations, 11 more influenza vaccinations, 45 more mammograms, and 8 more colonoscopy screenings. Data Source: E.H.R.; Claims

133244705.2.1	***2.7***	***2.7.1***	Implement Evidence-based Disease Prevention Programs	
Rolling Plains Memorial Hospital				*132244705*
Related Category 3 Outcome Measure(s):	*133244705.3.2*	IT-2.10	Flu and pneumonia Admission Rate **:** *(Standalone measure)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
of innovative care that can lead to a system that delivers better health, better care at reduced costs. Milestone 1 Estimated Incentive Payment (*maximum amount)*: $507,475 *Add more milestones and metrics as applicable*	Incentive Payment: $588,229		Milestone 3 Estimated Incentive Payment: $594,309	Milestone 3 Estimated Incentive Payment: $509,191
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $ 507,475	Year 3 Estimated Milestone Bundle Amount: $588,229		Year 4 Estimated Milestone Bundle Amount: $594,309	Year 5 Estimated Milestone Bundle Amount: $509,191
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:*** $2,199,204				

Pass 2
Summary Information: 13244705.2.2

- Provider: Rolling Plains Memorial Hospital is a 42 bed hospital in Sweetwater, TX serving 912 square mile area and a population of approximately 15,000.

- Intervention(s): This project will implement an integrated care model and cost accounting system that reduces costs while improving quality.

- Need for the project: Providing quality care while reducing costs is essential to benefit not only the Hospital, but the citizens of Nolan County. Our mission statement includes providing quality care at a minimal cost.

- Medicaid and Uninsured Target population: All patient populations will benefit from this project as a result of not only reduced costs, but better quality of care, which could result in decreased readmissions. Approximately 25% of our population is Medicaid/Indigent and Uninsured.

- Category 1 or 2 expected patient benefits: The project seeks to decrease healthcare costs while improving patient care. Improvements in patient care result in reduced admissions and healthier populations. In 2011, we performed 489 surgeries. We will determine a cost for each type of these surgeries by DY3 and show a reduction in these costs by DY5.

- Category 3 outcomes: IT-5.1 Our goal is to demonstrate cost savings in care delivery. We plan to show a decrease in the cost of colorectal screenings. We will determine cost of 83 colorectal screenings from FYE 2011 by DY3 and show a 3% reduction in costs by DY5

Pass 2

Category 2: Program Innovation and Redesign

- **Identifying Project and Provider Information:** Redesign for Cost Containment-Develop an integrated care model with outcome-based payments 133244705.2.2,2.5 Rolling Plains Memorial Hospital/133244705

Project Description: Rolling Plains Memorial Hospital desires to implement an integrated care model and cost accounting system that reduces costs while improving quality. The Hospital plans to employ a consultant to implement cost-accounting systems, measure intervention impacts, establish a method to measure cost containment, establish a baseline for cost, and measure cost containment. By DY5, the Hospital expects to show an improvement in the area of cost of surgical services, and increase in patient satisfaction. An additional finance FTE is also planned to be responsible for the cost accounting system and analysis of data. This project will help the Hospital to Improve cost-effectiveness of care through improved care delivery for individuals, families, employers, and the government. The Hospital expects to show improvements both in cost and in quality of care after implementation of this project. The Hospital will conduct a quality improvement project using rapid cycle improvement to determine project impacts.

Starting Point/Baseline: The hospital plans to first apply this project in the area of surgical services. The hospital currently has 2 general surgeons and in 2011 performed 489 surgeries. A baseline for cost of each type of surgery performed will be established after implementation of the project. The Hospital expects by DY5 to show a 3% cost savings overall for each type of surgery performed, benefiting patients, third party payors, and governmental payors. Specific dollar amount related to the 3% decrease will be determined in DY3.

Rationale: Healthcare today contains greater challenges than ever. Providing quality care while reducing costs is essential to benefit not only the Hospital, but the citizens of Nolan County. Our mission statement includes providing quality care at a minimal cost. CN.2 recognized health care costs for preventable diseases as a community concern. As health care costs rise – regulators, policymakers and industry leaders are increasingly interested in developing accurate ways to measure and, ultimately to try to reduce health care costs for individuals, as well as society. Developing cost-of-care measures that can help those who get, give and pay for care understand how different providers use resources and compare them to national benchmarks is essential to controlling costs. This relates to the regional goals to further the Triple Aim: right care, right setting and right time as well as progress transformational delivery system reform such as right cost and patient centered healthcare.

Related Category 3 Outcome Measure(s): Improved cost savings: Demonstrate cost savings in care delivery IT 5.1 Health care is faced with the challenges of large numbers of uninsured and concerns for quality, safety, cost, and workforce shortages. Ultimate solutions to this complex array of issues will likely be national, but local healthcare can contribute to solutions now by developing approaches that lead not just to improvements in certain processes within the system but also to developing solutions that lead to system transformation. The Hospital plans to develop a model and cost accounting system to achieve cost savings. The Hospital plans to show a reduction in cost of colorectal screenings.

- **Relationship to other Projects:** Expand Specialty Care Capacity 1.9.1, 133244705.1.1; Implement Evidence-based Disease Prevention Programs, 133244705.2.1
  Our other projects focus on prevention and will also result in cost savings, not only to our Hospital, but to other healthcare providers who have to care for the potential complications of illness that arise if prevention measures are not in place. Our project to expand our OB specialty will result in increased access to care, which will result in healthier moms and babies. Our project to increase screenings and immunizations will result in less complications related to flu and pneumonia, as well as quicker detection of certain cancers, all of which impact healthcare costs.
- **Relationship to Other Performing Providers' Projects in the RHP:** If applicable, a list of other providers in the RHP that are proposing similar projects and will be members of a learning collaborative to support this project and share best practices, new ideas, and solutions across the RHP.
- **Plan for Learning Collaborative:** If applicable, describe plans for participating in a RHP-wide learning collaborative with other providers with similar projects. Describe how the learning collaborative will promote sharing of challenges and testing of new ideas and solutions between providers implementing similar projects.

- **Project Valuation:** We valued the project at $1,073,896 based on the following**:**

  Size: This project will encompass every area of the hospital, whether revenue producing or non revenue producing. We have also never done a project of this sort, so it will involve a great deal of research, consulting, and education. It is also anticipated that a finance FTE will be added to be responsible for the implementation, input and analysis of date in the cost reporting system.

  Project Scope: The Hospital will evaluate numerous cost accounting systems, and will employ consultants, as needed, to determine the best integrated model and method to achieve the savings goal. It will involve input and coordination hospital wide, as all areas of the hospital will be impacted. The Hospital performed 489 surgeries and 2011 and will first use the cost

accounting system to determine a cost of for each type of surgery.. We will determine a cost for each type of these surgeries by DY3 and show a reduction in these costs by DY5.

Populations served: Cost savings will serve not only the patients of the hospital, but the taxpayers of Nolan County, who could see reduced need for taxes with better efficiencies in healthcare costs. Patients of the hospital will also benefit from improvements in patient care.

Community Benefit: Citizens of Nolan County will benefit from improvements in patient care at a lower cost and potential tax savings in taxes needed to operate the Hospital

Cost Avoidance: The reduction in healthcare costs that can be realized through this project can be significant. In 2008, Kaiser Permanente recognized $30 million in cost savings for its 12,000 members enrolled in the Cardiac Care portion of its integrated care model. Along with this, they saw a 73% reduction in cardiac mortality (Source: B.G. Sandoff, "Collaborative Cardiac Care Service: A multidisciplinary approach to caring for patients with coronary heart disease" Permanente Journal 2008, Volume 12, Number 3, pp. 4-11). The reduction in costs, along with improved patient outcomes, will result in savings not only for the Hospital, but for all forms of third party payment, including Medicare and Medicaid.

Priority Community Need: A local community needs assessment identified cost of medical care and access to quality care as concerns of the local community.

Estimated Local Funding: Local funding is through our Hospital District.

133244705.2.2	***2.5.1***	***2.5.1 A - D***	Redesign for Cost Containment-Develop an integrated care model with outcome-based payments	
Rolling Plains Memorial Hospital				*133244705*
Related Category 3 Outcome Measure(s):	*133244705.3.3*	*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. Milestone: Develop/identify a cost-accounting methodology to quantify the financial impact of quality and efficiency improvement interventions P-1.1. Metric: Cost-accounting methodology/metric a. Documentation of the methodology and metric (e.g., average cost per case for each hospital bed day for chosen specific clinical conditions; average annual cost of hospitalization for chosen specific primary diagnoses clinical conditions; average cost per case for each bed day for patients hospitalized for chosen specific primary diagnoses clinical conditions)	**Milestone 2** P-2. Milestone: Establish a baseline for cost P-2.1. Metric: Establish a baseline for cost a. Submission of baseline data b. Data Source: Cost-accounting system or another administrative, financial, or clinical data set c. Rationale/Evidence: An accurate baseline for cost per unit of service must be established in order for a Performing Provider to effectively measure its progress towards lowering costs. *Baseline/Goal: Determine cost of each type of surgical procedure performed in 2011.*		**Milestone 4** P-3. Milestone: Implement the cost-accounting methodology and related systems to measure intervention impacts P-3.1. Metric: Cost-accounting system a. Documentation of adoption, installation, upgrade and/or interface of technology, and/or implementation of system using existing technology b. Data Source: Cost-accounting system c. Rationale/Evidence: Interventions require the investment of numerous resources at many levels of the delivery system. A cost accounting system provides the system with the necessary tool to	**Milestone 5** I-10. Milestone: Per episode cost of care measurement quantifies the services involved in the diagnosis, management and treatment of specific clinical conditions. Episode-of-care measures can be developed for the full range of acute and chronic conditions, including diabetes, congestive heart failure, acute myocardial infarction, asthma, low back pain and many others. I-10.1. Metric: a. Numerator: total cost for each type of surgical procedure performed in a month b. Denominator: total number of each type of surgical

133244705.2.2	***2.5.1***	***2.5.1 A - D***	Redesign for Cost Containment-Develop an integrated care model with outcome-based payments	
Rolling Plains Memorial Hospital				*133244705*
Related Category 3 Outcome Measure(s):	*133244705.3.3*	*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)**
b. Data Source: Cost-accounting system or another administrative, financial or clinical data set c. Rationale/Evidence: An accurate cost-accounting methodology/metric is a necessary tool for a Performing Provider to gauge the impact of quality and efficiency improvement interventions on the cost per unit of service for the delivery component the Performing Provider is trying to improve *Baseline/Goal: 489 Surgeries performed in FYE 2011* Milestone 1 Estimated Incentive Payment (*maximum amount)*: $247,537	Milestone 2 Estimated Incentive Payment: $ 143,633 **Milestone 3** P-5. Milestone: Train Finance staff on costing methodologies and define, develop, and document methodologies with departments for allocation of costs to specific services. P-5.1. Metric: Staff trainings and department specific methodologies a. Submission of trainings and department documents b. Data Source: Training materials, meeting minutes, cost-accounting system or another administrative, financial, or clinical data set. c. Rationale/Evidence: An accurate cost-accounting		gauge the financial return on investment of intervention(s). *Baseline/Goal: Determination of current costs of each surgical procedure performed in years after 2011 to establish trends; begin measures to improve costs* Milestone 4 Estimated Incentive Payment: $291,747	procedure in one month c. Data source: EHR; provider and regional data; d. Rationale: As health care costs rise – regulators, policymakers and industry leaders are increasingly interested in developing accurate ways to measure and, ultimately to try to reduce health care costs for individuals, as well as society. Developing cost-of-care measures that can help those who get, give and pay for care understand how different providers use resources and compare them to national benchmarks was one of the TX HHSC DSRIP project's goals

133244705.2.2	***2.5.1***	***2.5.1 A - D***	Redesign for Cost Containment-Develop an integrated care model with outcome-based payments	
Rolling Plains Memorial Hospital				*133244705*
Related Category 3 Outcome Measure(s):	*133244705.3.3*	*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)**
Add more milestones and metrics as applicable	methodology/metric is a necessary tool for a Performing Provider to gauge the impact of quality and efficiency improvement interventions on the cost per unit of service for the delivery component the Performing Provider is trying to perform *Baseline/Goal: Successful training of FTE dedicated to accurate use of the cost t accounting system* Milestone 3 Estimated Incentive Payment: $143,634			*Baseline/Goal: Overall decrease of 3% in cost of each type of surgical procedure from cost determined in DY3 Specific dollar amount is TBD in DY3 so cannot be stated at this time* Milestone 5 Estimated Incentive Payment: $247,345
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $247,537	Year 3 Estimated Milestone Bundle Amount: $287,267		Year 4 Estimated Milestone Bundle Amount: $291,747	Year 5 Estimated Milestone Bundle Amount: $247,345
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $1,073,896				

Category 3

Category 3: Quality Improvements

3.IT-1.7: Primary Care and Chronic Disease Management

Unique Project ID: 0094104901.3.1

Facility Description: Anson General Hospital-0944104901

Outcome Measurement Description:

Process Milestones are to be used in the project planning which will include the establishing of a baseline of patients with the diagnosis of hypertension. In DY 2 we will determine baselines and needed resources for training and education . Set up and determine timelines, policies and documentation and implementation plans We will use logs, registry and primary care physicians and staff. DY3 we will establish baselines for the numerators and denominators to be used in blood pressure control. The numerator will be the number of patients in the denominator whose most recent blood pressure is adequately controlled (BP<140/90mm/Hg) during measurement year. The denominator will be the patients age 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension. Physician and staff will attend education and training classes and we will be able to monitor with clinic appointments, records, logs, training logs and manuals and policy and procedure manual completion. In DY4 we will be able to show a 2% improvement in the baseline established in DY3 and in DY5 we will see a continuation in Blood Pressure control with a 4% improvement over DY4.

Rationale:

Approximately 76.4 million (33.5 percent) of people in the United States 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; results are particularly striking in elderly with hypertension, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5 mm to 6 mm Hg reduction in diastolic blood pressure was associated with a 42 percent reduction in stroke mortality and a 14 percent to 20 percent reduction in mortality from coronary heart disease
(CHD). Literature from clinical trials indicates that 53 percent to 75 percent 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 USPSTF and the Joint

National Committee. In Jones County the Community Health Assessment done by the University of Texas Health Science Center states that 66% of their respondents cited someone in the household as having high blood pressure. Again in Jones County the Community Health Assessment also stated that there were 94.6 deaths per 100,000 compared to the 47.0 deaths per 100,000 population in the United States.

Outcome Measure Valuation:

We have chosen only one outcome measure, Controlling High Blood Pressure as blood press ranks twice the national average at 94.6 deaths per 100,000 population as compared to 47.0 deaths per 100, in the United States . Controlling blood pressure also lowers the risk of death, heart attack and stroke. We believe that this is where improvement of care will benefit patients in the community by preventing or improving co-morbidities. Recruiting another physician and support staff will be allow us to offer additional primary care to the 20,202 citizens of Jones County and reduce the number of patients that seeking care for chronic conditions in the Emergency Department.

0094104901.3.1	3.IT-1.7	**Controlling high blood pressure *(Standalone measure)***	
[Anson General Hospital]			0094104901
Related Category 1 or 2 Projects:	0094104901.1.1		
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, determine baselines and needed resources for training and education. Determine timelines, policies and documentation. Implementation Plans. Data Source: Logs, Registry and primary care physicians and staff Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $50,000	**Process Milestone 2** P-2 Establish baseline numerators and denominators. Establish education and training classes Data Source: Clinic appointments, records, logs, Training logs and manuals and polices Process Milestone 3 Estimated Incentive Payment: $12,000	**Outcome Improvement Target** IT-1.7 Percent improvement in the baseline established DY3 Percent over improvement of patient baseline blood pressure showing control at <=140/80 Improvement Target: 2% increase over baseline DY3 Data Source: logs and records Outcome Improvement Target 2 Estimated Incentive Payment*:* $13,000	**Outcome Improvement Target 3** IT-1.7: Percent improvement over baseline set in DY4 Continued improvement of patients baseline blood pressure showing control at <=140/80 Improvement Target: 4% increase in control over DY4 Data Source: Log and records Outcome Improvement Target 3 Estimated Incentive Payment*:* $14,000

0094104901.3.1	3.IT-1.7	**Controlling high blood pressure *(Standalone measure)***	
[Anson General Hospital]			0094104901
Related Category 1 or 2 Projects:	0094104901.1.1		
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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $50,000	Year 3 Estimated Outcome Amount: $12,000	Year 4 Estimated Outcome Amount: $13,000	Year 5 Estimated Outcome Amount: $14,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $89,000			

Category 3: Quality Improvements

Identifying Information:

Outcome Measure: OD-1 Primary Care and Chronic Disease Management
Project Option: IT-1.18 Follow Up After Hospitalization for Mental Illness
Project Title: Expand Specialty Care
RHP Project ID Number: 1333387-07.3.1
RHP Performing Provider: Abilene Regional MHMR d/b/a Betty Hardwick Center
TPI: 133338707

Outcome Measure Description:

For demonstration years 3-5, Betty Hardwick Center has selected improvement outcome measure IT-1.18, Follow Up After Hospitalization for Mental Illness, which is a standalone measure.

The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. This will involve determining our current rate of patient follow up after inpatient hospitalization, establishing the follow up measure baseline in year 2. The improvement targets will then be set for years 3-5.

Rationale:

Betty Hardwick Center has selected improvement outcome measure IT-1.18, Follow Up After Hospitalization for Mental Illness, out of the Outcome Domain-1, Primary Care and Chronic Disease Management category for quality improvement. One of the purposes of this project is for clients to realize better access to psychiatry providers at initial intake, in a crisis and in follow up to inpatient care to provide the right care at the right time. Presently, Betty Hardwick Center makes some effort to provide follow up care for all patients who are referred from inpatient care, but we do not routinely track data regarding face to face visits with medical services providers specifically after inpatient care. For this reason, Process Measure P-2 was selected in order for us to determine baseline rates. As a result, the Outcome Improvement targets, noted as "tbd" in the Category 3 Milestone/Metric table will be set for implementation in DY3.

Outcome Measure Valuation: We valued this Category 3 project at $741,564 based upon the following-

Project Size – This project will cover follow up services to individuals served by Betty Hardwick Center residing in 5 of the 15 counties in RHP 11.

Project Scope – The services to be provided in this project will consist of outpatient psychiatric services that include diagnosis and treatment services. Most typically, those services will be psychiatric evaluations and medication management services

Population Served – The population to be served will include adults and child or adolescent patients of the local mental health authority who reside in Taylor, Jones, Callahan, Shackelford and Stephens counties and whom have been referred to our outpatient clinic following an inpatient psychiatric hospitalization. The local mental health authority serves patients who meet DSHS established priority population including adults with serious and persistent mental illness and children or adolescents with serious emotional, behavioral or mental disorders. Clients served may be involved in ongoing outpatient care or brief crisis intervention care.

Community Benefit – Access to appropriate levels of psychiatric care in an outpatient setting is a benefit to our community and the individuals in need of care. Betty Hardwick Center used data and reports provided by the UT Austin Center for Social Work Research in determining some aspects of valuation. The valuation is aligned with the Demonstration program goals to develop programs that enhance access to healthcare, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served. In developing this plan, the primary valuation method uses cost-utility analysis (a type of cost effectiveness research) and additional information is reported on potential future costs saved and quality adjusted life years (QALYs) analysis that combines health quality (utility) with length of time in a particular health state. This threshold has been a standard way of valuing life years in terms of whether the cost of the intervention exceeds this standard. The number of life years added is based on a review of the scientific literature. There are a variety of studies about the cost effectiveness of medication therapy for persons with severe and persistent mental illness, about the cost savings of providing timely outpatient care versus hospitalization emergency or inpatient costs. Another valuation factor used for this project is the monetary value for behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

Cost Avoidance – Appropriate levels of outpatient medication care can reduce cost of psychiatric care over the long term (Martin and Leslie, 2003).

Priority Community Need – The community needs assessment completed for RHP 11's planning purposes identified CN.3, shortage of healthcare professionals, including mental health care providers as a significant need in the region.

Estimated Local Funding – Betty Hardwick Center has identified appropriate funds to cover the intergovernmental transfer for the project proposed.

1333387-07.3.1	*IT-1.18*	*Follow Up After Hospitalization for Mental Illness*	
Abilene Regional MHMR d/b/a Betty Hardwick Center			RHP 11 - 1333387-07
Related Category 1 or 2 Projects:	***1.9.3***		
Starting Point/Baseline:	*To be established in year 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)**
Process Milestone 1 [*RHP PP Process Milestone* – P-2]: Establish baseline rates. Data Source: Internal data reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $0	**Outcome Improvement Target 1** [IT-1.18]:Follow up after hospitalization for mental illness Improvement Target: tbd Data Source: Internal data reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $168,722	**Outcome Improvement Target 2** [IT-1.18]:Follow up after hospitalization for mental illness Improvement Target: tbd Data Source: Internal data reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $180,493	**Outcome Improvement Target 3** [IT-1.18]: Follow up after hospitalization for mental illness Improvement Target: tbd Data Source: Internal data reports Outcome Improvement Target 3 Estimated Incentive Payment*:* $392,376
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $0	Year 3 Estimated Outcome Amount: $168,722	Year 4 Estimated Outcome Amount: $180,493	Year 5 Estimated Outcome Amount: $392,376
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $741,591			

Category 3: Quality Improvements

Pass 3B

Identifying Outcome Measure and Provider Information:

Outcome Measure Title: OD-9: Right Care, Right Setting

Project Option: IT-9.1 Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings

Project Title: Betty Hardwick Center Mobile Crisis Outreach Team Expansion

RHP Project ID Number: 1333387-07.3.2

Performing Provider: Abilene Regional MHMR Center d/b/a Betty Hardwick Center

TPI: 133338707

Pass 3b
Category 3: Quality Improvements

Identifying Outcome Measure and Provider Information:

Outcome Measure Title: OD-9: Right Care, Right Setting

Project Option: IT-9.1 Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings

Project Title: Betty Hardwick Center Mobile Crisis Outreach Team Expansion

RHP Project Old ID Number: 1333387-07.3.2
New ID Number:1333387-07.3.3

Performing Provider: Abilene Regional MHMR Center d/b/a Betty Hardwick Center

TPI: 133338707

Outcome Measure Description:
Betty Hardwick Center's identified process measure for DY1 will be P-1, Project planning – engaging stakeholders, identifying current capacity and needed resources, determining timelines and document implementation plans for tracking the intended improvements. In DY2, the process measure will be P-3, Develop and test data systems. Our goal will be to establish methods for accurately capturing data related to this population, tracking diversions from criminal justice settings, and establishing the baseline measures. For demonstration years 3-5,

Betty Hardwick Center has selected OD-9, IT-9.1 Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings. We have selected this measure because we believe that our enhanced MCOT capabilities will further enable us to have an impact on determining that individuals receive the right care in the right setting, and will appropriately divert individuals from criminal justice settings.

Rationale:

In FY 2012 Betty Hardwick Center received over 4800 crisis calls for the RHP 11 five Betty Hardwick Center counties with over 1700 being legitimate "go mobile" response situations. The current Mobile Crisis Outreach team is responding to calls throughout the rural area of the West Texas RHP 11 counties. Process measures were identified to facilitate further assessment of the Betty Hardwick Center's crisis response system to identify crisis call patterns, determine data points and methods of collection and to seek stakeholder input. The improvement targets were chosen based upon the belief that enhanced Mobile Crisis Outreach team efforts will lead to an increase in consumer diversion from the emergency rooms, jails, and inpatient facilities. This will result in more appropriate right care, right setting, and right time treatment for our behavioral health consumers. Betty Hardwick Center currently provides these crisis services with only two dedicated Mobile Crisis Outreach staff members and an on call rotation after hours with other staff in the RHP 11 service area. These staff are responsible for responding to crisis calls within one hour of notification on a 24/7 call rotation.

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 homeless ness increased propensity to use emergency department and inpatient services. Interventions which can prevent individuals from cycling through the criminal justice system can help aver poor health and mental health outcomes reduce long term medical costs and improve functioning.

Outcome Measure Valuation:

We valued this project at $319,608 based upon the following –

As Improvement Targets are "to be determined," valuations were allocated by percentage of Category 1 valuation allocations.

Project Size – The project will cover a five county area of West Central Texas in RHP 11. The population of the targeted service area is 178,260 and covers 4,594 square miles.

Project Scope – The services to be provided in this project will be available to everyone in the community with a behavioral health crisis and will work closely with individual citizens, hospital emergency rooms, law enforcement, jails and many other community agencies.

Community Benefit - This project will decrease the cost of care through increased diversion of consumers from jails as well as decrease the cost of inpatient care through inappropriate

admissions to psychiatric facilities and other high cost settings. The project will meet the waiver goals additionally through more right care, right setting and right time treatment provision. The project will increase access to crisis response services through additional Mobile Crisis Outreach team members. It will decrease response times for these staff to assist emergency rooms and law enforcement agencies with mental health crisis situations.

Cost Avoidance - According to txpricepoint.org, the average cost for just one possible preventable admission, such as severe psychological disorders including Schizophrenia, among all Taylor County hospitals for Federal Year 2011 was $10,519.00 average charge per average length of stay for this diagnosis (excludes physician cost). Further research shows the average cost to transport an individual to a local hospital by local EMS services is $535.00. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, where an officer is on hand, can range from 1 to 3 hours, sometimes substantially more. A law enforcement officer's average pay can range from $12.50 to $18 per hour, so in an average situation this would be an additional $30-$45 cost per event. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services. Additionally, the small rural police or sheriff's department, often employing due to lack of resources, a low ratio of officers to citizens, is left significantly understaffed while an officer is on duty at the emergency department or transporting clients to distant inpatient sites. Even though these financial costs are significant, the human cost which is much harder to measure can be even more significant. Additionally, the cost of an average stay in the Taylor County Jail runs $50 per day, but that does not include the cost of additional supervision and psychiatric medication for a person who is suffering from untreated or undertreated mental illness.

Priority Community Need - RHP 11 Rural Community Needs Assessment numbers CN.2, High costs associated with preventable hospitalization admissions and readmissions and CN.3, Shortages of health care professionals, including mental health care providers, will be addressed through this project.

Estimated Local Funding - Betty Hardwick Center has identified appropriate funds to cover the Interlocal governmental transfer for the project proposed.

New 1333387-07.3.3 **Old** 1333387-07.3.2	OD-9	IT-9.1 Decrease in Mental Health Admissions and Readmissions to Criminal Justice Settings Project Title: Betty Hardwick Center Mobile Crisis Outreach Team Expansion	
Abilene Regional MHMR Center d/b/a Betty Hardwick Center		13338707	
Related Category 1 or 2 Projects	New 1333387-07.1.3/ Old 1333387-07.1.2		
Starting Point/Baseline	To be established DY 2		
Year 2 (10/1/2012-9/30/2013)	**Year 3 (10/1/13-9/30/14)**	**Year 4 (10/1/14-9/30/15)**	**Year 5 (10/1/15-9/30/16)**
Milestone 1: Process Milestone P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determined timelines and document implementation plans. Metric: Number of meetings and participants. Data Source: Attendance Lists Baseline: N/A	Milestone 2: Process Milestone P-3: Develop and test data systems. Metric: Produce a report format that identifies data to be measured and process for doing so. Data Source: Internal data sources. Baseline: N/A Goal: Published report	**Outcome Improvement Target 1:** IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Improvement target: 10% over the baseline. a. Numerator: the number of individuals receiving project intervention who had a potentially preventable admission/readmission to a criminal justice setting within the measurement period.	**Outcome Improvement Target 2:** IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons Improvement target: 15% over the baseline. a. Numerator: the number of individuals receiving project intervention who had a potentially preventable admission/readmission to a criminal justice setting within the measurement period. b. Denominator: the number of

Goal: Will conduct a minimum of 1 stakeholder meeting. Process Milestone 1 Estimated Incentive Payment: $0.00	format for implementation. Process Milestone 2 Estimated Incentive Payment*:* $49,707	b.Denominator: the number of individuals receiving project intervention. Data Source: Claims/encounter and clinical record data, anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records. Baseline: DY2 Data Report Outcome Improvement Target 1 Estimated Incentive Payment*: $ 80,178*	individuals receiving project intervention. Data Source: Claims/encounter and clinical record data, anchor hospital and other hospital records, criminal justice system records, local MH authority and state MH data system records. Baseline: DY2 Data Report Outcome Improvement Target 2 Estimated Incentive Payment*:* $189,723
Year 2 Estimated Outcome Amount: $0.00	Year 3 Estimated Outcome Amount: $49,707	Year 4 Estimated Outcome Amount: $80,178	Year 5 Estimated Outcome Amount: $189,723
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $319,608			

Category 3 DSRIP Project Narrative

Central Texas MHMR Center dba Center for Life Resources – 133339505.3.1

Outcome Domain: OD-9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate Utilization (Standalone measure). Reduce Emergency Department visits for target conditions. Target conditions being Behavioral Health/Substance Abuse.
Unique RHP Outcome Identification Number: 133339505.3.1

Title of Category 1 or 2 Project: 133339505.1.1 - Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services
Performing Provider Name: Central Texas MHMR Center dba Center for Life Resources
Performing Provider TPI #: 133339505

Outcome Measure Description:
OD -9 – Right Care, Right Setting
IT-9.2 – ED Appropriate Utilization: Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse.

Process Milestones:

- **DY 2:**
  - P-1 Project planning -engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2 Establish baseline rates

- **DY 3:**
  - P-3 Develop and test data systems
  - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Target for each year:

- **DY 4:**

- IT-9.2 ED appropriate utilization, Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse – Reduction to Baseline to be determined

- **DY 5:**
  - IT-9.2 ED appropriate utilization, Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse Reduction to Baseline to be determined

Rationale:
We chose to use project planning and establishing baselines in DY2 in order to form a solid foundation to measure the change we hope to introduce. In DY3 we will test our conclusions from DY2 and make adjustments in order to better plan, do, study and act. In DY4 and DY5 we will implement what we have learned in the previous years. We expect to see the resultant information become useful for other rural/frontier areas facing similar issues.

Outcome Improvement Targets:
Our goal with the right care, right setting emphasis is to do just what is implied but also to reduce unnecessary emergency room visits. As our program begins to provide services to those who thought they would need to go to an emergency room for behavioral health/substance use treatment previously. Individuals will now have a choice to receive telemedicine services in their own community without having to drive to another county. This would both benefit the consumer as well as the emergency departments of Comanche County that are already stretched for resources.

Outcome Measure Valuation:
According to txpricepoint.org, the average cost accounted for just one possibly preventable condition such as psychosis at Brownwood Regional Medical Center (BRMC) located in Brown County is $6,030 a day with a median charge of $14,472. Further research shows the average cost to transport an individual to a local hospital by local EMS services is $655. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, were an officer is on hand, can range from 1 to 3 hours. A law enforcement deputy's average pay can range from $12.50 to $25+ per hour, so in an average situation this would be an additional $30-$75 cost. When multiplied by the average number of preventable situations per year, 24, the total costs for EMS transport and law enforcement time is around $17,000 per year. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services. The given $17,000 is solely an average and our best estimation based on prior experience. The Central Texas MHMR Center dba Center for Life Resources (CFLR)

currently provides behavioral health services for clients with Medicaid, Medicare, private insurance and both uninsured and underinsured clients. CFLR does not currently receive any U.S. Department of Health and Human Services for telemedicine services. Given the data above provided from txpricepoint.org and independent local research found in the rationale section, costs were determined to be roughly $17,000.00 per event. The stated per event cost multiplied by the number of individuals we plan to serve is significant and offers tremendous value through telemedicine. For instance, providing the same 72 encounters we intend to provide in DY4 in the current system would cost over 1.2 million dollars (72 *17,000 =1,224,000). When adding in the additional services in DY5 the costs of provision for just those two years in the current system would be over 2.6 million dollars (84* 17,000 = 1,428,000 + 1,224,000= 2,652,000). Given the total four-year incentive payment of $426,344 the cost savings and value of providing right care in the right setting is a fraction of the cost (16%). It is our belief that our commitment to right care, at the right time, in the right setting offers an alternative option that would greatly improve patient and community care through local access at a comparatively lower cost. We do not believe that the value is limited to just cost savings.
Similar to other projects in our region we also looked at cost utility analysis and quality of adjusted life year (QALY) with respect to the varying level these were valued. Data provided by the Agency of Health Care Research and Quality (AHRQ) gave a range from $50,000 to $200,000 per (QALY) in the United States.
http://www.ahrq.gov/research/iomqrdrreport/futureqrdrapf1.htm

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

Central Texas MHMR Center dba Center for Life Resources 133339505.1.1 (Project 1.11.1) Related Category 3 Outcomes			
133339505.3.1	**IT-9.2**	**IT-9.2 – ED Appropriate Utilization: Reduce Emergency Department visits for target conditions-Behavioral Health/Substance Abuse**	
Central Texas MHMR Center dba Center for Life Resources			**133339505**
Related Category 1 or 2 projects:	133339505.1.1		
Starting Point/Baseline:	**Starting Point/Baseline is TBD for DY2**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Program records, agendas and minutes. **Process Milestone 1 Estimated Incentive Payment: $0** **Process Milestone 2** [P-2]: Establish baseline rate **Data Source:** Anasazi, program records, law enforcement, EMS **Process Milestone 2 Estimated Incentive Payment: $0**	**Process Milestone 3** [P-3]: Develop and test data systems **Data Source**: Anasazi, Program Records, Law Enforcement, EMS **Process Milestone 3 Estimated Incentive Payment: $10,000** **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** QM data reports and Communication documents **Process Milestone 3 Estimated Incentive Payment: $ 9,000**	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization, reduce ED visits for targeted conditions – behavioral health/substance abuse **Improvement Target:** TBD depending on baseline established during DY 2 and confirmed during DY 3. **Data Source:** Anasazi, Program Records, Law Enforcement, and EMS **Process Milestone 3 Estimated Incentive Payment: $22,000**	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization, reduce ED visits for targeted conditions – behavioral health/substance abuse **Improvement Target:** TBD depending on baseline established during DY 2 and confirmed during DY 3. **Data Source:** Anasazi, Program Records, Law Enforcement, and EMS **Estimated Incentive Payment: $43,625**
Year 2 Estimated Outcome Amount:	**Year 3 Estimated Outcome Amount:**	**Year 4 Estimated Outcome Amount:**	**Year 5 Estimated Outcome Amount:**

$0	**$19,000**	**$22,000**	**$43,625**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $84,625			

Category 3 DSRIP Project Narrative
Central Texas MHMR Center dba Center for Life Resources – 133339505.3.2

Outcome Domain: OD-9 Right Care, Right Setting
Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate Utilization (Standalone measure). Reduce Emergency Department visits for target conditions. Target conditions being Behavioral Health/Substance Abuse.
Unique RHP Outcome Identification Number: 133339505.3.2

Title of Category 1 or 2 Project: 133339505.1.2 - Implement technology-assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified providers).
Performing Provider Name: Central Texas MHMR Center dba Center for Life Resources
Performing Provider TPI #: 133339505

Outcome Measure Description:
OD -9 – Right Care, Right Setting
IT-9.2 – ED Appropriate Utilization: Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse.

Process Milestones:

- **DY 2:**
  - P-1 Project planning -engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
  - P-2 Establish baseline rates

- **DY 3:**
  - P-3 Develop and test data systems
  - P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Target for each year:

- **DY 4:**

- IT-9.2 ED appropriate utilization, Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse – Reduction to Baseline to be determined

- **DY 5:**
  - IT-9.2 ED appropriate utilization, Reduce Emergency Department visits for target conditions- Behavioral Health/Substance Abuse Reduction to Baseline to be determined

Rationale:
We chose to use project planning and establishing baselines in DY2 in order to form a solid foundation to measure the change we hope to introduce. In DY3 we will test our conclusions from DY2 and make adjustments in order to better plan, do, study and act. In DY4 and DY5 we will implement what we have learned in the previous years. We expect to see the resultant information become useful for other rural/frontier areas facing similar issues.

Outcome Improvement Targets:
Our goal with the right care, right setting emphasis is to do just what is implied but also to reduce unnecessary emergency room visits. As our program begins to provide services to those who thought they would need to go to an emergency room for behavioral health/substance use treatment previously. Individuals will now have a choice to receive telemedicine services in their own community without having to drive to another county. This would both benefit the consumer as well as the emergency services of Brown and Eastland Counties that are already very stretched for resources.

Outcome Measure Valuation:
According to txpricepoint.org, the average cost accounted for just one possibly preventable condition such as psychosis at Brownwood Regional Medical Center (BRMC) located in Brown County is $6,030 a day with a median charge of $14,472. Further research shows the average cost to transport an individual to a local hospital by local EMS services is $655. The costs of law enforcement officials used in preventable situations also must be measured. The average time that these situations last, were an officer is on hand, can range from 1 to 3 hours. A law enforcement deputy's average pay can range from $12.50 to $25+ per hour, so in an average situation this would be an additional $30-$75 cost. When multiplied by the average number of preventable situations per year, 24, the total costs for EMS transport and law enforcement time is around $17,000 per year. This number may vary from $15,000-$20,000 depending on hours of law enforcement time and travel time for EMS services. The given $17,000 is solely an average and our best estimation based on prior experience. The Central Texas MHMR Center dba Center for Life Resources (CFLR)

currently provides behavioral health services for clients with Medicaid, Medicare, private insurance and both uninsured and underinsured clients. CFLR does not currently receive any U.S. Department of Health and Human Services for telemedicine services. Given the data provided above from txpricepoint.org and independent local research found in the rationale section, costs were determined to be roughly $17,000.00 per event. The stated per event cost multiplied by the number of individuals we plan to serve is significant and offers tremendous value through telemedicine. For instance, providing the same 108 encounters we intend to provide in DY4 in the current system would cost over 1.8 million dollars (108 *17,000 = 1,836,000). When adding in the additional services in DY5 the costs of provision for just those two years in the current system would be over 3.8 million dollars (120* 17,000 = 2,040,000 + 1,836,000= 3,876,000). Given the total four-year incentive payment of $1,853,205 the cost savings and value of providing right care in the right setting is a fraction of the cost (47%). It is our belief that our commitment to right care, at the right time, in the right setting offers an alternative option that would greatly improve patient and community care through local access at a comparatively lower cost. We do not believe that the value is limited to just cost savings.
Similar to other projects in our region we also looked at cost utility analysis and quality of adjusted life year (QALY) with respect to the varying level these were valued. Data provided by the Agency of Health Care Research and Quality (AHRQ) gave a range from $50,000 to $200,000 per (QALY) in the United States. http://www.ahrq.gov/research/iomqrdrreport/futureqrdrapf1.htm

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

Central Texas MHMR Center dba Center for Life Resources 133339505.1.2 (Project 1.11.2) Related Category 3 Outcomes			
133339505.3.2	**IT-9.2**	**IT-9.2 – ED Appropriate Utilization: Reduce Emergency Department visits for target conditions-Behavioral Health/Substance Abuse**	
Central Texas MHMR Center dba Center for Life Resources			**133339505**
Related Category 1 or 2 projects:	133339505.1.2		
Starting Point/Baseline:	**Starting Point/Baseline is TBD for DY2**		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Program records, agendas and minutes. **Process Milestone 1 Estimated Incentive Payment: $0** **Process Milestone 2** [P-2]: Establish baseline rate **Data Source:** Anasazi, program records, law enforcement, EMS **Process Milestone 2 Estimated Incentive Payment: $0**	**Process Milestone 3** [P-3]: Develop and test data systems **Data Source**: Anasazi, Program Records, Law Enforcement, EMS **Process Milestone 3 Estimated Incentive Payment: $25,000** **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** QM data reports and Communication documents **Process Milestone 3 Estimated Incentive Payment: $ 25,000**	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization, reduce ED visits for targeted conditions – behavioral health/substance abuse **Improvement Target:** TBD depending on baseline established during DY 2 and confirmed during DY 3. **Data Source:** Anasazi, Program Records, Law Enforcement, and EMS **Process Milestone 3 Estimated Incentive Payment: $55,000**	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization, reduce ED visits for targeted conditions – behavioral health/substance abuse **Improvement Target:** TBD depending on baseline established during DY 2 and confirmed during DY 3. **Data Source:** Anasazi, Program Records, Law Enforcement, and EMS **Estimated Incentive Payment: $148,000**
Year 2 Estimated Outcome Amount:	**Year 3 Estimated Outcome Amount:**	**Year 4 Estimated Outcome Amount:**	**Year 5 Estimated Outcome Amount:**

$0	**$50,000**	**$55,000**	**$148,000**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over Years 2-5): $253,000			

Category 3: Quality Improvements

IT-2.10: Flu and Pneumonia Admission Rate

Unique Project ID: Old: 281406301.3.1 New 281406301.3.4

Outcome Measure Description:

Percent of all Discharges of age 65 years and older with a principal diagnosis code of flu or pneumonia. Set baseline in DY 2, decrease baseline by 2% in DY 3, decrease baseline by 4% in DY 4, decrease baseline by 6% in DY 5.

Rationale:

Comanche County Medical Center (CCMC) recognizes that patients admitted for flu and pneumonia are one of the most expensive conditions for hospitalization at our facility and in the State (Statistical Brief, TDSHS, May 2011). It is CCMC's goal with it's Category 2 project, "Community immunization Program" to reduce flu and pneumonia hospitalizations as discussed in the Outcome Measure Description above which is expected to prevent or reduce the overall cost for caring for these patients in a hospital inpatient or emergency setting.

According to the RHP 11 Community needs assessment, the high costs associated with preventable hospitalizations admissions and readmissions is rated at the second most priority (CN.2). "According to a recent analysis of THCIC data, RHP 11 received $413,525,403 between 2005 and 2009 for hospitalizations that may have been preventable. The two most costly hospitalizations per county resident were pneumonia ($476 per adult resident) and CHF ($430 per adult resident). These conditions in particular may be focus areas for quality improvement. Provider-specific data regarding volume and other burden to the current healthcare infrastructure may be supplemented here to drive initiatives in these two high-burden conditions." (RHP 11 CNA).

Outcome Measure Valuation:

As described in the narrative and the Outcome Measure Description above, CCMC will develop a baseline (TBD) for the Flu and Admission Rate for the target population in DY2 and its goal is to improve upon the baseline data by 2% each year through DY 5. The cost of these admissions are potentially preventable because if the individual had access and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred. According to the Texas Department of State Health Services December 2010 Statistical Brief, "the mean charge per stay (or per day) was $23,000,"which it CCMC's efforts are successful could avoid such costs related to a hospital stay. CCMC will use local funding through funds generated by the hospital and with funds from the Comanche County Consolidated Hospital District to help support this initiative.

Process Milestones/Outcome Improvement Targets Table for each Category 3 Outcome Measure shall include:

Identifying Outcome and Provider Information:

281406301.2.1, 2.7 Implement Evidence-based Disease Prevention Programs 2.7.6, 281406301.3.1 Category 3 OD-2 Potentially Preventable Admissions, IT-210 Flu and Pneumonia Admission Rate, Comanche County Medical Center/281406501

Starting Point/Baseline (if applicable): Flu and Pneumonia Admission Rate for DY 2 will be calculated as baseline.

Process Milestones/Outcome Improvement Targets:
IT-2.10 Flu and Pneumonia Admission Rate (Standalone Measure)

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: EHR, Claims, Other reports
Rationale/Evidence: Hospitalizations for the Bacterial Pneumonia are
considered "potentially preventable," because if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred. The methodology used to identify "potentially preventable hospitalizations" was developed by the Agency for Healthcare Research and Quality (AHRQ). AHRQ is the lead federal agency responsible for research on healthcare quality costs, outcomes and patient safety.

RHP Planning Protocol Reference: IT-2.10 Flu and Pneumonia Admission Rate (Standalone Measure)

Incentive Payment Amount: Estimated DSRIP funding (maximum DSRIP amount for achieving each process milestone/outcome improvement target) by demonstration year. The process milestone/outcome improvement target DSRIP funding must equal the total DSRIP funding per outcome per demonstration year as indicated in the electronic workbook.

DY 2 - $63,198, DY 3 - $97,674, DY 4 - $130,610, DY 5 - $244,184

Maximum DSRIP thru DY 5 - $535,666

Old: 281406301.3.1 *New: 281406301.3.4*	*IT-2.10*	*Flu and Pneumonia Admission Rate*	
Comanche County Medical Center			*281406301*
Related Category 1 or 2 Projects:	*Old: 281406301.2.1 New: 281406301.2.2*		
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: Flu and Pneumonia Admission Rate [IT-210] Establish Baseline. **Data Source:** EHR, Claims, Other reports **Starting Point/Baseline**: TBD **Process Milestone 1 Estimated Incentive Payment *(maximum amount):*** $63,198	**Outcome Improvement Target 1** [IT-2.1]: **Improvement Target:** Baseline plus 2% **Data Source:** EHR, Claims, other reports **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $97,674	**Outcome Improvement Target 2** [IT-2.1]: **Improvement Target:** Baseline plus 4% **Data Source:** EHR, Claims, Other reports **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $130,610	**Outcome Improvement Target 3** [IT-2.1]: **Improvement Target:** Baseline plus 6% **Data Source:** EHR, Claims, Other reports **Outcome Improvement Target 3 Estimated Incentive Payment*:*** $244,184
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $63,198	Year 3 Estimated Outcome Amount: $97,674	Year 4 Estimated Outcome Amount: $130,610	Year 5 Estimated Outcome Amount: $244,184
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $535,666			

Pass 3b

Category 3: Quality Improvements

OD-6: Patient Satisfaction
Unique Project ID: New: 281406301.3.3; **OLD:** 281406301.3.2

Facility Description: Comanche County Medical Center-281406301

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)

We will set baseline in DY 3, increase baseline by 2% in DY 4, increase baseline by 4% in DY 5.

Rationale:

It is Comanche County Medical Center (CCMC)'s goal to survey all of our clinic patients for improvement of patient satisfaction much like the hospital's patients are already surveyed. The patient surveys will be used in conjunction with our physician recruitment category 1 project to help us better identify the physician and other healthcare needs of the patients we serve. "Patients would much rather their voices be heard than exit out of frustration….we should all work together to hear patients' voices clearly and meet their needs better." (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1116581/).

Outcome Measure Valuation:

Process Milestones/Outcome Improvement Targets Table for each Category 3 Outcome Measure shall include:

Identifying Outcome and Provider Information:

New:281406301.1.2; Old:281406301.1.1, 1.1 Expand Primary Care Capacity 1.1.2 Expand Existing Primary Care Capacity, **New:** 281406301.3.3; **OLD:** 281406301.3.2 Category 3 ID-6 Patient Satisfaction, IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores (all questions), Comanche County Medical Center/281406501

Starting Point/Baseline (if applicable): The survey instrument and method of capture will be developed in DY 2 and the baseline will be developed in DY 3.

Process Milestones/Outcome Improvement Targets:
Process Milestone/Outcome Improvement Targets:

Process Milestone 1 (DY 2): Develop survey and method of capture. IT-6.1 Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a standalone measure). The survey will conform with CG-CAHPS standards.

Numerator: Percent improvement in targeted patient satisfaction domain
Denominator: Number of patients who were administered the survey
Data Source: Patient Survey
Rationale/Evidence: The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patient's perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care by increasing the transparency of the quality of institutional care provided in return for public investment.

A patient survey for the rural health clinic will be developed in DY 2 which will use the adult CG-CAHPS survey questions and add supplemental questions that will be used for targeting other opportunities to improve the care for the patients we serve. "Patients

would much rather their voices be heard than exit out of frustration…we should all work together to hear patient's voices clearly and meet their needs better." (http://ncbi.nlm.nih.gov/pmc/articles/PMC116581/).

Process Milestone 2 (DY 3): Compile survey results to set baseline for improvement. IT-6.1 Percent improvement over baseline of patient satisfaction scores (all question within a survey need to be answered to be a standalone measure)

Numerator: Percent improvement in targeted patient satisfaction domain

Denominator: Number of patients who were administered the survey

Data Source: Patient Survey

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

Once the survey instrument and the method of capture are determined in DY 2, then the baseline will be determined in DY 3 after the new physician is in practice. The baseline and additional information obtained from the survey is expected to help us find ways to increase quality of care through the patient's feedback.

RHP Planning Protocol Reference: IT-6.1 Percent improvement over baseline of patient satisfaction scores (All questions - Standalone Measure)

Incentive Payment Amount: Estimated DSRIP funding (maximum DSRIP amount for achieving each process milestone/outcome improvement target) by demonstration year. The process milestone/outcome improvement target DSRIP funding must equal the total DSRIP funding per outcome per demonstration year as indicated in the electronic workbook.

DY 2 - $30,282, DY 3 - $46,689, DY 4 - $62,632, DY 5 - $116,397

Maximum DSRIP thru DY 5 - $256,000

New: 281406301.3.3; **OLD:** 281406301.3.2	*IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores (all questions)*	
Comanche County Medical Center			*281406301*
Related Category 1 or 2 Projects:	*New:281406301.1.2; Old:281406301.1.1*		
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: Develop survey and method of capture. [IT-6.1] **Starting Point/Baseline:** N/A **Data Source:** Patient Survey **Process Milestone 1 Estimated Incentive Payment *(maximum amount):*** $32,307	**Process Milestone 2:** Compile survey results to set baseline for improvement. [IT-6.1]: **Starting Point/Baseline:** TBD **Data Source:** Patient Survey **Process Milestone 1 Estimated Incentive Payment *(maximum amount):*** $49,990	**Outcome Improvement Target 1** [IT-6.1]: **Improvement Target:** Baseline plus 2% **Data Source:** Patient Survey **Outcome Improvement Target 1 Estimated Incentive Payment*:*** $67,196	**Outcome Improvement Target 2** [IT-6.1]: **Improvement Target:** Baseline plus 4% **Data Source:** Patient Survey **Outcome Improvement Target 2 Estimated Incentive Payment*:*** $124,312
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $32,307	Year 3 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):$ 49,990	Year 4 Estimated Outcome Amount: $67,196	Year 5 Estimated Outcome Amount: $124,312
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $273,805			

Category 3: Quality Improvements

IT-2.2: End-Stage Renal Disease Admission Rate

Unique Project ID: 137074409.3.1

Facility Description: Eastland Memorial Hospital: 137074409

- **Identifying Outcome Measure and Provider Information:** OD-2 Potentially Preventable Admissions, IT-2.2 End-Stage Renal Disease (ESRD) Admission Rate (Standalone measure) New ID:137074409.3.4 Old ID:137074409.3.1 Eastland Memorial Hospital/137074409
- **Outcome Measure Description:** IT-2.2 End-Stage Renal Disease (ESRD) Admission Rate (Standalone measure) has been selected. Eastland Memorial Hospital will spend DY2 and DY3 planning and establishing baselines. Eastland Memorial Hospital will show improvements in DY4 and DY5. DY2: P-1 Project Planning - engage stakeholders, determine current capacity and needed resources, determine timelines and document implementation plans Data Source: Minutes from meeting(s); DY3: P-2 Establish baseline rates Data Source: EMR / Hospital Claims; DY4: Outcome Improvement Target 1 [IT-2.2]: Improvement Target: End-Stage Renal Disease (ESRD) Admission Rate (Standalone) Numerator: All discharges of age 18 years and older with a principal diagnosis code for end stage renal disease Denominator: Discharges in the numerator are assigned to the denominator based on the Metro Are or county of patient residence, not the Metro Area or county of the hospital where the discharge occurred. Data Source: EMR / Hospital Claims – Improvement over baseline to be determined (TBD). DY5: Continue IT-2.2 Improvement Target – Improvement over baseline and DY4 to be determined (TBD)
- **Rationale:** Eastland Memorial Hospital's rationale for choosing IT-2.2 Improvement Target was to relate the compliance of patients receiving outpatient dialysis treatments to fewer admissions for these patients. Patients that are not compliant have been shown to have more admissions and complications. Hospitalization rates are an important indicator of patient morbidity and quality of life. On average, dialysis patients are admitted to the hospital twice a year and hospitalizations account for approximately 36 percent of total Medicare expenditures for dialysis patients (U.S. Renal Data System, 2007). Measures of the frequency of hospitalization help efforts to control escalating medical costs, and play an important role in providing cost effective health care. With the improved access to care, patients have a better opportunity to be compliant.
- **Outcome Measure Valuation:** Valuation was based on the allocated value for the related Category 1 Project – Outpatient Dialysis Center. Also considered was the value of improving the patient's quality of life with fewer admissions to the hospital. Eastland Memorial Hospital is located within a hospital district, but tax revenues are limited and

do not currently cover the financial assistance program offered by the hospital for low-income patients.

New ID:137074409.3.4 *Old ID:137074409.3.1*	*3.IT-2.2*	*End-Stage Renal Disease (ESRD) Admission Rate (Standalone)*	
Eastland Memorial Hospital			*137074409*
Related Category 1 or 2 Projects:	*New ID: 137074409.1.4 Old ID: 137074409.1.1*		
Starting Point/Baseline:	*TBD in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [*P-1*]: Project Planning - engage stakeholders, determine current capacity and needed resources, determine timelines and document implementation plans Data Source: Minutes from meeting(s) Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 74,262	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: EMR / Hospital Claims Numerator: All discharges of age 18 years and older with a principal diagnosis code for end stage renal disease Denominator: Discharges in the numerator are assigned to the denominator based on the Metro Area or county of patient residence, not the Metro Area or county of the hospital where the discharge occurred. Process Milestone 3 Estimated Incentive Payment: $ 111,398	**Outcome Improvement Target 1** [IT-2.2]: End-Stage Renal Disease (ESRD) Admission Rate (Standalone) Improvement Target: Decrease discharges over baseline TBD Numerator: All discharges of age 18 years and older with a principal diagnosis code for end stage renal disease Denominator: Discharges in the numerator are assigned to the denominator based on the Metro Area or county of patient residence, not the Metro Area or county of the hospital where the discharge occurred.	**Outcome Improvement Target 2** [IT-2.2]: End-Stage Renal Disease (ESRD) Admission Rate (Standalone) Improvement Target: Decrease discharges over baseline TBD Numerator: All discharges of age 18 years and older with a principal diagnosis code for end stage renal disease Denominator: Discharges in the numerator are assigned to the denominator based on the Metro Area or county of patient residence, not the Metro Area or county of the hospital where the discharge occurred.

New ID:137074409.3.4 *Old ID:137074409.3.1*	*3.IT-2.2*	*End-Stage Renal Disease (ESRD) Admission Rate (Standalone)*	
Eastland Memorial Hospital			*137074409*
Related Category 1 or 2 Projects:	*New ID: 137074409.1.4 Old ID: 137074409.1.1*		
Starting Point/Baseline:	*TBD in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
		Data Source: EMR / Hospital Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 148,818	Data Source: EMR / Hospital Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 297,700
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 74,262	Year 3 Estimated Outcome Amount: $ 111,398	Year 4 Estimated Outcome Amount: $ 148,818	Year 5 Estimated Outcome Amount: $ 297,700
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $ 632,178			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Category 3: Quality Improvements

IT-9.2: ED Appropriate Utilization-reduce pediatric ED Visits

Unique Project ID: 137074409.3.2

Facility Description: Eastland Memorial Hospital: 137074409

- **Identifying Outcome Measure and Provider Information:** OD-9 Right Care, Right Setting IT-9.2 ED appropriate utilization – reduce pediatric Emergency Department visits (CHIPRA Core Measure) New ID:137074409.3.5 Old ID:137074409.3.2 Eastland Memorial Hospital/137074409
- **Outcome Measure Description:** Eastland Memorial Hospital has selected IT-9.2 ED appropriate utilization (Standalone measure) as the outcome measure. This measure has three options including reduce all ED visits (including ACSC), reduce pediatric Emergency Department visits (CHIPRA Core Measure), and reduce Emergency Department visits for target conditions. Eastland Memorial Hospital selected reduce pediatric Emergency Department visits from these options. DY2: P-1 Project Planning - engage stakeholders, determine current capacity and needed resources, determine timelines and document implementation plans Data Source: Minutes from meeting(s); DY3: P-2 Establish baseline rates Data Source: EMR / Hospital Claims; DY4 and DY5: Outcome Improvement Target 1 [IT-9.2]: Improvement Target: Reduce pediatric Emergency Department visits Numerator: Number of ED visits for patients aged 19 and younger Denominator: Number of ED visits Data Source: EMR / Hospital Claims Improvement over baseline and DY4 TBD
- **Rationale:** With the addition of Otolaryngology (ENT) services in the related Category 1 Project – Expand Surgical Services, Eastland Memorial Hospital plans to reduce pediatric ED visits related to ear infections and issues caused by complications of chronic tonsillitis. By overcoming low-income patient access to care barriers (CN.5), this allows patients to receive preventative surgical treatments that should reduce non-emergent ED visits.
- **Outcome Measure Valuation** Valuation was based on the allocated value for the related Category 1 Project – Expand Surgical Services. Also considered was the value of improving the patient's quality of life with fewer ED visits. Eastland Memorial Hospital is located within a hospital district, but tax revenues are limited and do not currently cover the financial assistance program offered by the hospital for low-income patients. Since the patient base for these services include uninsured and patients insured by CHIP or Medicaid, reducing non-emergent pediatric visits would lower cost of the Eastland Memorial Hospital's financial assistance program and Medicaid cost for ED visits.

New ID:137074409.3.5 *Old ID:137074409.3.2*	*3.IT-9.2*	*ED Appropriate utilization – Reduce pediatric Emergency Department visits*	
Eastland Memorial Hospital			*137074409*
Related Category 1 or 2 Projects:	*New ID: 137074409.1.5 Old ID: 137074409.1.2*		
Starting Point/Baseline:	*TBD in DY3 using DY2 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-1*]: Project Planning - engage stakeholders, determine current capacity and needed resources, determine timelines and document implementation plans Data Source: Minutes from meeting(s) Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 50,254	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: EMR / Hospital Claims Numerator: Number of ED visits for patients aged 19 and younger Denominator: Number of ED visits Process Milestone 3 Estimated Incentive Payment: $ 81,043	**Outcome Improvement Target 1** [IT-9.2]: Reduce pediatric Emergency Department visits Improvement Target: TBD Numerator: Number of ED visits for patients aged 19 and younger Denominator: Number of ED visits Data Source: EMR / Hospital Claims Improvement over baseline TBD Outcome Improvement Target 1 Estimated Incentive Payment*:*	**Outcome Improvement Target 2** [IT-9.2]: Reduce pediatric Emergency Department visits Improvement Target: TBD Numerator: Number of ED visits for patients aged 19 and younger Denominator: Number of ED visits Data Source: EMR / Hospital Claims Improvement over DY4 TBD Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 183,403

New ID:137074409.3.5 *Old ID:137074409.3.2*	*3.IT-9.2*	*ED Appropriate utilization – Reduce pediatric Emergency Department visits*	
Eastland Memorial Hospital			*137074409*
Related Category 1 or 2 Projects:	*New ID: 137074409.1.5 Old ID: 137074409.1.2*		
Starting Point/Baseline:	*TBD in DY3 using DY2 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)**
		$ 108,515	
Year 2 Estimated Outcome Amount: $ 50,254	Year 3 Estimated Outcome Amount: $ 81,043	Year 4 Estimated Outcome Amount: $ 108,515	Year 5 Estimated Outcome Amount: $ 183,403
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 423,215			

Pass 2

Category 3: Quality Improvements

IT-9.2: ED Appropriate Utilization

Unique Project ID: 137074409.3.3

Facility Description: Eastland Memorial Hospital-137074409

Outcome Measure Description:

Eastland Memorial Hospital has selected IT-9.2 ED appropriate utilization (Standalone measure) as the outcome measure. This measure has three options including reduce all ED visits (including ACSC), reduce pediatric Emergency Department visits (CHIPRA Core Measure), and reduce Emergency Department visits for target conditions. Eastland Memorial Hospital selected to reduce all Emergency Department visits from these options. DY2: P-1 Project Planning - engage stakeholders, determine current capacity and needed resources, determine timelines and document implementation plans Data Source: Minutes from meeting(s); DY3: P-2 Establish baseline rates Data Source: EMR / Hospital Claims; DY4 and DY5: Outcome Improvement Target 1 [IT-9.2]: Improvement Target: Reduce all Emergency Department visits Numerator: Number of ED visits Denominator: Not applicable Data Source: EMR / Hospital Claims Improvement over baseline and DY4 TBD.

Rationale:

With the expansion of primary care in Eastland County, non-emergent visits in the ED will be reduced.

Outcome Measure Valuation:

Valuation was based on the allocated value for the related Category 1 Project – Physician Recruitment. Also considered was the value of improving the patient's quality of life with fewer ED visits. Eastland Memorial Hospital is located within a hospital district, but tax revenues are limited and do not currently cover the financial assistance program offered by the hospital for low-income

patients. Since the patient base for these services include uninsured and patients insured by CHIP or Medicaid, reducing non-emergent ED visits would lower cost of the Eastland Memorial Hospital's financial assistance program and Medicaid cost for ED visits.

137074409.3.3	*3.IT-9.2*	*ED Appropriate utilization – Reduce all Emergency Department visits*	
Eastland Memorial Hospital			*137074409*
Related Category 1 or 2 Projects:	*137074409.1.3*		
Starting Point/Baseline:	*TBD in DY3 using DY2 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-1*]: Project Planning - engage stakeholders, determine current capacity and needed resources, determine timelines and document implementation plans Data Source: Minutes from meeting(s) Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 31,348	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: EMR / Hospital Claims Numerator: Number of ED visits Denominator: Not applicable Process Milestone 3 Estimated Incentive Payment: $ 48,506	**Outcome Improvement Target 1** [IT-9.2]: Reduce pediatric Emergency Department visits Improvement Target: TBD Numerator: Number of ED visits Denominator: Not applicable Data Source: EMR / Hospital Claims Improvement over baseline TBD Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 65,200	**Outcome Improvement Target 2** [IT-9.2]: Reduce pediatric Emergency Department visits Improvement Target: TBD Numerator: Number of ED visits Denominator: Not applicable Data Source: EMR / Hospital Claims Improvement over DY4 TBD Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 120,620

137074409.3.3	*3.IT-9.2*	*ED Appropriate utilization – Reduce all Emergency Department visits*	
Eastland Memorial Hospital			*137074409*
Related Category 1 or 2 Projects:	*137074409.1.3*		
Starting Point/Baseline:	*TBD in DY3 using DY2 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)**
Year 2 Estimated Outcome Amount: $ 31,348	Year 3 Estimated Outcome Amount: $ 48,506	Year 4 Estimated Outcome Amount: $ 65,200	Year 5 Estimated Outcome Amount: $ 120,620
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 265,674			

Category 3: Quality Improvements

IT-6.1: Patient Satisfaction

Unique Project ID: New ID: 112692202.3.5/ Old ID: 112692202.3.1

Facility Description: Fisher County Hospital District-112692202

Outcome Measure Description:

Fisher County Hospital District will address the Chronic Disease issues prevalent in our community by utilizing the Chronic Care Model, developed by Ed Wagner with the information and resources from the Institute for Healthcare Improvement. The project will include self-management support, delivery system design, decision support, clinical information systems, organization of health care, and community support.

Our plan focuses on a variety of chronic care issues, specific to our community. Statistical analysis reveals that almost 60% of our patient population has been diagnosed with one or more chronic diseases, including diabetes, hypertension, asthma, arthritis, depression, congestive heart failure, and chronic obstructive pulmonary disease. These same chronic conditions are prevalent in the RHP 11 service area. The integration of the Chronic Care Model and the expansion of access to primary care are consistent with the goals of the RHP 11 plan to transform regional health care.

As more patients are enrolled in our Chronic Care Model, we anticipate that patient satisfaction scores will improve as patients participate in our health education and become more pro-active in the management of their own healthcare. Through our outcome measure, we will document our progress to improve patient satisfaction scores for timeliness of care, appointments and information as we increase access to care and improve management of chronic conditions.

The process milestone for DY02 is devoted to project planning, engaging stakeholders and identifying current capacity and needed resources. During DY03, we will establish a baseline from the first year surveys.

Our outcome measure OD-6-IT-6.1, which measures the percent improvement over baseline of patient satisfaction scores to establish if patients are getting timely care, appointments, and information, will be measured in DY04 and DY05 as follows:

OD-6-IT-6.1: Percent improvement over baseline of patient satisfaction scores to establish if patients are getting timely care, appointments, and information

a. Numerator: Percent improvement in targeted patient satisfaction domain
b. Data source: Patient survey
c. Denominator: Number of patients who were administered the survey

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

The baseline for this outcome measure is currently zero. In DY3, a baseline will be established from the first year surveys. Projected long-term outcomes are:

DY4 – Patient surveys will indicate that at least 75% of patients are getting timely care, appointments, and information.

DY5 - Patient surveys will indicate that a minimum of 80% of patients are getting timely care, appointments, and information.

Our goal is to receive 580 completed surveys per year.

60 percent of our patients have been diagnosed with one or more chronic health illnesses. We can significantly improve our patients' state of health and quality of life through the implementation of the Chronic Care Model. Our long-range goals are to decrease unnecessary emergency room visits and hospital admission while improving the quality of life for our patients.

Rationale/Evidence:

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

One of the challenges we currently face is the ability for patients to obtain timely appointments. The implementation of this outcome improvement measure will help us to monitor and focus on quality improvement in this area.

Outcome Measure Valuation:

Our project will integrate patient satisfaction measures across our continuum of health care services. Local funding for Category 2 will be $408,348 and Category 3 will be $149,143; a total of $557,491 for the complete project, as per the workbook. As our project is fully implemented in DY5, we expect to have achieved a significant transformation in health care delivery. Patients will be more satisfied with care as timeliness to care, appointments and information increases.

A. Size factor: Surveys will be made available to hospital inpatients and outpatients, emergency room patients and to clinic patients. All patients should have the opportunity to participate in the surveys if they choose to do so. During the twelve months ending October 2012, there were 5,771 encounters in our rural health clinic and 1,513 encounters in our emergency department.
B. Project scope: Hospital personnel will be trained in the implementation of patient surveys. These surveys will be made available to patients in our outpatient and inpatient settings as we work to fully integrate health care services in our medically underserved community.
C. Populations served: All patient populations will potentially benefit from the implementation of our patient survey program. We especially hope that feedback from minority populations will increase as patients are given the opportunity to voice their opinions. Surveys will be translated into Spanish for our Hispanic speaking patients. In the time period from November of 2011 until October of 2012, our practitioners had 5,771 encounters in the Clear Fork Health Center. Many of these encounters were provided to Medicaid, uninsured and underinsured patients, our target population.
D. Community benefit: Standardized survey programs are designed to allow objective comparisons among hospitals. Public reporting is designed to create incentives for institutions to improve their quality of care. As a public hospital, one of our core values is to be accountable to our community.
E. Cost avoidance: Timely access to health care and appointments and availability of health information will transform health care delivery into more preventive health care, and timely interventions to medical problems, therefore reducing unnecessary hospital admissions and the total cost of health care.
F. Addressing priority community need: A disproportionate number of our patients are elderly, low-income, and lack a basic understanding of how to access health care or health care information. Implementing the Chronic Care Model and improving access to appointments and health care information will
to appointments and health care information will benefit a great number of our patients.

New ID: 112692202.3.5/ Old ID: 112692202.3.1	***OD-6-IT-6.1***	***Primary Care and Chronic Disease Management/Improvement of patient satisfaction scores***	
Fisher County Hospital District			***112692202***
Related Category 2 Projects:	***New ID: 112692202.2.2/Old ID: 112692202.2.1***		
Starting Point/Baseline: 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)**
P-1. Milestone 1: Project planning, engage stakeholders, identify current capacity and needed resources Data sources: Documentation of strategic planning meetings, appropriate capacity and needs assessments Estimated Incentive Payment: $90,328	**P-2. Milestone 1:** Establish baseline survey numbers from first year surveys conducted DY03 Data sources: CAHPS - Visit surveys Estimated Incentive Payment: $67,549	**Outcome Improvement Target 1** OD-6-IT-6.1: Improvement Target: Improvement over baseline of patient satisfaction scores used to establish if patients are getting timely care, appointments, and information Data sources: CAHPS- Visit surveys Outcome Improvement Target 1 – minimum of 80% of patients will report timely care, appointments and information / Target: 580 surveys year Estimated Incentive Payment:	**Outcome Improvement Target 2** OD-6-IT-6.1: Improvement Target: Improvement over baseline of patient satisfaction scores used to establish if patients are getting timely care, appointments, and information Data sources: CAHPS - Visit surveys Outcome Improvement Target 2 – minimum 85% of patients will report timely care, appointments and information Target: 580 surveys/year Estimated Incentive Payment:

New ID: 112692202.3.5/ Old ID: 112692202.3.1	***OD-6-IT-6.1***	***Primary Care and Chronic Disease Management/Improvement of patient satisfaction scores***	
Fisher County Hospital District			***112692202***
Related Category 2 Projects:	***New ID: 112692202.2.2/Old ID: 112692202.2.1***		
Starting Point/Baseline: 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)**
		$90,328	$168,874
Year 2 Estimated Outcome Amount: (add **incentive** payments amounts from each milestone/outcome improvement target): $43,707	Year 3 Estimated Outcome Amount: $67,549	Year 4 Estimated Outcome Amount: $90,328	Year 5 Estimated Outcome Amount: $168,874
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $370,458			

Pass 2
IT-1.12 Primary Care and Chronic Disease Management – Diabetes Care

Unique Project ID: 112692202.3.2

Facility Description: Fisher County Hospital District-112692202

Outcome Measure Description:

Fisher County Hospital District will specifically work to improve the treatment of diabetic patients and to reduce the incidence of complications due to diabetes. Our overarching goal is to improve access to healthcare by providing the right patient care at the right time and in the right setting. As we work toward our local and regional goals, we will devote more effort to preventive healthcare, and will treat more patients in the primary care setting. Our five-year goal is to not only improve access to health care, but also to improve health outcomes and patient satisfaction among our patients. Unnecessary emergency room care and inpatient care will be reduced, which is consistent with the long-term goals of our Regional Health Plan.

The incidence of diabetes is high in our local service area and throughout the region. Diabetes is the most prevalent chronic diagnosis among our outpatients and clinic patients as well. As we increase access to care, we will be able to devote more resources to preventive care. Our long-term goals are to reduce the secondary complications of diabetes and to improve the health status and satisfaction of our diabetic patients. Costly inpatient care and emergent care will be reduced. These goals are consistent with the efforts of RHP 11 to transform health care in our region.

In DY02, planning will be completed and we will engage stakeholders. Through collaboration and strategic planning, we will identify appropriate capacity and needed resources. Baseline data will be determined in DY03 for the three outcome improvement targets.

The outcome improvement milestones for DY04 and DY05 are:

IT-1.12 Diabetes care: *Retinal eye exam235—NQF 0055*

a Numerator: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

b Denominator: Members 18 to 75 years of age as of December 31 of the

measurement year with diabetes (type 1 and type 2)

c Data Source: EHR, Registry, Claims, Administrative clinical data

d Rationale/Evidence: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

The baseline for this outcome measure is currently zero. The long-term outcome measures are:

DY4 – A minimum of 75% of diabetic patients will be referred for retinal eye exams.

DY5 – A minimum of 80% of diabetic patients will be referred for retinal eye exams.

Rationale/Evidence:

Diabetes is one of the most costly and highly prevalent chronic diseases in our community, our region and across the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars. .

Outcome Measure Valuation:

Our project will improve patient care among our diabetic patients in our hospital, outpatient and clinic settings. Local funding for Pass 2 Category 3 will be $13,147.00, as per the workbook.

A. Size factor: Diabetes is the most prevalent chronic diagnosis among our clinic patients and the leading chronic diagnosis in the outpatient setting. During 2011, we treated 333 diabetic patients in our clinic and had 273 diabetic encounters in the emergency department.
B. Project scope: This project will be implemented across the continuum of our healthcare services, including the clinic, outpatient settings and among inpatients.
C. Populations served: Evidence based protocols will become our standard of care in the treatment of patients diagnosed with diabetes. Diabetes is especially prevalent

among our Hispanic population. Medically indigent patients, Medicaid patients and elderly Medicare patients with the diagnosis of diabetes will be served.

D. Community benefit: Diabetic patients will experience a better quality of life, with fewer diabetic complications.
E. Cost avoidance: Improved management of diabetes will result in better overall health, with fewer diabetic complications. Emergency room visits and unnecessary hospitalizations will be reduced among diabetic patients.
F. Addressing priority community need: Diabetes is one of the most prevalent and malevolent diseases among our local patient population and within the Region 11 Texas Health Partnership.

112692202.3.2	*IT-1.12*	*Diabetes care: Retinal eye exam235—NQF 0055*	
Fisher County Hospital District			*112692202*
Related Category 1 or 2 Projects:	*112692202.1.1*		
Starting Point/Baseline: TBD			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-1. Milestone 1: Project planning, engage stakeholders, identify current capacity and needed resources Data sources: Documentation of strategic planning meetings, appropriate capacity and needs assessments Estimated Incentive Payment: $1,274	**P-2. Milestone 1:** Establish baseline from DY03 improvement data Data sources: EHR, registry, claims, administrative clinical data Estimated Incentive Payment: $2,180	**Outcome Improvement Target 1** IT-1.12 Diabetes care: Retinal eye exam 235 – NQF 0055 Improvement Target: A minimum of 75% of diabetic patients will be referred for eye exam(FY11 – 300 patient encounters) Data sources: EHR, registry, claims Estimated Incentive Payment: $2,508	**Outcome Improvement Target 1** IT-1.12 Diabetes care: Retinal eye exam 235 – NQF 0055 Improvement Target: A minimum of 80% of diabetic patients will be referred for eye exam(FY11 – 300 patient encounters) Data Source: EHR, registry, claims Estimated Incentive Payment: $4,664

112692202.3.2	*IT-1.12*	*Diabetes care: Retinal eye exam235—NQF 0055*	
Fisher County Hospital District			*112692202*
Related Category 1 or 2 Projects:	*112692202.1.1*		
Starting Point/Baseline: TBD			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $1,274	Year 3 Estimated Outcome Amount: $2,180	Year 4 Estimated Outcome Amount: $2,508	Year 5 Estimated Outcome Amount: $4,664
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $10,626			

Pass 2
Category 3: Quality Improvements

IT-1.13: Primary Care and Chronic Disease Management – Diabetes care

Unique Project ID: 112692202.3.3

Facility Description: Fisher County Hospital District 112692202

Outcome Measure Description:

Fisher County Hospital District will specifically work to improve the treatment of diabetic patients and to reduce the incidence of complications due to diabetes. Our overarching goal is to improve access to healthcare by providing the right patient care at the right time and in the right setting. As we work toward our local and regional goals, we will devote more effort to preventive healthcare, and will treat more patients in the primary care setting. Our five-year goal is to not only improve access to health care, but also to improve health outcomes and patient satisfaction among our patients. Unnecessary emergency room care and inpatient care will be reduced, which is consistent with the long-term goals of our Regional Health Plan.

The incidence of diabetes is high in our local service area and throughout the region. Diabetes is the most prevalent chronic diagnosis among our outpatients and clinic patients as well. As we increase access to care, we will be able to devote more resources to preventive care. Our long-term goals are to reduce the secondary complications of diabetes and to improve the health status and satisfaction of our diabetic patients. Costly inpatient care and emergent care will be reduced. These goals are consistent with the efforts of RHP 11 to transform health care in our region.

In DY02, planning will be completed and we will engage stakeholders. Through collaboration and strategic planning, we will identify appropriate capacity and needed resources. Baseline data will be determined in DY03 for the three outcome improvement targets.

The outcome improvement milestones for FY04 and FY05 are:

IT-1.13 Diabetes care: Foot exam-NQF 0056

a Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) during the measurement year.

b Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2).

c Data Source: EHR, Registry, Claims, Administrative clinical data.

d Rationale/Evidence: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

The baseline for this outcome measure is currently zero. The long-term outcome measures are:

DY4 – A minimum of 75% of diabetic patients will be referred for foot exam.

DY5 – A minimum of 80% of diabetic patients will be referred for foot exam.

Rationale/Evidence:

Diabetes is one of the most costly and highly prevalent chronic diseases in our community, our region and across the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars. .

Outcome Measure Valuation:

Our project will improve patient care among our diabetic patients in our hospital, outpatient and clinic settings. Local funding for Pass 2 Category 3 will be $13,147.00, as per the workbook.

A. Size factor: Diabetes is the most prevalent chronic diagnosis among our clinic patients and the leading chronic diagnosis in the outpatient setting. During 2011, we treated 333 diabetic patients in our clinic and had 273 diabetic encounters in the emergency department.
B. Project scope: This project will be implemented across the continuum of our healthcare services, including the clinic, outpatient settings and among inpatients.
C. Populations served: Evidence based protocols will become our standard of care in the treatment of patients diagnosed with diabetes. Diabetes is especially prevalent among our Hispanic population. Medically indigent patients, Medicaid patients and elderly

Medicare patients with the diagnosis of diabetes will be served.

D. Community benefit: Diabetic patients will experience a better quality of life, with fewer diabetic complications.
E. Cost avoidance: Improved management of diabetes will result in better overall health, with fewer diabetic complications. Emergency room visits and unnecessary hospitalizations will be reduced among diabetic patients.
F. Addressing priority community need: Diabetes is one of the most prevalent and malevolent diseases among our local patient population and within the Region 11 Texas Health Partnership

112692202.3.1	***OD-6-IT-6.1***	***Primary Care and Chronic Disease Management/Improvement of patient satisfaction scores***	
Fisher County Hospital District			***112692202***
Related Category 2 Projects:	***112692202.2.1***		
Starting Point/Baseline: 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)**
P-1. Milestone 1: Project planning, engage stakeholders, identify current capacity and needed resources Data sources: Documentation of strategic planning meetings, appropriate capacity and needs assessments Estimated Incentive Payment: $43,706	**P-2. Milestone 1:** Establish baseline survey numbers from first year surveys conducted DY03 Data sources: CAHPS - Visit surveys Estimated Incentive Payment: $67,549	**Outcome Improvement Target 1** OD-6-IT-6.1: Improvement Target: Improvement over baseline of patient satisfaction scores used to establish if patients are getting timely care, appointments, and information Data sources: CAHPS- Visit surveys Outcome Improvement Target 1 – minimum of 80% of patients will report timely care, appointments and information Target: 500 surveys per year Estimated Incentive Payment: $90,327	**Outcome Improvement Target 2** OD-6-IT-6.1: Improvement Target: Improvement over baseline of patient satisfaction scores used to establish if patients are getting timely care, appointments, and information Data sources: CAHPS - Visit surveys Outcome Improvement Target 2 – minimum 85% of patients will report timely care, appointments and information Target: 500 surveys per year Estimated Incentive Payment: $168,873

112692202.3.1	***OD-6-IT-6.1***	***Primary Care and Chronic Disease Management/Improvement of patient satisfaction scores***	
Fisher County Hospital District			***112692202***
Related Category 2 Projects:	***112692202.2.1***		
Starting Point/Baseline: 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)**
Year 2 Estimated Outcome Amount: (add **incentive** payments amounts from each milestone/outcome improvement target): $43,707	Year 3 Estimated Outcome Amount: $67,549	Year 4 Estimated Outcome Amount: $90,327	Year 5 Estimated Outcome Amount: $168,873
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $370,455			

Pass 2

Category 3: Quality Improvements

IT-1.14: Primary Care and Chronic Disease Management – Diabetes care

Unique Project ID: 112692202.3.4

Facility Description: Fisher County Hospital District 112692202

Outcome Measure Description:

Fisher County Hospital District will specifically work to improve the treatment of diabetic patients and to reduce the incidence of complications due to diabetes. Our overarching goal is to improve access to healthcare by providing the right patient care at the right time and in the right setting. As we work toward our local and regional goals, we will devote more effort to preventive healthcare, and will treat more patients in the primary care setting. Our five-year goal is to not only improve access to health care, but also to improve health outcomes and patient satisfaction among our patients. Unnecessary emergency room care and inpatient care will be reduced, which is consistent with the long-term goals of our Regional Health Plan.

The incidence of diabetes is high in our local service area and throughout the region. Diabetes is the most prevalent chronic diagnosis among our outpatients and clinic patients as well. As we increase access to care, we will be able to devote more resources to preventive care. Our long-term goals are to reduce the secondary complications of diabetes and to improve the health status and satisfaction of our diabetic patients. Costly inpatient care and emergent care will be reduced. These goals are consistent with the efforts of RHP 11 to transform health care in our region.

In DY02, planning will be completed and we will engage stakeholders. Through collaboration and strategic planning, we will identify appropriate capacity and needed resources. Baseline data will be determined in DY03 for the three outcome improvement targets.

The outcome improvement milestones for FY04 and FY05 are:

IT-1.14 Diabetes care: *Microalbumin/Nephropathy- NQF 0062*

a Numerator: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.

b Denominator: Patients 18-75 years of age as of December 31 of the measurement

year who had a diagnosis of diabetes (type 1 or type 2).

c Data Source: EHR, Registry, Claims, Administrative clinical data.

d Rationale/Evidence: Diabetes is one of the most costly and highly prevalent chronic diseases in the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars.

The baseline for this outcome measure is currently zero. The long-term outcome measures are:

DY4 – A minimum of 75% of diabetic patients will receive nephropathy screening.

DY5 – A minimum of 80% of diabetic patients will receive nephropathy screening.

Rationale/Evidence:

Diabetes is one of the most costly and highly prevalent chronic diseases in our community, our region and across the United States. Approximately 20.8 million Americans have diabetes, and half these cases are undiagnosed. Complications from the disease cost the country nearly $100 billion annually. In addition, diabetes accounts for nearly 20 percent of all deaths in people over 25 years of age. Many complications, such as amputation, blindness, and kidney failure, can be prevented if detected and addressed in the early stages. Although many people live with diabetes years after diagnosis, it is a costly condition that leads to serious and potentially fatal health complications. Diabetes control can improve the quality of life for millions of Americans and save billions of health care dollars. .

Outcome Measure Valuation:

Our project will improve patient care among our diabetic patients in our hospital, outpatient and clinic settings. Local funding for Pass 2 Category 3 will be $13,147.00, as per the workbook.

A. Size factor: Diabetes is the most prevalent chronic diagnosis among our clinic patients and the leading chronic diagnosis in the outpatient setting. During 2011, we treated 333 diabetic patients in our clinic and had 273 diabetic encounters in the emergency department.
B. Project scope: This project will be implemented across the continuum of our healthcare services, including the clinic, outpatient settings and among inpatients.
C. Populations served: Evidence based protocols will become our standard of care in the treatment of patients diagnosed with diabetes. Diabetes is especially prevalent among

our Hispanic population. Medically indigent patients, Medicaid patients and elderly Medicare patients with the diagnosis of diabetes will be served.

D. Community benefit: Diabetic patients will experience a better quality of life, with fewer diabetic complications.
E. Cost avoidance: Improved management of diabetes will result in better overall health, with fewer diabetic complications. Emergency room visits and unnecessary hospitalizations will be reduced among diabetic patients.
F. Addressing priority community need: Diabetes is one of the most prevalent and malevolent diseases among our local patient population and within the Region 11 Texas Health Partnership.

112692202.3.4	*IT-1.14*	*Diabetes care: Microalbumin/Nephropathy- NQF 0062*	
Fisher County Hospital District			*112692202*
Related Category 1 or 2 Projects:	*112692202.1.1*		
Starting Point/Baseline: TBD			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-1. Milestone 1: Project planning, engage stakeholders, identify current capacity and needed resources Data sources: Documentation of strategic planning meetings, current capacity and needs assessment Estimated Incentive Payment: $1,274	**P-2. Milestone 1:** Establish baseline of IT-1.114 quality improvement Data sources: EHR, registry, claims, administrative clinical data Estimated Incentive Payment: $2,181	**Outcome Improvement Target 3** IT-1.14 Diabetes care: Microalbumin and Nephropathy NQF 0062 Improvement Target: A minimum of 80% of diabetic patients will receive nephropathy screening (FY11 – 300 patient encounters) Data Source: EHR, registry, claims Estimated Incentive Payment: $2,509	**Outcome Improvement Target 3** IT-1.14 Diabetes care: Microalbumin and Nephropathy NQF 0062 Improvement Target: A minimum of 85% of diabetic patients will receive nephropathy screening (FY11 – 300 patient encounters) Data Source: EHR, registry, claims Estimated Incentive Payment: $4,664

112692202.3.4	*IT-1.14*	*Diabetes care: Microalbumin/Nephropathy- NQF 0062*	
Fisher County Hospital District			*112692202*
Related Category 1 or 2 Projects:	*112692202.1.1*		
Starting Point/Baseline: TBD			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $1,274	Year 3 Estimated Outcome Amount: $2,181	Year 4 Estimated Outcome Amount: $2,509	Year 5 Estimated Outcome Amount: $4,664
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $10,628			

Category 3: Quality Improvements

IT-9.2: Reduced ED Visits

Unique Project ID: 0094131202.3.1

Facility Description: Hamlin Memorial Hospital 0094131202

N. Category 3: Quality Improvements

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

Narrative for each Category 3 Outcome Measure shall include:

- The narrative for each Category 3 Outcome Measure is limited to 3 pages.
- **Identifying Outcome Measure and Provider Information**: Right Care Right Setting, OLD 094131202.3.1, NEW 094131202.3.4, Hamlin Memorial Hospital 094131202
- **Outcome Measure Description:** Reduce non-emergent ED visits. Overall increase clinic utilization and decrease non-emergent ED visits by 50% by end of
- **Rationale**: overall plan is to increase the capacity in the primary care clinic by adding an additional provider, thus being able to decrease the usage of ED for non-emergent visits. Right now an average of 65% of ED visits could be seen in another setting
- **Outcome Measure Valuation:** The valuation of the overall project is covered in many areas. First of all, the goal to increase patient visits in the clinic by 20%, with this we will have a decrease of ED visits which helps in many areas.
  - **D.** Reduce the volume thru the ED; this reduces costs to the taxpayers for coving losses at the hospital, a large community benefit.
  - **E.** Wait times in the clinic are less, thus improving patient satisfaction of the overall healthcare organization
  - **F.** Community need and cost avoidance is addressed with the cost being considerably less for a clinic visit versus an ED visit.

OLD 094131202.3.1 *NEW 094131202.3.4*	*094131202.3.IT-9.2*	*Reduce ED Visits*	
Hamlin Memorial Hospital, Expand Existing Primary Care Capacity			*094131202*
Related Category 1 or 2 Projects:	*OLD 094131202.1.1, NEW 094131202.1.3*		
Starting Point/Baseline:	*Current Non Emergent visits at 65% of overall ED visits due to inability to get visits in 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 stakeholder, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: data set from clinic and ED registrations stats Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $7,162 **Process Milestone 2** : P-2 Establish baseline rates Data Source: Clinic visit stats Process Milestone 2 Estimated	**Process Milestone 3** P-5 Disseminate findings, include lessons learned and best practices, to stakeholders Data Source: stats, benchmarking tools Process Milestone 3 Estimated Incentive Payment: $16,604	**Outcome Improvement Target 2** : : IT 9.4 Other outcome Improvement Must be evidence based, appropriate for proposed project, and meet the definition of an outcome measure Numerator: TBD by performing provider Denominator: TBD by performing provider Data source: TBD by performing provider Rationale/Evidence: Rational to include citation, evidence base and significance of target towards intervention	**Outcome Improvement Target 3** : IT 9.4 Other outcome Improvement Must be evidence based, appropriate for proposed project, and meet the definition of an outcome measure Numerator: TBD by performing provider Denominator: TBD by performing provider Data source: TBD by performing provider Rationale/Evidence: Rational to include citation, evidence base and significance of target towards intervention

OLD 094131202.3.1 *NEW 094131202.3.4*	*094131202.3.IT-9.2*	*Reduce ED Visits*	
Hamlin Memorial Hospital, Expand Existing Primary Care Capacity			*094131202*
Related Category 1 or 2 Projects:	*OLD 094131202.1.1, NEW 094131202.1.3*		
Starting Point/Baseline:	*Current Non Emergent visits at 65% of overall ED visits due to inability to get visits in 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)**
Incentive Payment: $7,162 *Add more process milestones/improvement targets, as applicable*		population or community of need Improvement Target: Reduce non emergent ED visits by 25% Outcome Improvement Target 2 Estimated Incentive Payment*:* $26,644	population or community of need Improvement Target: Reduce non emergent ED visits by 25% Outcome Improvement Target 3 Estimated Incentive Payment*:* $63,714
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $14,324	Year 3 Estimated Outcome Amount: $16,604	Year 4 Estimated Outcome Amount: $26,644	Year 5 Estimated Outcome Amount: $63,714
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $121,286			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Pass 2
Category 3: Quality Improvement

IT-6.1: Patient Satisfaction

Unique Project ID: 09413202.3.3

Facility Description: Hamlin Memorial Hospital-0094131202

Category 3: Quality Improvements

- **Narrative for each Category 3 Outcome Measure shall include:**

- **Identifying Outcome Measure and Provider Information** Patient Satisfaction, 094131202.3.3, Hamlin Memorial Hospital 094131202, Improving patient satisfaction.
- **Outcome Measure Description:** create and increase patient satisfaction scores for one or more of the scores by 15%
- **Rationale** increasing the patient satisfaction scores in the area's we are looking at it ensures that we are meeting performance indicator set in CAT 1 plan. The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to
- Produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment. . We, at this time other, than the HCAPS do not do a patient satisfaction survey. We believe that the quality of care of the patients can be improved by completing a patient satisfaction survey. While the HCAPS give us some information it is not did not detail enough nor does it cover enough of our patients across all departments. Patients will be given a scorecard at each visit so we have real-time data to make improvements

- **Outcome Measure Valuation:** The valuation of the overall project is covered in many areas. First of all, the goal to increase overall patient satisfaction by 15%. By creating, increasing and improving the patient satisfaction scores and obtaining data on issues patients are having or what the perceive, we will have real time data on issues that patients are having and to make timely changes thus increasing overall quality of care to all our patients

094131202.3.3	*094131202.3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Hamlin Memorial Hospital, Patient Satisfaction			*094131202*
Related Category 1 or 2 Projects:	*094131202.1.2*		
Starting Point/Baseline:	*Current patient satisfaction scores not at 92% goal*		
Year 2 (10/1/2012 – 9/30/2013)	**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 stakeholder, identify current capacity and needed resources, determine timelines and document implementation plans Improvement Target: establish baseline, create survey since none being done other than HCAPS Data Source: Patient satisfaction surveys Data Source: data set from current QA report and HCAPS, create patient satisfaction process Process Milestone 1 Estimated	**Outcome Improvement Target 1** IT 6.1 Percent improvement over baseline of patient satisfaction scores Improvement Target: Improve usage and dissemination of patient satisfaction surveys. Goal of 75% for patient Satisfaction and HCAPS Data Source: patient satisfaction surveys, HCAPS Outcome Improvement Target 1 Estimated Incentive Payment*:* $4,185	**Outcome Improvement Target 2** IT 6.1 Percent improvement over baseline of patient satisfaction scores Improvement Target: Improve HCAPS and patient satisfaction scores to 85% Data Source: Current HCAPS and Patient Satisfaction Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $6,750	**Outcome Improvement Target 3** IT 6.1 Percent improvement over baseline of patient satisfaction scores Improvement Target: Improve HCAPS scores to 92% or better, Improve patient satisfaction survey results to above 92% Data Source: Current HCAPS, Patient satisfaction surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $15,974

094131202.3.3	*094131202.3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Hamlin Memorial Hospital, Patient Satisfaction			*094131202*
Related Category 1 or 2 Projects:	*094131202.1.2*		
Starting Point/Baseline:	*Current patient satisfaction scores not at 92% goal*		
Year 2 (10/1/2012 – 9/30/2013)	**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):* $3,606			
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $3,606	Year 3 Estimated Outcome Amount: $4,185	Year 4 Estimated Outcome Amount: $6,750	Year 5 Estimated Outcome Amount: $15,974
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $30,515			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Pass 3B

Category 3 Quality Improvements

Patient Satisfaction OD-6

Project Option: IT 6.1 Percent Improvement over baseline of Patient Satisfaction Scores

Facility Description: Haskell Memorial Hospital-112702904

Unique Project ID: New 112702904.3.3
Old 112702904.3.1

- **Outcome Measure Description:**

  Process milestones to be used are (1)P-1 in DY 2-Project planning which will include establishing survey protocols such as number of patients to send survey to, questions to use, process to gather and report information, start date, and reviewing vendors to determine who would be best for our facility to use. Other decisions will be to decide how to use the data both internally and externally and how to use the data to improve patient experiences with the primary care provider for better health outcomes and patient satisfaction. (2) P-2 in DY 3-We will be able to establish our baselines in DY 3 when we have the physician started in his practice and have enough volume to have some baseline results for comparisons in DY 4&5. Outcome measure to be used is IT-6.1-Percent improvement over baseline of patient satisfaction scores. We expect an improved outcome of patient satisfaction scores of 2% in DY 4 over the baseline of DY 3 and 2 % in DY 5 over DY 4. We anticipate a 30 % return of our surveys which will equate to 150 in DY 3, 155 in DY 4, and 159 in DY 5.

- **Rationale:**

  The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The surveys are designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between institutions on domains that are important to consumers. Public reporting of the survey results is designed to create incentives for institutions to improve their quality

of care. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment

- **Outcome Measure Valuation:**

  We have chosen one outcome measure, patient satisfaction, that we believe will be a major determinant in improving patient care and outcomes. Because the survey will include a wide spectrum of questions for the patient to answer, it will assist us in determining where we need to make improvements in the patients care and communication and be able to improve the benefit to the community. In valuing the project the number one issue was addressing the priority community need which in a local needs assessment was additional primary care availability. Recruiting an additional primary care physician will be a community benefit and help serve the 5900 citizens of Haskell County.

  We expect an improved outcome of patient satisfaction scores of 2% in DY 4 over the baseline of DY 3 and 2 % improvement in DY 5 over DY 4. We anticipate a 30 % return of our surveys which will equate to 150 in DY 3, 155 in DY 4, and 159 in DY 5.

New 112702904.3.3 *Old 112702904.3.1*	*3.IT-6.1*	*Patient Satisfaction-Percent Improvement over baseline of patient satisfaction scores*	
Haskell Memorial Hospital			*112702904*
Related Category 1 or 2 Projects:	*New 112702901.1.2 old 112702904.1.1*		
Starting Point/Baseline:	*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: Baseline data will be gathered and patient satisfaction will improve incrementally by 2% each year. Data Source: Survey reporting vendors, management, physicians, Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 24,226	**Process Milestone 2** P- 2 Establish baseline survey numbers from first year surveys Baseline/Goal: Patient satisfaction will increase by 2% each year. Anticipate 150 surveys or 30% of encounter surveys to be returned Data Source: clinic appointment records, initial surveys, vendor reporting sites Process Milestone 2 Estimated Incentive Payment: $28,081	**Outcome Improvement Target 1** IT-6.1 Percent improvement over baseline of patient satisfaction scores (*all questions within a survey need to be answered to be a standalone measure**)*** Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients:	**Outcome Improvement Target 2** IT-6.1 Percent improvement over baseline of patient satisfaction scores (*all questions within a survey need to be answered to be a standalone measur**e)*** 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:

New 112702904.3.3 *Old 112702904.3.1*	*3.IT-6.1*	*Patient Satisfaction-Percent Improvement over baseline of patient satisfaction scores*	
Haskell Memorial Hospital			*112702904*
Related Category 1 or 2 Projects:	*New 112702901.1.2 old 112702904.1.1*		
Starting Point/Baseline:	*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)**
		(1) are getting timely care, appointments, and information; ***(Standalone measure)*** Baseline/Goal: Patient satisfaction will increase by 2% each year. Anticipate 155 surveys or 30% of encounter surveys to be returned Data Source: survey vendor Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 45,060	(1) are getting timely care, appointments, and information; ***(Standalone measure)*** Baseline/Goal: Patient satisfaction will increase by 2% each year. Anticipate 159 surveys or 30% of encounter surveys to be returned Data Source: survey vendor Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 107,753

New 112702904.3.3 *Old 112702904.3.1*	*3.IT-6.1*	*Patient Satisfaction-Percent Improvement over baseline of patient satisfaction scores*	
Haskell Memorial Hospital			*112702904*
Related Category 1 or 2 Projects:	*New 112702901.1.2 old 112702904.1.1*		
Starting Point/Baseline:	*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): $ 24,226	Year 3 Estimated Outcome Amount: $ 28,081	Year 4 Estimated Outcome Amount: $ 45,060	Year 5 Estimated Outcome Amount: $ 107,753
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 205,120			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Pass 3B
Category 3 Quality Improvements

3.IT-5.1: Improve Cost Savings

Unique Project ID: New 112702904.3.4
Old 112702904.3.2

Facility Description: Haskell Memorial Hospital 112702904

Outcome Measure Description:

Process milestone to be used is (1) P-1 in DY 2-Project planning which will include (a)indentifying needed resources to include type of CT scanner needed, getting quotes from vendors, getting references on scanners based on our anticipated needs (b) determine timelines- time it will take to install the scanner, what the construction needs will be for housing the scanner, what training will be needed for our employees to operate the scanner (c) document implementation plans to begin the project.

Improvement milestone to be used is IT-5.1-using the cost minimization analysis to show least costly among alternatives that produce equivalent outcomes.

Rationale:

We believe access to quality care and reasonable technology is vital for the health of our community. The overall cost of an episode of care for those patients who are being transported elsewhere for those services is costly. If there was a local option, it would reduce the cost of care and provide faster results and if in the emergency department, it would stop/reduce the burden on EMS for potential emergent transfers for our rural hospital to the urban hospital for CT scans that result in minor treatments that could have been done at our facility if we had the needed imaging equipment. In a recent study of the number of patients transported out of our ED for a cat scan, we have found an average of two per week go by ambulance with an average cost of $600 for the trip to Abilene which equates to **104** patients per year times $600 equal $62400 for just the transportation ED patients. Some of these patients may have to be sent by air which is an even greater cost. This does not take into account the delay of care for the

patient and cost to the family to drive to where the patient is going. We have transported approximately **16 p**atients in the last year that were inpatients in our facility to another facility for CT scan at an estimated transportation cost of $9600. Most of these patients are elderly and the transport is very difficult on them. An estimate from HMH physicians' offices of 10 per month or **120** per year patients are sent to Abilene for CT scans which cause the patient to incur cost for gas and the inconvenience of travel 120 miles round trip. Again, many of these patients are elderly and/or poor and this poses a hardship on them to travel elsewhere for the scan that is needed especially those that are indigent or Medicaid and already have limited financial resources

Outcome Measure Valuation:

We have chosen one outcome measure, conduct cost analysis by the cost minimization method that we believe will be show by using the alternative of providing CT scans locally rather than having to transport patients and wait for outcomes will provide better or equal patient care and access at a much lower cost. The project will encompass all populations in the community requiring a cat scan which was **240** in the past year but could potentially be needed for any of our 5900 residents in the county.

New 112702904.3.4 *Old 112702904.3.2*	*3.IT-5.1*	*Improved cost savings: demonstrate cost savings in care deliver*	
Haskell Memorial Hospital			*112702904*
Related Category 1 or 2 Projects:	*New 112702904.2.2/112702904.2.1*		
Starting Point/Baseline:	*DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 **P- 1** Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Survey reporting vendors, management, physicians,	**Outcome Improvement Target 1** **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	**Outcome Improvement Target 1** **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	**Outcome Improvement Target 1** **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

New 112702904.3.4 *Old 112702904.3.2*	*3.IT-5.1*	*Improved cost savings: demonstrate cost savings in care deliver*	
Haskell Memorial Hospital			*112702904*
Related Category 1 or 2 Projects:	*New 112702904.2.2/112702904.2.1*		
Starting Point/Baseline:	*DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 Estimated Incentive Payment *(maximum amount):* **$25,545**	Baseline will be determined by the # of patients being sent out of town for CT scans and the cost associated versus patients being able to have the test done at HMH Data source: Request for proposals submitted by contractors. Census and financial records, Medicare, Medicaid and other insurance provider cost and EMT records. Rationale/Evidence: Demonstration of improved patient care by faster diagnosis and treatment versus patients having to go by ambulance 60 miles for CT scan which is a less	Baseline: Number of CT scans performed at HMH after CT is installed and which diagnosis would have resulted in possible negative outcomes had the scan been delayed Goal: 240 patients for CT scans Data source: Census and financial records, Medicare, Medicaid and other insurance provider cost and EMT records. Rationale/Evidence: Demonstration of improved patient care by faster diagnosis and treatment versus patients having to go by ambulance 60 miles for CT scan which is a less costly alternative that	Baseline: Number of CT scans performed at HMH after CT is installed and which diagnosis would have resulted in possible negative outcomes had the scan been delayed Goal: 245 patients Data source: Cost reports, census and financial records, Medicare, Medicaid and other insurance provider cost and EMT records Rationale/Evidence: Demonstration of improved patient care by faster diagnosis and treatment versus patients having to go by ambulance 60 miles for CT scan which is a less

New 112702904.3.4 *Old 112702904.3.2*	*3.IT-5.1*	*Improved cost savings: demonstrate cost savings in care deliver*	
Haskell Memorial Hospital			*112702904*
Related Category 1 or 2 Projects:	*New 112702904.2.2/112702904.2.1*		
Starting Point/Baseline:	*DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	costly alternative that produces an equivalent outcome Process Milestone 2 Estimated Incentive Payment: **$39,527**	produces an equivalent outcome Estimated Incentive Payment*:* **$53,131**	costly alternative that produces an equivalent outcome Estimated Incentive Payment*:* **$98,293**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): **$25,545**	Year 3 Estimated Outcome Amount: **$39,527**	Year 4 Estimated Outcome Amount: **$53,131**	Year 5 Estimated Outcome Amount: **$98,293**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $216,496			

Category 3: Quality Improvements

3.IT-12.1: Breast Cancer Screening

Unique Project ID: 138644310.3.1

Facility Description: Hendrick Medical Center- 138644310

Outcome Measure Description:

P-2: Establish Baseline

P-3: Develop and Test Data Systems

OD-12: Primary Care and Primary Prevention.

IT-12.1: Breast Cancer Screening (HEDIS 2012) 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

Rationale:

The selection of this improvement target IT-12.1 will measure our Breast Cancer Screenings. Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

Outcome Measure Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 3 allocation in DY2 of 1,096,296 which is 10% of the total DY2 Pass 1 allocation of 10,962,958.
B. DY3 Outcome measures have been evenly valued based upon a total category 3 allocation in DY3 of 1,270,750 which is 10% of the total DY3 Pass 1 allocation of 12,707,498.
C. DY4 Outcome measures have been evenly valued based upon a total category 3 allocation in DY4 of 2,039,110 which is 15% of the total DY4 Pass 1 allocation of 13,594,068.

D. DY5 Outcome measures have been evenly valued based upon a total category 3 allocation in DY5 of 4,876,133 which is 33% of the total DY5 Pass 1 allocation of 14,776,161.
E. Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

138644310.3.1	*3.IT-12.1]*	*Breast Cancer Screening*	
Hendrick Medical Center			*138644310*
Related Category 1 or 2 Projects::	*138644310.1.1*		
Starting Point/Baseline:	*Baseline will be established in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*P*–2]: Establish Baseline Data Source: Hospital Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount): $73,087*	**Process Milestone 2 [**P-3**]:** Develop and test data systems Data Source: Hospital Documentation Process Milestone 2 Estimated Incentive Payment: $84,716	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening Improvement Target: Increase by 1% above baseline Data Source: Hospital Documentation Outcome Improvement Target 1 Estimated Incentive Payment*: $291,302*	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening Improvement Target: Increase by 2% above baseline Data Source: Hospital Documentation Outcome Improvement Target 2 Estimated Incentive Payment*: $696,592*
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $73,087	Year 3 Estimated Outcome Amount: $84,716	Year 4 Estimated Outcome Amount: $291,302	Year 5 Estimated Outcome Amount: $696,592
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,145,697			

Category 3: Quality Improvements

3.IT-12.1: Cervical Cancer Screening

Unique Project ID: 138644310.3.2

Facility Description: Hendrick Medical Center- 138644310

Outcome Measure Description:

P-2: Establish Baseline

P-3: Develop and Test Data Systems

OD-12: Primary Care and Primary Prevention.

IT-12.2: Cervical Cancer Screening. Numerator: Number of women aged 21 to 64 that have received a PAP in the measurement year or two prior years. Denominator: Women aged 21 to 64 in the patient or target population. Women who have had a complete hysterectomy with no residual cervix are excluded.

Rationale:

The selection of this improvement target IT-12.2 will measure our Cervical Cancer Screenings. Screening for cancer implies testing for early stages of disease before symptoms occur. It involves application of an early detection test to a large number of apparently healthy people to identify those having unrecognized cancer. People with positive screening tests are subsequently investigated with diagnostic tests and those with confirmed disease are offered appropriate treatment and follow-up. The objective of screening is to reduce incidence of and/or death from cancer by detecting early preclinical disease when treatment may be easier and more effective than for advanced cancer diagnosed after the symptoms occur. It is important to evaluate the efficacy of a given screening approach to reduce disease burden, harm and cost, as well as its overall cost-effectiveness, before it is considered for widespread implementation in large population settings. The only justification for a screening program is early diagnosis that leads to a cost-effective and significant reduction in disease burden.

Outcome Measure Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 3 allocation in DY2 of 1,096,296 which is 10% of the total DY2 Pass 1 allocation of 10,962,958.
B. DY3 Outcome measures have been evenly valued based upon a total category 3 allocation in DY3 of 1,270,750 which is 10% of the total DY3 Pass 1 allocation of 12,707,498.
C. DY4 Outcome measures have been evenly valued based upon a total category 3 allocation in DY4 of 2,039,110 which is 15% of the total DY4 Pass 1 allocation of 13,594,068.

D. DY5 Outcome measures have been evenly valued based upon a total category 3 allocation in DY5 of 4,876,133 which is 33% of the total DY5 Pass 1 allocation of 14,776,161.
E. Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

138644310.3.2	*3.IT-12.2*	*Cervical Cancer Screening*	
Hendrick Medical Center			*138644310*
Related Category 1 or 2 Projects::	*138644310.1.1*		
Starting Point/Baseline:	*Baseline will be established in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*P*–2]: Establish Baseline Data Source: Hospital Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount): $73,086*	**Process Milestone 2 [**P-3**]:** Develop and test data systems Data Source: Hospital Documentation Process Milestone 2 Estimated Incentive Payment: $84,716	**Outcome Improvement Target 1** [IT-12.2]: Cervical Cancer Screening. Improvement Target: Increase by 1% compared to baseline. Data Source: Hospital Documentation Outcome Improvement Target 1 Estimated Incentive Payment*: $291,302*	**Outcome Improvement Target 2** [IT-12.2]: Cervical Cancer Screening. Improvement Target: Increase by 2% compared to baseline. Data Source: Hospital Documentation Outcome Improvement Target 2 Estimated Incentive Payment*: $696,591*
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $73,086	Year 3 Estimated Outcome Amount: $84,716	Year 4 Estimated Outcome Amount: $291,302	Year 5 Estimated Outcome Amount: $696,591
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,145,695			

Category 3: Quality Improvements

Project Option IT-12.4: Pneumonia Vaccination for Adult

Unique Project ID: 138644310.3.3

Facility Description: Hendrick Medical Center-138644310

Outcome Measure Description:

P-2: Establish Baseline

P-3: Develop and Test Data Systems

OD-12: Primary Care and Primary Prevention.

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 aged 64 and older in the patient or target population.

Rationale:

The selection of this improvement target IT-12.4 will measure the pneumonia vaccination recipients within the primary care clinic. This will help keep patients healthy and will prevent pneumonia from occurring in already sick patients.

Outcome Measure Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 3 allocation in DY2 of 1,096,296 which is 10% of the total DY2 Pass 1 allocation of 10,962,958.

B. DY3 Outcome measures have been evenly valued based upon a total category 3 allocation in DY3 of 1,270,750 which is 10% of the total DY3 Pass 1 allocation of 12,707,498.

C. DY4 Outcome measures have been evenly valued based upon a total category 3 allocation in DY4 of 2,039,110 which is 15% of the total DY4 Pass 1 allocation of 13,594,068.

D. DY5 Outcome measures have been evenly valued based upon a total category 3 allocation in DY5 of 4,876,133 which is 33% of the total DY5 Pass 1 allocation of 14,776,161.

Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other

outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

138644310.3.3	*3.IT-12.4*	*Pneumonia Vaccination*	
Hendrick Medical Center			*138644310*
Related Category 1 or 2 Projects::	*138644310.1.1*		
Starting Point/Baseline:	*Baseline will be established in DY2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*P*–2]: Establish Baseline Data Source: Hospital Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount): $73,086*	**Process Milestone 2 [**P-3**]:** Develop and test data systems Data Source: Hospital Documentation Process Milestone 2 Estimated Incentive Payment: $84,716	**Outcome Improvement Target 1** [IT-12.4]: Pneumonia vaccination status for older adults. Improvement Target: Increase by 1% compared to baseline. Data Source: Hospital Documentation Outcome Improvement Target 1 Estimated Incentive Payment*: $291,301*	**Outcome Improvement Target 2** [IT-12.4]: pneumonia vaccination status for older adults. Improvement Target: Increase by 2% compared to baseline. Data Source: Hospital Documentation Outcome Improvement Target 2 Estimated Incentive Payment*: $696,591*
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $73,086	Year 3 Estimated Outcome Amount: $84,716	Year 4 Estimated Outcome Amount: $291,301	Year 5 Estimated Outcome Amount: $696,591
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,145,694			

Category 3: Quality Improvements

IT-9.2: Reduce Emergency Department Visits for Diabetes

Unique Project ID: 138644310.3.4

Facility Description: Hendrick Medical Center-138644310

Outcome Measure Description:

P-1: Project Planning
P-2: Establish Baseline
OD-9: Appropriate Utilization.
IT-9.2: Reduce Emergency Department visits for Diabetes.

Rationale:

The reasoning behind the selection of the Process milestones is because we will conduct project planning in DY 2 and establish our baseline in DY 3 and that will give us the ability to report on the ED appropriate utilization in DY's 4 & 5. The ED appropriate utilization milestone was chosen because the goal of expanding the medical care mission is to alleviate the burden from the emergency department and this will measure that alleviation.

Outcome Measure Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 3 allocation in DY2 of 1,096,295 which is 10% of the total DY2 Pass 1 allocation of 10,962,958.
B. DY3 Outcome measures have been evenly valued based upon a total category 3 allocation in DY3 of 1,270,748 which is 10% of the total DY3 Pass 1 allocation of 12,707,498.
C. DY4 Outcome measures have been evenly valued based upon a total category 3 allocation in DY4 of 2,039,109 which is 15% of the total DY4 Pass 1 allocation of 13,594,068.
D. DY5 Outcome measures have been evenly valued based upon a total category 3 allocation in DY5 of 4,876,134 which is 33% of the total DY5 Pass 1 allocation of 14,776,161.

Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other

outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

138644310.3.4	*3.IT-9.2*	*Reduce ED visits*	
Hendrick Medical Center			*138644310*
Related Category 1 or 2 Projects:	*138644310.2.1*		
Starting Point/Baseline:	*Baseline will be established in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P–1]:Project Planning . Data Source: Hospital Documentation. Process Milestone 1 Estimated Incentive Payment *(maximum amount): $219,259*	**Process Milestone 2 [**P-2**]: Establish Baseline Rates.** . Data Source: Hospital Documentation Process Milestone 2 Estimated Incentive Payment: $254,150	**Outcome Improvement Target 3** [IT-9.2]: Reduce emergency department visits for diabetes Improvement Target: Decrease by 1% compared to baseline. Data Source: EHR, Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $291,301	**Outcome Improvement Target 4** [IT-9.2]: Reduce emergency department visits for diabetes Improvement Target: Decrease by 2% compared to baseline. Data Source: EHR, Claims Outcome Improvement Target 4 Estimated Incentive Payment*:* $696,590
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $219,259	Year 3 Estimated Outcome Amount: $254,150	Year 4 Estimated Outcome Amount: $291,301	Year 5 Estimated Outcome Amount: $696,590
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,461,300			

Category 3: Quality Improvements

Option IT-2.13: Visits with Cellulitis

Unique Project ID: 138644310.3.5

Facility Description: Hendrick Medical Center-138644310

Outcome Measure Description:

P-1: Project Planning
P-2: Establish Baseline Rates
OD-2: Potentially Preventable Admissions.
IT-2.13: Numerator: Total number of Outpatient visits for Cellulitis conditions under age 75 years. Denominator: Total years population under age 75. (Exclusions: Individuals 75 years of age and older. Death before discharge.)

Rationale:

The process milestones were selected because this particular plan established a baseline in 2011 of 209 patients. But we will conduct project planning for this project in DY2 and will reestablish a baseline in DY3 which will essentially compare baselines. The improvement targets will be assessing the potentially preventable admissions in regards to cellulitis patients. The goal of the cellulitis program is to reduce the cellulitis admissions and treat them on an outpatient basis. This process milestone is the best measurement for that.

Outcome Measure Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 3 allocation in DY2 of 1,096,295 which is 10% of the total DY2 Pass 1 allocation of 10,962,958.
B. DY3 Outcome measures have been evenly valued based upon a total category 3 allocation in DY3 of 1,270,748 which is 10% of the total DY3 Pass 1 allocation of 12,707,498.
C. DY4 Outcome measures have been evenly valued based upon a total category 3 allocation in DY4 of 2,039,109 which is 15% of the total DY4 Pass 1 allocation of 13,594,068.
D. DY5 Outcome measures have been evenly valued based upon a total category 3 allocation in DY5 of 4,876,134 which is 33% of the total DY5 Pass 1 allocation of 14,776,161.

Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest

in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

138644310.3.5	*3.IT-2.13*	*Other Admission Rate*	
Hendrick Medical Center			*138644310*
Related Category 1 or 2 Projects::	*138644310.2.2*		
Starting Point/Baseline:	*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. Data Source: Hospital Documentation. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $219,259	**Process Milestone 2 [**P-2**]:** Establish baseline rates. Data Source: Hospital Documentation Process Milestone 2 Estimated Incentive Payment: $254,150	**Outcome Improvement Target 3** [IT-2.13]: Other admissions rate (Cellulitis) Improvement Target: Decrease by 1% compared to baseline. Data Source: EMR, Claims, IQR/NHSN data. Outcome Improvement Target 3 Estimated Incentive Payment*:* $291,301	**Outcome Improvement Target 4** [IT-2.13]: Other admissions rate (Cellulitis) Improvement Target: Decrease by 2% compared to baseline. Data Source: EMR, Claims, IQR/NHSN data. Outcome Improvement Target 4 Estimated Incentive Payment*:* $696,590
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $219,259	Year 3 Estimated Outcome Amount: $254,150	Year 4 Estimated Outcome Amount: $291,301	Year 5 Estimated Outcome Amount: $696,590
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,461,300			

Category 3: Quality Improvements

IT-13.4: Admits to ICU-last 30 days

Unique Project ID: 138644310.3.6

Facility Description: Hendrick Medical Center:-138644310

Outcome Measure Description:

P-1: Project Planning
P-2: Establish Baseline Rates
OD-13: Palliative Care.

IT-13.4: Proportion admitted to the ICU in the last 30 days of life Numerator: Patients who died from cancer and were admitted to the ICU in the last 30 days of life. Denominator: Patients who died from cancer. P-1: Project planning was selected in DY2 and P-2: Establish a baseline rate is selected for DY3.

Rationale:

The process milestones were selected because in DY2 the palliative care program will be planned and a business plan will be written. In DY3 the baseline will be established. The improvement milestone measuring the proportion of patients admitted to the ICU in the last 30 days of life was selected because that is another main purpose of the palliative care program to establish a better quality of life for the patients that need that type of care. Using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflect patient' desires to die at home and to not be connected to machines at the end-of-life. ICU use near the end of life may indicate a lack of discussion about advance directives. ICU care is expensive and uncomfortable, and generally not appropriate for the dying patient.

Outcome Measure Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 3 allocation in DY2 of 1,096,295 which is 10% of the total DY2 Pass 1 allocation of 10,962,958.
B. DY3 Outcome measures have been evenly valued based upon a total category 3 allocation in DY3 of 1,270,748 which is 10% of the total DY3 Pass 1 allocation of 12,707,498.
C. DY4 Outcome measures have been evenly valued based upon a total category 3 allocation in DY4 of 2,039,109 which is 15% of the total DY4 Pass 1 allocation of 13,594,068.
D. DY5 Outcome measures have been evenly valued based upon a total category 3 allocation in DY5 of 4,876,134 which is 33% of the total DY5 Pass 1 allocation of 14,776,161.

Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

138644310.3.6	*3.IT-13.4*	*Proportion admitted to the ICU in the last 30 days of life*	
Hendrick Medical Center			*138644310*
Related Category 1 or 2 Projects::	*138644310.2.3*		
Starting Point/Baseline:	*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 Data Source: Hospital Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $219,259	**Process Milestone 2 [**P-2**]** Establish baseline rates Data Source: Hospital Documentation Process Milestone 2 Estimated Incentive Payment: $254,150	**Outcome Improvement Target 3** [IT-13.4]: Proportion admitted to the ICU in the last 30 days of life. Improvement Target: Decrease by 1% compared to baseline. Data Source: EHR, Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $291,301	**Outcome Improvement Target 4** [IT-13.4]: Proportion admitted to the ICU in the last 30 days of life. Improvement Target: Decrease by 2% compared to baseline. Data Source: EHR, Claims Outcome Improvement Target 4 Estimated Incentive Payment*:* $696,590
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $219,259	Year 3 Estimated Outcome Amount: $254,150	Year 4 Estimated Outcome Amount: $291,301	Year 5 Estimated Outcome Amount: $696,590
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,461,300			

Category 3: Quality Improvements

IT-2.7: Diabetes Short-term Complication Admission Rat

Unique Project ID: 138644310.3.7

Facility Description: Hendrick Medical Center-138644310

Outcome Measure Description:

P-1: Project Planning
P-2: Establish Baseline Rates
OD-2: Potentially Preventable Admissions.
IT-2.7: Diabetes Short Term Complication Admission Rate. All non-maternal/non-neonatal discharges of age 18 years and older with a principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma) Denominator: Population in Metro Area or county, age 18 years and older.

Rationale:

The process milestone of project planning will occur in DY2 and in DY3, the establishment of a baseline will occur. There was a baseline in 2011 of 443 patients that attended the diabetes classes that we currently offer. The additional baseline that will be established in DY 3 will be based on the new implementation/expansion of the new diabetes promotional program. The outcome improvement target is to potentially prevent admissions through measuring the diabetes short term complication admission rate.

Outcome Measure Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 3 allocation in DY2 of 1,096,295 which is 10% of the total DY2 Pass 1 allocation of 10,962,958.
B. DY3 Outcome measures have been evenly valued based upon a total category 3 allocation in DY3 of 1,270,748 which is 10% of the total DY3 Pass 1 allocation of 12,707,498.
C. DY4 Outcome measures have been evenly valued based upon a total category 3 allocation in DY4 of 2,039,109 which is 15% of the total DY4 Pass 1 allocation of 13,594,068
D. DY5 Outcome measures have been evenly valued based upon a total category 3 allocation in DY5 of 4,876,134 which is 33% of the total DY5 Pass 1 allocation of 14,776,161.

Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest

in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit.

138644310.3.7	*3.IT-2.7*	*Diabetes Short Term Complication Rate*	
Hendrick Medical Center			*138644310*
Related Category 1 or 2 Projects::	*138644310.2.4*		
Starting Point/Baseline:	*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 [*RHP PP Process Milestone* –[P-1]: Project Planning Data Source: Hospital Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $219,259	**Process Milestone 2 [**P-2**]** Establish baseline rates. Data Source: Hospital Documentation Process Milestone 2 Estimated Incentive Payment: $254,150	**Outcome Improvement Target 3** [IT-2.7]: Diabetes Short Term Complication Admission Rate. Improvement Target: Decrease by 1% compared to baseline. Data Source: EHR, Claims. Outcome Improvement Target 3 Estimated Incentive Payment*:* $291,301	**Outcome Improvement Target 4** [IT-2.7]: Diabetes Short Term Complication Admission Rate. Improvement Target: Decrease by 2% compared to baseline. Data Source: EHR, Claims. Outcome Improvement Target 4 Estimated Incentive Payment*:* $696,590
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $219,259	Year 3 Estimated Outcome Amount: $254,150	Year 4 Estimated Outcome Amount: $291,301	Year 5 Estimated Outcome Amount: $696,590
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,461,300			

Pass 2
Category 3: Quality Improvements

IT-9.1: Decease in Mental Health Admissions

Unique Project ID: 138644310.3.8

Facility Description: Hendrick Medical Center-138644310

Outcome Measure Description:

P-1: Project Planning
P-2: Establish Baseline Rates
OD-9: Right Care, Right Setting.
IT-9.1: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. Numerator: the number of individuals receiving project intervention(s) that had a potentially preventable admission/readmission to a criminal justice setting (e.g. jail, prison, etc.) within the measurement period. Denominator: The number of individuals receiving project intervention(s).

Rationale:

The process milestone of project planning will occur in DY2, and in DY3 the establishment of a baseline will occur. The reason behind the selection of these milestones is because project planning and the baseline rates have to be established in order to support the outcome improvement target. 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 which can prevent individuals from cycling through the criminal justice system can help avert poor health and mental health outcomes, and reduce long term medical costs and improve functioning.

Outcome Measure Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 3 allocation in DY2 of $374,383 which is 10% of the total DY2 Pass 2 allocation of $3,743,833.
B. DY3 Outcome measures have been evenly valued based upon a total category 3 allocation in DY3 of $434,472 which is 10% of the total DY3 Pass 2 allocation of $4,344,733
C. DY4 Outcome measures have been evenly valued based upon a total category 3 allocation in DY4 of $700,808 which is 15% of the total DY4 Pass 2 allocation of $4,672,056.
D. DY5 Outcome measures have been evenly valued based upon a total category 3 allocation in DY5 of $1,658,292 which is 33% of the total DY5 Pass 2 allocation of $5,025,133.

Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit. Based on the criteria above is the reasoning behind our valuations.

138644310.3.8	*3.IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons*	
Hendrick Medical Center			*138644310*
Related Category 1 or 2 Projects::	*138644310.1.2*		
Starting Point/Baseline:	*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 Data Source: Hospital Documentation Process Milestone 1 Estimated Incentive Payment: $187,191	**Process Milestone 2 [**P-2**]** Establish Baseline Rates Data Source: Hospital Documentation Process Milestone 2 Estimated Incentive Payment: $217,236	**Outcome Improvement Target 1** [IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. Improvement Target: -1% Data Source: Hospital Documentation Outcome Improvement Target 1 Estimated Incentive Payment*:* $350,404	**Outcome Improvement Target 2** [IT-9.1]: Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons. Improvement Target: -2% Data Source: Hospital Documentation Outcome Improvement Target 2 Estimated Incentive Payment*:* $829,146
Year 2 Estimated Outcome Amount: $187,191	Year 3 Estimated Outcome Amount: $217,236	Year 4 Estimated Outcome Amount: $350,404	Year 5 Estimated Outcome Amount: $829,146
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,583,977			

Pass 2
Category 3: Quality Improvements

IT-3.5: Acute Myocardial Infarction Re-admits

Unique Project ID: 138644310.3.9

Facility Description: Hendrick Medical Center-138644310

Outcome Measure Description:

Heart Disease is one of the most serious health problems in Texas and through the implementation of our Cardiac health promotion program, we expect to not only educate the community and increase awareness, but we ultimately expect to reduce readmissions for Acute Myocardial Infarction (AMI) 30 day. The outcome measure that fits this project is the measurement of AMI. This directly relates to the goal of the project.

P-1: Project Planning

P-2: Establish Baseline Rates

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

IT-3.5: Acute Myocardial Infarction (AMI) 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 AMI 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 AMI and with a complete claims history for the 12 months prior to admission.

Rationale:

The process milestone of project planning will occur in DY2, and in DY3 the establishment of a baseline will occur. The reasoning behind the selection of these milestones is because these need to be established in order to support the outcome improvement target. The outcome improvement target is to potentially prevent readmissions through measuring Acute Myocardial Infarction (AMI) 30 day readmission rates.

Outcome Measure Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 3 allocation in DY2 of $374,382 which is 10% of the total DY2 Pass 2 allocation of $3,743,833.

B. DY3 Outcome measures have been evenly valued based upon a total category 3 allocation in DY3 of $434,472 which is 10% of the total DY3 Pass 2 allocation of $4,344,733.

C. DY4 Outcome measures have been evenly valued based upon a total category 3 allocation in DY4 of $700,808 which is 15% of the total DY4 Pass 2 allocation of $4,672,056.

D. DY5 Outcome measures have been evenly valued based upon a total category 3 allocation in DY5 of $1,658,292 which is 33% of the total DY5 Pass 2 allocation of $5,025,133.

Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit. Based on the criteria above is the reasoning behind our valuations.

138644310.3.9	*3.IT-2.1*	*Acute Myocardial Infarction (AMI) 30 day readmission rate*	
Hendrick Medical Center			*138644310*
Related Category 1 or 2 Projects:	*138644310.2.5*		
Starting Point/Baseline:	*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 Data Source: Hospital Documentation Process Milestone 1 Estimated Incentive Payment*:* $187,191	**Process Milestone 2 [**P-2**]** Establish baseline rates. Data Source: Hospital Documentation Process Milestone 2 Estimated Incentive Payment: $217,236	**Outcome Improvement Target 3** [IT-3.5]: Acute Myocardial Infarction (AMI) 30 day readmission rate. Improvement Target: -1% Data Source: EHR, Claims. Outcome Improvement Target 3 Estimated Incentive Payment*:* $350,404	**Outcome Improvement Target 4** [IT-3.5]: Acute Myocardial Infarction (AMI) 30 day readmission rate. Improvement Target: -2% Data Source: EHR, Claims. Outcome Improvement Target 4 Estimated Incentive Payment*:* $829,146
Year 2 Estimated Outcome Amount: $187,191	Year 3 Estimated Outcome Amount: $217,236	Year 4 Estimated Outcome Amount: $350,404	Year 5 Estimated Outcome Amount: $829,146
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,583,977			

Category 3: Quality Improvements

IT-10.1: Quality of Life

Unique Project ID: 127373205.3.1

Facility Description: Helen Farabee Center-127373205

Outcome Measure Description:

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 multi-purpose 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 developmental year 4 is to see improvement in quality of life, comparing assessments at first contact with assessments at 3 months, as measured by the Substance Abuse Adult/Child Treatment Assessment, for 5% of patients Haskell, Knox, and Stonewall counties. 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 the region. 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 room 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[24]. That savings amount was determined based on costs saved from incarceration, hospitalization, emergency department usage, and homelessness.

[24] 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*	
[The Helen Farabee Center]			*[127373205]*
Related Category 1 or 2 Projects:	127373205.1.1		
Starting Point/Baseline:	*0 Substance Abuse services provided outside of Wichita 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: Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 1:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment *(maximum*	**Process Milestone 2:** Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 2:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment *(maximum*	**Outcome Improvement Target 1:** **IT-10.1 Quality of Life-275,276,277 (*Standalone 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*:* $10,515	**Outcome Improvement Target 2:** **IT-10.1 Quality of Life-275,276,277 (*Standalone 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*:* $22,846

127373205.3.1	3.IT-10.1	*Quality of Life*	
[The Helen Farabee Center]			*[127373205]*
Related Category 1 or 2 Projects:	127373205.1.1		
Starting Point/Baseline:	*0 Substance Abuse services provided outside of Wichita 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)**
amount): $4,309 *Add more process milestones/improvement targets, as applicable*	*amount):* $9,835		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $4,309	Year 3 Estimated Outcome Amount: $9,835	Year 4 Estimated Outcome Amount: $10,515	Year 5 Estimated Outcome Amount: $22,846
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $47,505			

Category 3: Quality Improvements

IT-10.1: Quality of Life

Unique Project ID: 127373205.3.2

Facility Description: Helen Farabee Center-127373205

Outcome Measure Description:

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 multi-purpose 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 expected improvement milestone for developmental year 4 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 Haskell, Knox and Stonewall counties. 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 the region. 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. Based on past performance in fiscal year 2012, we estimate demand for psychiatric evaluations to be 914 per year. The result is a valuation of $1,119,344 per year (914 x 0.0245 x $50,000). 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 room visits that are avoided). In order to make the valuations fair across potentially different types of interventions the common health goal, or outcome, is the number of life-years added. 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)[25] 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)[26] 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.

[25] 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.

[26] 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*	
[The Helen Farabee Center]			127373205
Related Category 1 or 2 Projects:	127373205.1.2		
Starting Point/Baseline:	*0 routine on demand psychiatric evaluations in the region 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: Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 1:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 1 Estimated Incentive Payment *(maximum*	**Process Milestone 2:** Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 2:** Submit findings, lessons and best practices to stakeholders a. Numerator: Number of findings, lessons learned and best practices submitted to stakeholders b. Denominator: Number of findings, lessons learned and best practices Data Source: Service Activity Database and Meeting Minutes Process Milestone 2 Estimated Incentive Payment *(maximum*	**Outcome Improvement Target 1:** **IT-10.1 Quality of Life-275,276,277 (*Standalone 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*:* $1,825	**Outcome Improvement Target 2:** **IT-10.1 Quality of Life-275,276,277 (*Standalone 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*:* $3,980

127373205.3.2	3.IT-10.1	*Quality of Life*	
[The Helen Farabee Center]			127373205
Related Category 1 or 2 Projects:	127373205.1.2		
Starting Point/Baseline:	*0 routine on demand psychiatric evaluations in the region 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)**
amount): $666 *Add more process milestones/improvement targets, as applicable*	*amount):* $1,700		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $666	Year 3 Estimated Outcome Amount: $1,700	Year 4 Estimated Outcome Amount: $1,825	Year 5 Estimated Outcome Amount: $3,980
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $8,171			

Category 3: Quality Improvements

IT-6.2: Other Target Improvement-HCAHPS Scores

Unique Project ID: 121053602.3.1

Facility Description: Knox County Hospital-121053602

- **Identifying Outcome Measure and Provider Information**
  IT-6.2 Title of Outcome Measure: Other Outcome Improvement Target: Percent improvement of hospital HCAHPS scores over baseline.
  Unique RHP Outcome ID #: 121053602.3.1
  Performing Provider: Knox County Hospital District
  TPI#: 121053602

- **Outcome Measure Description**
  Other Outcome Improvement Target: Percent improvement of hospital HCAHPS scores over baseline.
  Numerator: Percent improvement in targeted patient satisfaction domain.
  Denominator: Number of patients who were administered the survey
  Data Source: HCAHPS Survey

  The Outcome Measure selected encompasses the entire patient experience and will provide data that indicates the success of every patient encounter by providing the percent of improvement of the hospital HCAHPS scores over baseline.

  HCAHPS scores over the last twelve months indicate a need for a transformation of our culture to improve patient experience which will enable patients to become more engaged and to take responsibility for their health.

  Process milestones have been selected and include the following:

  <u>10/01/2012 – 09/30/2013</u>
  P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

  <u>10/01/2013 – 09/30/2014</u>
  P-3 Develop and test data systems.

  <u>10/01/2014 – 09/30/2015</u>
  IT-6.1 – Percent improvement over baseline of patient satisfaction scores.
  Numerator: Percent improvement in targeted patient satisfaction domain.

Data Source: Patient survey

10/01/2015 – 09/30/2016
IT-6.2 - TBD

- **Rationale**

  This Outcome Measure was selected as it represents the entire patient experience and provides an indication of whether providers and staff members are pro-actively engaging in improvement of patient experience.

  HCAHPS scores over the last twelve months indicate a need for a transformation of our culture to improve patient experience which will enable patients to become more engaged and to take responsibility for their health.

  These process milestones were selected to provide a logical transition from the current culture to a patient experience centered culture. The process will begin with the appointment of a current executive to lead the transformation and will filter throughout the organization. By the end of the waiver, the cultural shift becomes a way of life within the organization and HCAHPS scores under 90% will improve 5% and scores over 90% will improve 2%.

- **Outcome Measure Valuation**

  Knox County Hospital District serves an estimated county population of 3,758. Twenty-one percent are over the age of 65 and 16% live below the poverty level. Improvement to an individual's healthcare relies not only on successful healing, but on offering each and every patient an experience that exceeds all expectations. Valuation will rely on continuous HCAHPS survey results. Improvement in these scores will indicate that providers and staff have embraced the transformation to a customer experience focused organization resulting in patients who are provided with opportunities to understand health issues and treatments and are engaged in their healthcare and lifestyle decisions. Ongoing efforts to ensure patient compliance will empower patients to take control and responsibility of their health and will result in cost avoidance when they are treated before a condition requires the more intensive and costly inpatient setting and will ultimately improve community health.

121053602.3.1		2.4 - Redesign to Improve Patient Experience	
Knox County Hospital			*121053602*
Related Category 1 or 2 Projects:	121053602.2.1		
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: Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Organizational Chart Process Milestone 1 Estimated Incentive Payment - $ 16,782.00	**Process Milestone 3** P3: Develop and test data systems. Data Source: System resources. Process Milestone 3 Estimated Incentive Payment: $ 25,937.00	**Outcome Improvement Target** IT 6.1: Percent improvement over baseline of patient satisfaction scores: Data Source: Patient survey Estimated Incentive Payment: $34,683.00	**Outcome Improvement Target 1** [IT-6.2]: Improvement Target: TBD Data Source: HCACPS Surveys Outcome Improvement Target 3 Estimated Incentive Payment: $64,843.00
Year 2 Estimated Outcome Amount: $16,782.00	Year 3 Estimated Outcome Amount: $ 25,937.00	Year 4 Estimated Outcome Amount: $34,683.00	Year 5 Estimated Outcome Amount: $ 64,843.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 142,245.00			

Add additional outcomes selected by the Performing Provider; repeat tables for every provider participating in Category 1 or 2 projects

Pass 2
Category 3: Quality Improvements

IT-6.1: Patient Satisfaction Scores

Unique Project ID: 121053602.3.2

Facility Description: Knox County Hospital-121053602

Outcome Measure Description

IT-6.1 Percent improvement over baseline of patient satisfaction scores.
Numerator: Percent improvement in targeted patient satisfaction domain
Data Source: Patient survey.
Denominator: Number of patients who were administered the survey

The Outcome Measure selected encompasses indicators related to the redesign of primary care including various modules used to establish if patients are getting timely care, appointments, and information.

Process milestones have been selected and include the following:

Year 2
P-1. Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.
Data Source: Review of systems and resources

Year 3
P-2 Establish baseline data for each: patient appointment 'no-show' rates, days to third-next available appointment, and primary care visit cycle times 101.

Data Source: Scheduling System

Year 4

IT-6.1 Patient Satisfaction
Data Source: Patient Satisfaction Surveys

Year 5

IT-6.1 Improvement Target: TBD
Data Source: Patient Satisfaction Surveys

Rationale

This Outcome Measure was selected as it represents not only the entire patient experience, but provides feedback relating to access of primary care and rates it at a patient's perspective.

Improvement targets are not yet determined, but will be determined in Year 2 for implementation in Year 3.

Outcome Measure Valuation

Knox County Hospital District serves an estimated county population of 3,758. Within its umbrella, the District operates two rural health clinics in which approximately 7,500 patient encounters are recorded annually. Twenty-one percent of our population is over the age of 65 and 16% live below the poverty level. Valuation will rely on continues survey results from clinic employees. Improvement in these scores will indicate that from a patient's perspective, providers and staff have embraced a redesign of primary care that focuses on each patient. When patients are able to see a provider of choice at their convenience with limited wait times, access is improved, continuity of care is increased, and patient no-shows are decreased.

121053602.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction scores.*	
Knox County Hospital District			*121053602*
Related Category 1 or 2 Projects:	*121053602.2.2*		
Starting Point/Baseline:	*TBD in DY 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)**
Process Milestone 1 P-1. Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Review of systems and resources Process Milestone 1 Estimated Incentive Payment (*maximum amount):* $3,380.00	**Process Milestone 2** P-2. Establish baseline rates. Data Source: Patient Surveys Process Milestone 3 Estimated Incentive Payment $3,922	**Outcome Improvement Target 2** IT-6.1 Patient Satisfaction Improvement Target: TBD Data Source: Patient Surveys Outcome Improvement Target 2 Estimated Incentive Payment $4,218	**Outcome Improvement Target 3** IT-6.1 Patient Satisfaction Improvement Target: TBD Data Source: Patient Surveys Outcome Improvement Target 3 Estimated Incentive Payment: $4,537
Year 2 Estimated Outcome Amount: $3,380	Year 3 Estimated Outcome Amount: $3,922	Year 4 Estimated Outcome Amount: $4,217	Year 5 Estimated Outcome Amount: $4,537
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $16,056			

Category 3: Quality Improvements

IT-9.2: ED Appropriate Utilization

Unique Project ID: New 1363251113.3
Old 136325111.3.1

Facility Description: Mitchell County Hospital-136325111

Outcome Measure Description:

Mitchell County Hospital will be replacing one Primary Care Provider (PCP) that we will be losing in December of 2012 and also hiring one additional PCP in an effort to meet the needs of our community in the appropriate setting as identified in our Community Needs Assessment performed in FY 2011. This will meet the criteria set forth in IT 9.2 ED appropriate utilization. By replacing the one (1) PCP that is leaving our Rural Health Clinic (RHP) and with the addition of one (1) additional PCP we will be able to see more patients in the right/appropriate setting. MCHD will track, trend and review the numbers from our clinic in DY 2 as a means of setting our baseline for DY 3. We will utilize our current EMR system as our data source and as the tool to set our baseline based on total number of emergency room visits/non-emergency room visits.

Rationale:

With the additional PCP's in our RHC we will be able to offer more RHC office schedule times for those non emergent patients that currently must visit our emergency department due to the lack of PCP appointment times. We will utilize the DY2 emergency department numbers to set our baseline in DY3

Outcome Measure Valuation:

Valuation is based on the relation to Category 1 Project-Expand Primary Care Capacity. We also are expecting that our patient satisfaction will go up as we are addressing a concern that was expressed in our Community Needs assessment that was completed in FY 2011. With a high patient base in our emergency department that include, but are not limited to uninsured and Medicaid patients that are sometime non emergent we feel we will be able to lower the cost for our patients as well and to alleviate some burden on Mitchell County Hospital's indigent care and Medicaid programs.

New 136325111.3.3 Old 136325111.3.1	IT-9.2	ED appropriate utilization	
Mitchell County Hospital			136325111
Related Category 1 or 2 Projects::	New 136325111.3.2 Old 136325111.3.1		
Starting Point/Baseline:	*TBD in DY3 Using DY2 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-1: [*Insert Project Planning-review data, develop strategy, review resources to indentify any needs and identify and set timelines* Data Source: Project planning documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $63,198	**Process Milestone 2 [P-2]** Develop baseline standards Data Source: Project planning documentation and EMR system Numerator: Number of Emergency Department visits screened to RHC and non emergent emergency department visits Denominator: Total number of Emergency Department visits Process Milestone 2 Estimated Incentive Payment: $97,673	**Outcome Improvement Target 1** [IT-9.2]: ED appropriate utilization Improvement Target: TBD Data Source: EMR Numerator: Number of Emergency Department visits screened to RHC and non emergent emergency department visits Denominator: Total number of Emergency Department visits Outcome Improvement Target 1 Estimated Incentive Payment*:* $130,610	**Outcome Improvement Target 2** [IT-9.2]: ED appropriate utilization Improvement Target: TBD Data Source: EMR Numerator: Number of Emergency Department visits screened to RHC and non emergent emergency department visits Denominator: Total number of Emergency Department visits Outcome Improvement Target 2 Estimated Incentive Payment*:* $244,183
Year 2 Estimated Outcome Amount: $63,198	Year 3 Estimated Outcome Amount: $97,673	Year 4 Estimated Outcome Amount: $130,610	Year 5 Estimated Outcome Amount: $244,183

New 136325111.3.3 Old 136325111.3.1	IT-9.2	ED appropriate utilization	
Mitchell County Hospital			136325111
Related Category 1 or 2 Projects::	New 136325111.3.2 Old 136325111.3.1		
Starting Point/Baseline:	*TBD in DY3 Using DY2 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 *:* $535,664			

Pass 2
Category 3: Quality Improvements

IT-6.1: Patient Satisfaction

Unique Project ID: 136325111.3.2

Facility Description: Mitchell County Hospital-136325111

Outcome Measure Description:

OD-6 Patient Satisfaction, IT-6.1 Percent Improvement over baseline of patient satisfaction scores as the outcome measure for this project including milestones to reduce wait times for Rural Health Care Pri: mary Care Clinic visits and provide a location for a more appropriate and less costly visit for our patients.

Mitchell County Hospital will beginning planning and implementation of a Chronic Care/Urgent Care Clinic that will be located next to our Emergency Department with the goal to appropriately place all patients in both the correct location and level of care needed to move our method of care from acute towards preventive and maintenance of chronic disease processes. Redesigning how we see patient's is expected to streamline RHC visits, reduce Emergency Department visits and place greater focus on the treatment of chronic disease processes.

Rationale:

With the addition of a Chronic/Urgent Care Clinic we will be able to provide more times for chronic care and non emergent patients that currently do not have a place to go for care or must visit our emergency department due to the lack of PCP appointment times. We will utilize the DY2 visit numbers to set our baseline in DY3 & 4

Outcome Measure Valuation:

Valuation is based on the relation to Category 1 Project-Expand Primary Care Capacity. We also are expecting that our patient satisfaction will go up as we are addressing a concern that was expressed in our Community Needs assessment that was completed in FY 2011. With a high patient base in our emergency department that include, but are not limited to uninsured and Medicaid patients that are sometime non emergent we feel we will be able to lower the cost for our patients as well and to alleviate some burden on Mitchell County Hospital's indigent care and Medicaid programs.

136325111.3.2	IT-6.1	**IT-6.1: Patient Satisfaction**	
Mitchell County Hospital			136325111
Related Category 1 or 2 Projects:	136325111.2.1		
Starting Point/Baseline:	*TBD in DY3 Using DY2 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-1: [*Insert Project Planning-review data, develop strategy, review resources to indentify any needs and identify and set timelines* Data Source: Project planning documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $10,607	**Process Milestone 2 [P-2]** Develop baseline standards Data Source: EMR Scheduling System Numerator: Total number of patients seen in the Chronic Care/Urgent Care Clinic Denominator: number of patients screened to the Chronic Care/Urgent Care Clinic from the Emergency Department Process Milestone 2 Estimated Incentive Payment: $12,310	**Outcome Improvement Target 1** [IT-6.1]: Improvement Target: TBD Data Source: Patient satisfaction surveys Numerator: Percent improvement in targeted patient satisfaction domain Denominator: Number of patients who were administered the survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $19,854	**Outcome Improvement Target 2** [IT-6.1]: ED appropriate utilization Improvement Target: TBD Data Source: Patient satisfaction surveys Numerator: Percent improvement in targeted patient satisfaction domain Denominator: Number of patients who were administered the survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $46,983

136325111.3.2	IT-6.1	**IT-6.1: Patient Satisfaction**	
Mitchell County Hospital			136325111
Related Category 1 or 2 Projects:	136325111.2.1		
Starting Point/Baseline:	*TBD in DY3 Using DY2 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)**
Year 2 Estimated Outcome Amount: $10,607	Year 3 Estimated Outcome Amount: $12,310	Year 4 Estimated Outcome Amount: $19,854	Year 5 Estimated Outcome Amount: $46,983
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *:* $89,754			

Category 3: Quality Improvements

IT-9.2: ED Appropriate Utilization

Unique Project ID: 130724106.3.1

Facility Description: Pecan Valley Centers for Behavioral and Developmental Healthcare - 130724106

Outcome Description:

By the end of the waiver, our goal is to have 20% 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. There is one emergency room department in Palo Pinto County. Local law enforcement agencies (police departments and sheriff department) in the county will also be part of the stakeholder discussion.
- In DY3, we will establish a baseline of emergency department utilization for behavioral health and substance abuse. By utilizing the data collection mechanisms developed in DY 2, baseline data will be developed to set standard improvement. The data collection will be for those identified as Pecan Valley individuals assessed through the intake process and how many present at the ED.
- In DY4, our goal is to reduce ED utilization by 10% of the baseline identified in DY 3.
- In DY 5, the project aims to reduce ED utilization contacts by 20% from the established baseline. By meeting this 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.5

Rationale:

Behavioral health conditions, account for increased health care expenditures such as higher rates of potentially preventable inpatient admissions and ED utilization. Texas Medicaid data on potentially preventable inpatient readmissions demonstrates that behavioral health conditions are a significant driver of inpatient costs. People being engaged and receiving services in a more timely manner may result in less admissions the ED because of medication issues, crisis events, as well as decreasing potential law enforcement contacts. The average cost for an emergency room visit is $ 986. Community-based mental health services cost an average of $12 per day for adults and $13 a day for children. This is by far the most cost effective manner to provide local services. After community-based services, State Hospitals are the next line of defense in the public mental health safety net. Compared to the cost of providing community-based services (average of $12-$13 per day), State Hospitals are considerably more expensive, with an average per day cost of $401. The average length of stay in the State Hospital system is 29 days,

meaning that the average cost of a State Hospital stay is $11,629. Mental health and substance abuse conditions comprise 8 percent of initial inpatient readmissions to general acute and specialty inpatient hospitals but represent 24 percent of potentially preventable admissions.[27] According to report by Texas Department of State Health Services, an average of 32% of preventable admissions was individuals with a secondary mental illness diagnosis. According to local ER data, approximately 39% of individuals presenting in one local ER, also have a mental illness.

By improving access to behavioral health services in order for individuals to be seen quicker for those services, the use if the emergency department should decrease as people are getting their behavioral health needs met. By improving access to psychiatric services, there would be a decrease in ED events for medication related issues. The process milestones will be targeted towards establishing a data collection and sharing process to evaluate the use of the emergency room 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 rooms.

Outcome Measure Valuation:

A. **Provider size:** Involves the one mental health clinic in Palo Pinto County that currently operates with 4 staff Monday thru Friday 8am -5pm. Four additional staff are planned as part of the project as well as expanded clinic hours and expanded services.
B. **Project size:** Involves an average of 120 new clients per year coming in for their first psychiatric evaluation with the doctor (10 new clients admitted per month on average for routine services).
C. **Project scope:** An average of 10 new clients are admitted for routine services each month and we propose to provide their initial psychiatric evaluation within 10 days of their first contact at least 60% of the time. The current wait time for psychiatric evaluation is over 30 days. The increased access to psychiatric evaluations will also provided better access for ongoing services for individuals beyond initial eligibility. As a result the full impact of the project could affect all adults receiving mental health services in Palo Pinto County.
D. **Population served:** The population of Palo Pinto County is 28,111 and 16.8% of that population lives at or below the poverty level according to the 2010 Census (Palo Pinto County Profile, The County Information Project, Texas Association of Counties). An average of 272 clients (adults and youth) with severe mental illness have been provided mental health services each month by Pecan Valley Centers since December 2011. The targeted population of this project will those individuals who meet the diagnostic eligibility for services and who require psychiatric services.
E. **Community benefit:** The community will benefit from the improved access to mental health services by providing quicker engagement to services (shorter wait times for the

[27] Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal Year 2010, Texas Health and Human Services Commission (2012)

initial psychiatric evaluation) and by providing expanded services by adding additional mental health providers including a psychiatrist as well as other clinicians. One of the most significant barriers identified in the community assessment was overcoming access barriers to care. The improved access to these services will benefit the community by providing more engagement to behavioral health providers.

F. **Cost avoidance:** The establishment of the open access model will increase capacity and decrease wait times. This will impact both the behavioral health and hospital systems. People being engaged and receiving services in a more timely manner may result in less admissions to the ED, because of medication issues and crisis events. The earlier engagement with individuals will also prevent repeated unnecessary ED visits by following up with referrals and linked services. Community-based mental health services cost an average of $12 per day for adults and $13 a day for children. This is by far the most cost effective manner to provide local services. The average cost for an emergency room visit is $ 986 per event. It is obvious that getting people into community-based mental health services in a timely and efficient manner is the best and most cost-effective method of treatment.

G. **Addressing priority community need:** Palo Pinto County is a rural county and transportation issues are a problem for many making access to mental health services difficult. It is also medically underserved which includes a shortage of mental health providers as well. The RHP 11 Summary of Community Needs, CN.3 stated, "Shortages of health care professionals, including mental health care providers." This project is an attempt to alleviate this shortage by providing 4 additional mental health staff, including a psychiatrist.

H. **Estimated local funding:** Pecan Valley has sufficient local funding in order to make the necessary IGT allocations to fund the 40% of the total allocation.

Related Category 1 and/or 2 projects. Please list the projects linked to this outcome below.

a. 130724106***.1.1-EXPAND SPECIALTY CARE ACCESS***

130724106.*3.1*	*3.IT-9.2*	**ED appropriate utilization *(Standalone measure)***	
Pecan Valley Centers for Behavioral and Developmental Healthcare			130724106
Related Category 1 or 2 Projects:	130724106.*1.1* ***ACCESS REDESIGN TO TARGET QUICKER ACCESS TO PSYCHIATRIC SERVICES***		
Starting Point/Baseline:	*(*Need data from ER 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):* $ 12,291	**Process Milestone 2 [P-2]:** Establish baseline- by utilizing data collections mechanisms developed in DY 2 of Cat 1 project. Data Source: EHR, encounter data and hospital ED utilization Process Milestone 2 Estimated Incentive Payment: $ 28,490	**Outcome Improvement Target 1 [IT-9.2]** Reduce Emergency Department visits for behavioral health/substance abuse Improvement Target: TBD- based upon baseline information since the current number of ER visits is not known. The goal is to decrease the number of ED visits for new Pecan Valley patients by 10% Data Source: Data collection/analysis between PP and ED of local hospitals Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 30,472	**Outcome Improvement Target 2 [IT-9.2]** Reduce Emergency Department visits for behavioral health/substance abuse Improvement Target: TBD TBD based upon baseline information since the current number of ER visits is not known. The goal is to decrease the number of ED visits for new Pecan Valley patients by 20% Data Source: Data collection/analysis between PP and ED of local hospitals Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 66,246

130724106.*3.1*	*3.IT-9.2*	**ED appropriate utilization *(Standalone measure)***	
Pecan Valley Centers for Behavioral and Developmental Healthcare			130724106
Related Category 1 or 2 Projects:	130724106.*1.1* ***ACCESS REDESIGN TO TARGET QUICKER ACCESS TO PSYCHIATRIC SERVICES***		
Starting Point/Baseline:	(Need data from ER 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 12,291	Year 3 Estimated Outcome Amount: $ 28,490	Year 4 Estimated Outcome Amount: $ 30,472	Year 5 Estimated Outcome Amount: $ 66,246
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $ 137,499			

Category 3: Quality Improvements

IT-1.7: Controlling High Blood Pressure

Unique Project ID: Pass 3B, New: 138950412.3.4 (OLD: 138950412.3.1)

Facility Description: Palo Pinto General Hospital-138950412

Outcome Measure Description:

In a grant with Texas A & M School of Medicine, it was determined the #1 health issue in Palo Pinto County is hypertension. By expanding clinic capacity and recruiting additional physician coverage (Project Pass 3B, New: 138950412.1.3 (OLD: 138950412.1.1)), the number of Medicaid, uninsured and underinsured in the community will be able to access primary care in the right setting. Hypertension is a leading cause of preventative death in Palo Pinto County and the right care could be the #1 prevention of preventable hospital admissions, deaths and visits to the ED. When hypertension is caught early, medications and other preventative measures can be administered. Therefore the Outcome selected for this is Controlling High Blood Pressure.

Milestones:

P-2: Establish Baseline

P-3: Develop and Test Data Systems

IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)

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 18-85 years of age as of December 31 of the measurement year with a diagnosis of hypertension.
c. **Data Source:** HER, Registry
d. **Rationale/Evidence:** Approximately 76.4 million (33.5%) of the people in the United States 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; results are particularly striking in elderly people with hypertension, which are more likely to have heart failure. A pool of past clinical trials demonstrated that a 5mm to 6 mm Hg reduction in diastolic blood pressure as associated with a 42 percent reduction in stroke mortality and a 14% to 20% reduction in mortality from coronary heart disease (CHC). 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 USPSTF and the Joint National Committee.

Rationale:

According to the Community Needs Assessment, the community is in great need of PCP's that will be able to monitor and control the high blood pressure. Over 35% of the residents of Palo Pinto County are considered obese.

Because the county has a very high uninsured population and the private primary care physicians do not take Medicaid, it is crucial to the residents that the hospital expand the health clinic to give access to these patients for primary care, i.e. controlling high blood pressure and reduce the patients dependence on the ED as their primary care physician.

Project valuation:

The project valuation was determined by the number of patients using the ED for strokes due to hypertension (approximately 100 per year at an average ED cost of over $800.00 in addition to the patients that require air transports to a higher level of care). The needs of Medicaid, uninsured and under insured patients to treat hypertension is great because the providers in the community do not take these patients and the hospitals clinic is the safety net for these patients. A transformation in the delivery system to change how patients access care and to ensure they can access care at the appropriate setting, time and plan.

Pass 3B, New: 138950412.3.4 (OLD: 138950412.3.1)	*3.IT-1.7*	*Reducing High Blood Pressure*	
Palo Pinto General Hospital			*138950412*
Related Category 1 or 2 Projects:	*138950412 .1.1*		
Starting Point/Baseline:	*Baseline will be established in DY 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)**
Process Milestone 1 (P-2) – Establish baseline, write policies/procedures and implementation plans. Data Source: EHR Baseline/Goal: Determine the approximately 100 patients visiting ED to determine if they are compliant with physician appts and medications. Determine the appropriate software to tract the patients. Process Milestone 1 Estimated Incentive Payment *(maximum amount): $224,645*	**Process Milestone 2 [P-3]** Develop and test data collection. Establish education and training classes. Data Source: EHR Baseline/Goal: Clinics will be held around the county to encourage citizens to get BP readings. If the patient is Medicaid or uninsured, they will be assisted in making physician appts. at the hospital's clinic. Assist any patients with medication needs. Anticipate 1,000 patients by end DY 3.	**Outcome Improvement Target 1** [IT-1.7]: Reducing High Blood Pressure. Improvement Target 1: Decrease baseline by 5%. Data Source: EHR Baseline/Goal: Patients will be treated by a physician. Data collected will be analyzed and documented to determine the progress made against hypertension within the county. Continue to assist patients with medication needs. Anticipate to have an additional 500 patients in hypertension group by DY 4	**Outcome Improvement Target 2** [IT-1.7]: Reducing High Blood Pressure. Improvement Target: Decrease over DY 4 by 8%. Data Source: EHR Baseline/Goal: Continue to encourage, monitor patients progress, hold Region 11 workshops to share information. Continue to treat patients, gather and analyze collected data. Continue to follow patients and their needs. Anticipate to have 2,500 in hypertension group by DY 5.

Pass 3B, New: 138950412.3.4 (OLD: 138950412.3.1)	*3.IT-1.7*	*Reducing High Blood Pressure*	
Palo Pinto General Hospital			*138950412*
Related Category 1 or 2 Projects:	*138950412 .1.1*		
Starting Point/Baseline:	*Baseline will be established in DY 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)**
	Process Milestone 3 Estimated Incentive Payment: $260,392	Outcome Improvement Target 1 Estimated Incentive Payment*:* $417,839	Outcome Improvement Target 2 Estimated Incentive Payment*:* $999,182
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $224,645	Year 3 Estimated Outcome Amount: $260,392	Year 4 Estimated Outcome Amount: $417,839	Year 5 Estimated Outcome Amount: $999,182
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,902,058			

Category 3: Quality Improvements

IT-1.7: Controlling High Blood Pressure

Unique Project ID: Pass 3B, New: 138950412.3.5 (OLD: 138950412.3.2)

Facility Description: Palo Pinto General Hospital-138950412

Project Description:
Low birth weight babies weighing less than 2,500 grams account for almost 8% of the babies born at Palo Pinto General Hospital. These babies usually need to be care flight (approximate cost = $15,000.00) to Cook Children's Hospital for a higher level of care and a long length of stay.
Providing prenatal care through physician intervention and education will decrease the number of low birth weight babies.

Outcome Measure Description:
OD-8 Perinatal Outcomes

d. Numerator: The number of babies born weighing <2,500 grams at birth
e. Denominator: All births
f. Data source: EHR, claims

This Quality improvement supports Project 2.9 in that when mothers are not educated about early intervention when they are pregnant, the outcome is usually preterm births, low birth weight babies and most of these babies are Medicaid or uninsured. Hispanic births account for 22% and 21% are teenagers. If we can educate the students from the 5 – 12 grades about contraceptives and prenatal care, we can reduce the number of low birth weight babies.

Deliveries of mothers between the ages of 13-19 years has increased to 22% of the deliveries at the hospital. According to the Community Needs Assessment (CN.8) unmarried women giving birth is 42.5%. Many of these deliveries are of under weight babies. Twenty-three percent of the underage mothers do not receive prenatal care in the 1st trimester of the pregnancy. Data will be obtained from HER to determine baseline.

Milestones
P-2: Establish baseline and program
P-3: Increase patient engagement and coordinate community resources.

IT-8.2 Percentage of Low Birth-weight births (CHIPRA/NQF # 1382)

a. Numerator: The number of babies born weighing <2,500 grams at birth
b. Denominator: All births
c. Data source: HER, claims
d. Rational/Evidence: IT-8.2 will measure the low birth weight of babies. With the aid of an OB/GYN willing to assist, women, especially those under 19 years of age,

Hispanic, and those uninsured or Medicaid, will be educated on early prenatal care and if not pregnant, will be counseled on birth control.

Rationale:

If the patient population, most vulnerable, can be intervened with at an early age or stage of pregnancy, low birth rates can be reduced.

Project valuation:

The project valuation was determined by the number of pregnant women needing education, and the increasing number of low birth weight babies born at the hospital.

The project valuation was determined by the number of babies (38 per year) born under 2,500 grams and the number of teen mothers not receiving prenatal care before delivery. Medicaid and indigent pregnant women, births and children are the focus. Pregnancies and deliveries are a major cost driver. Healthy baby initiatives seek to encourage pregnant women to carry their baby to full term and seek proper prenatal care, which will reduce costs associated with an emergency delivery. The funds will be used to educate teens and pregnant women on the importance of early prenatal care. Because most of these mothers are Medicaid or indigent, funding will go to education and assisting in the care. Funding will be used to educate the care givers on identifying those most at risk for not receiving early prenatal care.
Each air transport costs approximately $15,000 in addition to the long length of stay at Cook Children's Hospital.

Pass 3B, New: 138950412.3.5 (OLD: 138950412.3.2)	*3.IT-8.2*	*Reduce Low Weight Babies*	
Palo Pinto General Hospital			*138950412*
Related Category 1 or 2 Projects:	*Pass 3B, New: 138950412.2.2 (OLD: 138950412.2.1)*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-2: Establish baseline and program Data Source: TBD Process Milestone 1Estimated Incentive Payment: $20,871	**Process Milestone 2** P-3: Increase patient engagement and coordinate community resources. Data Source: Community and patient events. Process Milestone 1Estimated Incentive Payment*:* $12,096.50 **Outcome Improvement Target 1** [IT-8.2]: Reduce the percentage of low birth weight babies. Improvement Target: Reduce low birth babies by 3%. Data Source: EHR	**Outcome Improvement Target 2** [IT-8.2]: Reduce the percentage of low birth weight babies Improvement Target: Reduce low birth weight babies by 2% over prior year. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $38,821	**Outcome Improvement Target 3** [IT-8.2]: Reduce the percentage of low birth weight babies. Improvement Target: Reduce low birth weight babies by 2% over prior year. Data Source: EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $92,834

Pass 3B, New: 138950412.3.5 (OLD: 138950412.3.2)	*3.IT-8.2*	*Reduce Low Weight Babies*	
Palo Pinto General Hospital			*138950412*
Related Category 1 or 2 Projects:	*Pass 3B, New: 138950412.2.2 (OLD: 138950412.2.1)*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Outcome Improvement Target 1 Estimated Incentive Payment*:* $12,096.50		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $20,871	Year 3 Estimated Outcome Amount: $24,193	Year 4 Estimated Outcome Amount: $38,821	Year 5 Estimated Outcome Amount: $92,834
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $176,719			

Pass 2
Facility Description: Palo Pinto General Hospital-138950412

Category 3: Quality Improvements –Pass 2
IT-9.2: Reducing ED Visits
Unique Project ID: 138950412.3.3

Outcome Measure and Provider Information:

By expanding primary &specialty care services, the citizens in the community will be able to access more care in the right setting and at a lower cost. Due to the lack of primary & specialty physicians (primary care, general surgeon, pediatrician and pulmonologist), patients use the ED for their doctors and usually need to be admitted to the hospital or transported to a higher level of care because their condition was not treated at the onset of their disease.

OD-2 Potentially Preventable Admissions TPI# 138950412.1.2, Palo Pinto General Hospital 138950412**.**

Outcome Measure Description

P-2: Establish Baseline
P-3: Develop and Test Data Systems
P-4: Decrease ED Admissions
P-5: Decrease ED Admissions and Inpatient Admissions

Rationale

Due to the lack of care within the county, all patients presenting to the ED must be transported or care flighted to the metro plex for treatment of acute care illnesses. If care were provided within the county within an appropriate time, this transport would be avoided. Currently, it is almost impossible to transfer Medicaid, uninsured and underinsured patients as tertiary facility do not want to take a patient with these payor sources.

Baseline/Goal:

Reduce admission from ED for specialty care.**IT-9.2 ED Appropriate Utilization**
Reduce all ED visits (including ACSC)
Reduce pediatric Emergency Department visits (CHIPRA Core Measure)
Reduce Emergency Department visits for target conditions

COPD
Asthma
Pediatrics

Data Source: EHR, Registry

Project Valuation:

The project valuation was determined by the data recorded in the ED department, the number of patients seeking treatment that was not ED level visits and those patients that could have been treated early in the disease process but due to the payor, did not have provider in the community that would treat them so that had to go to the ED for treatment. Fifty-five per cent of the 20,000 visits per year do not require ED level treatment. And another 22% could have their disease controlled by a physician in a clinic setting but there are not any in the community that will take the payor source. At a cost of more than $800.00 per visit, a significant savings could be recognized.

138950412.3.3	*3.IT-9.2*	*Reducing ED visits*	
Palo Pinto General Hospital			*138950412*
Related Category 1 or 2 Projects:	138950412.1.2		
Starting Point/Baseline:	*Baseline will be established in DY 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)**
Process Milestone 1 (P-2) – Establish baseline, write policies/procedures and implementation plans. **Rationale:** Due to the lack of specialty care, primary care and providers that do not take Medicaid or uninsured within the county, all patients presenting to the ED must be treated and or transported or care flight to the metro plex for treatment at a higher level. Data Source: EHR Baseline/Goal: With over 20,000 visits per year in the ED, 55% of the patients treated do not require that level of care. At a cost of over $800 per visit, the hospital will be	**Process Milestone 2 [P-3]** Develop and test data collection. Establish education and training classes. Data Source: EHR Baseline/Goal: Reduce admissions from ED by 2% and reduce low level ED visits by 5%. Process Milestone 2 Estimated Incentive Payment: $71,732	**Outcome Improvement Target 1** [IT-9.2]: Reducing ED visits. Improvement Target 1: Decrease baseline by 5%. Data Source: EHR Baseline/Goal: Reduce admission from ED by 2% from prior year and reduce low level ED visits by another 5%. Outcome Improvement Target 1 Estimated Incentive Payment: $115,704	**Outcome Improvement Target 2** [IT-9.2]: Reducing ED visits. Improvement Target 2: Decrease over DY 4 by 5%. Data Source: EHR Baseline/Goal: Reduce admission from ED by 2% from prior year and reduce low level ED visits by another 5%. Outcome Improvement Target 2 Estimated Incentive Payment: $273,785

138950412.3.3	*3.IT-9.2*	*Reducing ED visits*	
Palo Pinto General Hospital			*138950412*
Related Category 1 or 2 Projects:	138950412.1.2		
Starting Point/Baseline:	*Baseline will be established in DY 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)**
recruiting physicians and expanding clinic capacity to treat these patients in a more appropriate setting.			
Year 2 Estimated Outcome Amount: $61,811	Year 3 Estimated Outcome Amount: $71,732	Year 4 Estimated Outcome Amount: $115,704	Year 5 Estimated Outcome Amount: $273,785
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $523,032			

Category 3: Quality Improvements

IT-8.2: Percentage of Low Birth Weight

Unique Project ID: 133244705.3.1

Facility Description: Rolling Plains Memorial Hospital-133244705

O. Category 3: Quality Improvements

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

Narrative for each Category 3 Outcome Measure shall include:

- The narrative for each Category 3 Outcome Measure is limited to 3 pages.

Identifying Outcome Measure and Provider Information:

Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 *(Standalone measure)* IT-8.2; 133244705.3.1, Rolling Plains Memorial Hospital/133244705

- **Outcome Measure Description:** Decrease number of babies with low birth rate to 6% by DY5.

- **Rationale:** Low birth weights result in increased length of stay, increased risk of complications, and future health issues. The ability to provide prenatal care decreases the risk of low birth weight and results in better neonatal outcomes, and positively impacts healthcare costs. Our goal to decrease the low birth rate to 6% will result in more positive outcomes for Mother and baby.

- **Outcome Measure Valuation:** We valued the project at $447,577 based on the following:

  Project Size: We expect to recruit a physician and increase our births to 200 by DY5.

Project Scope: We will improve access to quality labor and delivery services by increasing OB coverage and capacity for deliveries and increasing prenatal capacity services.

Populations Served: This project will provide improved access to pre-natal coverage to all expectant moms, but especially the low income as continuous travel is not an option for them

Community Benefit: Access to quality prenatal and LDR services locally which will reduce unnecessary travel and missed work days while improving the health outcomes for mother and baby.

Cost Avoidance: Low birth weights result in longer lengths of stay in the hospital, and increases the risk for other health issues that could also result in higher health costs. Decreasing the rate of low birth weights will result in significant healthcare cost savings. Per the National Bureau of Economic Research, babies weighing 2000-2100 grams have inpatient charges $10,000 higher than babies weighing at least 2500 grams (5lbs 8ozs). This does not include future costs due to other health issues related to low birth weight.

Priority Community Need: Providing and maintaining quality Obstetrics care has been identified as a need in the community per a Community Needs Analysis performed for Nolan County in 2011.

Local Funding: This project will be funded entirely by the Hospital District.

133244705.3.1	3.IT-8.2	Percentage of Low Birth- weight births	
Rolling Plains Memorial Hospital			*133244705*
Related Category 1 or 2 Projects:	133244705.1.1		
Starting Point/Baseline:	**11.7% low birth weight 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)**
Process Milestone 1 **Milestone 1** P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation <u>Metric 1</u> Documentation of specialty care access plan Baseline/Goal: a. Numerator: 0 if no documentation is provided, 1 if documentation is provided. b. Denominator: NA Data Source: evidence of specialty care access plan Incentive Payment *:* $42,290	**Process Milestone 2** P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans <u>Metric 1</u> Implement specialty care access plan Data Source: Document demonstrating employed or contracted physician Milestone 2 Estimated Incentive Payment: $49,019	**Outcome Improvement Target 1** : IT-8.2 Percentage of Low Birth-weight births (CHIPRA/NQF # 1382)263 *(Standalone measure)* a. Numerator: The number of babies born weighing <2,500 grams at birth b. Denominator: All births c. Data source: EHR, claims Improvement Target: Decrease low birth weight rate to 8%. Outcome Improvement Target 2 Estimated Incentive Payment*:* $78,658	**Outcome Improvement Target 2**: IT-8.2 Percentage of Low Birth-weight births (CHIPRA/NQF # 1382)263 *(Standalone measure)* a. Numerator: The number of babies born weighing <2,500 grams at birth b. Denominator: All births c. Data source: EHR, claims Improvement Target: Decrease low birth weight rate to 6%. Outcome Improvement Target 3 Estimated Incentive Payment*:* $188,096

133244705.3.1	3.IT-8.2	Percentage of Low Birth- weight births	
Rolling Plains Memorial Hospital			*133244705*
Related Category 1 or 2 Projects:	133244705.1.1		
Starting Point/Baseline:	**11.7% low birth weight 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)**
Year 2 Estimated Outcome Amount: $42,290	Year 3 Estimated Outcome Amount: $49,019	Year 4 Estimated Outcome Amount: $78,658	Year 5 Estimated Outcome Amount: $188,096
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**: $358,063***			

Category 3: Quality Improvements

IT-2.10: Flu and Pneumonia Admission Rate

Unique Project ID: 133244705.3.2

Facility Description: Rolling Plains Memorial Hospital-133244705

P. Category 3: Quality Improvements

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

Narrative for each Category 3 Outcome Measure shall include:

- The narrative for each Category 3 Outcome Measure is limited to 3 pages.

  Identifying Outcome Measure and Provider Information: Flu and pneumonia Admission Rate: IT-2.10 *(Standalone measure)* 133244705.3.2, Rolling Plains Memorial Hospital/133244705

- **Outcome Measure Description:** Reduce flu and pneumonia admission rate for population over 18 by 15%, or by 25 admissions, over baseline.

- **Rationale:** Rationale/Evidence: Hospitalizations for the Bacterial Pneumonia are considered "potentially preventable," because if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred. The methodology used to identify "potentially preventable hospitalizations" was developed by the Agency for Healthcare Research and Quality (AHRQ). AHRQ is the lead federal agency responsible for research on healthcare quality costs, outcomes and patient safety.

  Outcome Measure Valuation: We valued the project at $447,577 based on the following:

Project Size: We currently screen and offer flu and pneumonia vaccinations to our patients admitted to the hospital. We plan to expand this to include or Emergency Room population and outside of the hospital at events such as Health Fairs. We expect our from flu and pneumonia admissions rate to decrease by 15%, or 25 admissions, as result of this effort.

Project Scope: We will provide education, publicity, and outreach to increase awareness of the flu and pneumonia vaccination. We also plan to increase the scope of the populations offered the vaccination. Through these preventive measures we expect to prevent hospitalizations and complications related to flu and pneumonia, which will improve patient outcomes and reduce costs.

Populations Served: This measure will reach out to populations over 18 in Nolan County. The populations will include patients seen in the hospital, as well as others reached at events such as health fairs.

Community Benefit: The program will reduce the risk of individuals being infected with flu or pneumonia, resulting in a healthier population and reduced healthcare costs.

Cost Avoidance: DSHS estimated hospital charges in Nolan County related to Bacterial Pneumonia to be $2,170,797 from 2005 - 2010. In 2011, we had 200 admissions related to flu and pneumonia. This represented 1.8% of the population 18 and over. Approximately 75% were Medicare patients and roughly 10% were Medicaid. To project cost avoidance for all payers, which is the basis for DSHS database, we anticipate preventing at least 25 hospitalizations over the next 4 years at an average cost of $10,000 to $12,000 per hospitalization to save at least $250,000 to $300,000 in health care costs.

Community Need: Disease prevention activities will improve our immunization access and rates. The community has less risk of developing flu or pneumonia or complications related to these illnesses, resulting in a healthier population.

Estimated Local Funding: Funding will be by the Hospital District.

133244705.3.2	*3.IT-2.10*	Flu and pneumonia Admission Rate **:** IT-2.10 *(Standalone measure)*	
Rolling Plains Memorial Hospital			*133244705*
Related Category 1 or 2 Projects:	Implement Evidence-based Disease Prevention Programs 133244705.2.1		
Starting Point/Baseline:	*200 Admissions-1.8% of the 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- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Performing Provider evidence of plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $66,958	**Process Milestone 2 Milestone** P- 3 Develop and test data systems Data Source: Data Source: Documentation development and testing Process Milestone 3 Estimated Incentive Payment: $77,614	**Outcome Improvement Target 1** IT-2.1]: 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: E.H.R; Claims Improvement Target: 11% decrease in admission rate, or 15 less admissions than baseline year Estimated Incentive Payment*:* $124,543	**Outcome Improvement Target 2** [IT-2.1 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: E.H.R; Claims Improvement Target: 16% decrease in admission rate, or 25 less admissions than baseline year Estimated Incentive Payment*:* $297,820

133244705.3.2	*3.IT-2.10*	Flu and pneumonia Admission Rate **:** IT-2.10 *(Standalone measure)*	
Rolling Plains Memorial Hospital			*133244705*
Related Category 1 or 2 Projects:	Implement Evidence-based Disease Prevention Programs 133244705.2.1		
Starting Point/Baseline:	*200 Admissions-1.8% of the 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)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $66,958	Year 3 Estimated Outcome Amount: $77,614	Year 4 Estimated Outcome Amount: $124,543	Year 5 Estimated Outcome Amount: $297,820
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $566,935			

Pass 2

Category 3: Quality Improvements

IT-5.1: Improve Cost Savings

Unique Project ID: 133244705.3.3

Facility Description: Rolling Plains Memorial Hospital-133244705

Category 3: Quality Improvements

- **Identifying Outcome Measure and Provider Information:** Improved cost savings: Demonstrate cost savings in care delivery IT-5.1 (*Standalone measure)*133244705.3.3, Rolling Plains Memorial Hospital/133244705
- **Outcome Measure Description:** Show reduction in healthcare costs over for colorectal screenings over baseline year. Goal to TBD after baseline is established in DY 3.. Our milestones chart our progress over the Demonstration Years to finally measure our outcome improvement.
- **Rationale:** As health care costs rise – regulators, policymakers and industry leaders are increasingly interested in developing accurate ways to measure and, ultimately to try to reduce health care costs for individuals, as well as society. Developing cost-of-care measures that can help those who get, give, and pay for care understand how different providers use resources and compare them to national benchmarks was one of the TX HHSC DSRIP project's goals. The Hospital has chosen to target surgical services in measuring costs and ways to improve costs for this particular episode of care. Surgery is one of the most expensive forms of healthcare. The establishment of a cost accounting system will help the Hospital find areas of improvement, resulting in savings to not only the patient, but third party payors, including Medicare and Medicaid payors. The Hospital has a related plan of increasing colorectal screenings. Cost savings in this area will make the screening more affordable, resulting in increased screenings, and thus prevention of more costly cancer treatment.

  Outcome Measure Valuation: We value this project at $232,734 based on the following:

Size: This project will encompass every area of the hospital, whether revenue producing or non revenue producing. Determining the best method to measure cost savings will require a great deal of research, education, and decision making.

Project Scope: We expect to hire a consultant, purchase a cost accounting system, and possibly add an FTE in finance to accomplish this objective. This project will encompass all areas of the hospital and require a significant amount of coordination and input from all hospital departments.

Populations Served: Cost savings will benefit not only all hospital patients, third party payors, and taxpayers of Nolan County as well, who could see potential tax savings if the tax burden can be decreased due to the cost savings.

Community Benefit: Lower healthcare costs result in less dollars being expended by private and public third party payors, more affordable care for those without insurance, and lower tax burden for all citizens of the Hospital District. The potential for reducing costs in colorectal screenings could result in an increase in number of these performed, resulting in disease prevention.

Cost Avoidance: The reduction in healthcare costs that can be realized through this project can be significant. In 2008, Kaiser Permanente recognized $30 million in cost savings for its 12,000 members enrolled in the Cardiac Care portion of its integrated care model. (Source: B.G. Sandoff, "Collaborative Cardiac Care Service: A multidisciplinary approach to caring for patients with coronary heart disease" Permanente Journal 2008, Volume 12, Number 3, pp. 4-11).

Priority Community Need: A local community needs assessment identified cost of medical care and access to quality care as concerns of the local community

Estimated Local Funding: Local Funding is through our Hospital District.

If a project includes more than one outcome measure, complete the entire Section E. (narrative and table) for each outcome measure.

133244705.3.3	*3.IT-5.1*	*Improved Cost Savings: Demonstrate cost savings in care delivery*	
Rolling Plains Memorial Hospital			*133244705*
Related Category 1 or 2 Projects:	Redesign for Cost Containment-Develop an integrated care model with outcome-based payments 133244705.2.2		
Starting Point/Baseline:	*83 Colorectal Screenings cost of 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)**
Process Milestone 1 P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: Documentation of plan for integrated model and cost accounting system Data Source: Evidence of plan/cost accounting system Rationale: Cost containment can be defined as any set of policies or measures intended to affect one or more of the	Process in baseline year Milestone 2 P-2 Establish baseline rates Metric: Establish a baseline for cost – costing method TBD after establishment of cost accounting system Data Source: Evidence of use of cost-accounting system or another administrative, financial, or clinical data set to determine cost of colorectal screenings Process Milestone 2 Estimated Incentive Payment: $31,919	**Outcome Improvement Target 1** IT-5.1: Improved cost savings: Numerator: Cost of each colorectal screening performed in DY3 Denominator: Total number of colorectal screenings performed in DY3 Data Source: E.H.R.; Cost accounting system Improvement Target: 2% decrease in average cost of colorectal screenings performed in baseline year. Dollar amount TBD after establishment of cost in DY3. Outcome Improvement Target	**Outcome Improvement Target2** IT-5.1: Improved cost savings: Numerator: Cost of each type of colorectal screening performed in DY3 Denominator: Total number of colorectal screenings performed in DY3 Data Source: : E.H.R.; Cost accounting system Improvement Target: 3% decrease in average cost of colorectal screenings performed in baseline year. Dollar amount TBD after establishment of cost in DY3

133244705.3.3	*3.IT-5.1*	*Improved Cost Savings: Demonstrate cost savings in care delivery*	
Rolling Plains Memorial Hospital			*133244705*
Related Category 1 or 2 Projects:	Redesign for Cost Containment-Develop an integrated care model with outcome-based payments 133244705.2.2		
Starting Point/Baseline:	*83 Colorectal Screenings cost of 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)**
following factors: Population needs or morbidity, access to services, propensity to seek services, volume, nature, or intensity of services supplied or ordered, and unit cost or price of services Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $27,504		1 Estimated Incentive Payment*:* $51,485	Outcome Improvement Target 2 Estimated Incentive Payment*:* $121,826
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $27,504	Year 3 Estimated Outcome Amount: $31,919	Year 4 Estimated Outcome Amount: $51,485	Year 5 Estimated Outcome Amount: $121,826
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $232,734			

Category 3: Quality Improvements

IT-9.2: ED Appropriate Utilization

Unique Project ID: 126842705.3.1

Facility Description: Stamford Memorial Hospital-126842705
.

Category 3: Quality Improvements

IT-9.2: ED Appropriate Utilization

Unique Project ID: New ID: 126842705 3.3
Old ID: 126842705.3.1

Facility Description: Stamford Memorial Hospital-126842705
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Outcome Measure Description:

Our outcome measure is OD-9, Right Care, Right Setting. Our goal is to direct non-emergent visits to our urgent care clinic or our RHC. Our IT is to decrease ED visits by 5% each DY starting in DY3.

Rationale:

The most recent data we have suggests that 88% of our 2011 ED visits are classified as non-emergent. We are penalized for these visits; therefore, we would like to improve patient access to an urgent care clinic and expand our RHC's capacity to accept these patients in a timelier manner. We are implementing an urgent care clinic at the hospital so that patients can be seen the day that they call for an appointment instead of utilizing the ED as a walk-in clinic. We will improve access to non-emergent care and also educate patients on appropriate use of the ED.

Outcome Measure Valuation:

Our total ED visits for 2011 were 2,561. We project that DY 2 will be slightly increased. An analysis of the type of ED visits showed that 88% of our ED visits are non-emergent. 42% of all ED visits are seen during the hours of 8 a.m. to 5 p.m. By opening an urgent care clinic, we will improve access to care by increasing staff. We will also reduce costs by shifting non-emergent care from the ER to the urgent care setting. It will cost the patients less and the hospital less because the appropriate care is being given in the appropriate setting. We will not be penalized for seeing a patient in the ED with a non-emergent diagnosis. 70% of our 2011 ED visits were Stamford residents. Stamford Memorial Hospital is a hospital district; therefore, we will provide our own IGT to support this project.

New ID: 126842705.3.3 Old ID: 126842705.3.1	*IT-9.2*	*ED appropriate utilization*	
Stamford Memorial Hospital			*126842705*
Related Category 1 or 2 Projects:	New ID: 126842705 1.3 Old ID: 126842705.1.1		
Starting Point/Baseline:	*ED visits from DY 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)**
Process Milestone 1 P-1. Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: RHC and ED patient surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $22,683 **Process Milestone 2** [P-2]: Data Source: : ED Utilization Analysis (non-emergent vs. emergent) Process Milestone 2 Estimated Incentive Payment: $$22,683	**Process Milestone 3** **Est. baseline** Data Source: DY 2 data Process Milestone 3 Estimated Incentive Payment: $52,585 **Outcome Improvement Target 1** [IT-9.2]: Reduce total, non-emergent ED visits for patients using the Walk In Clinic. Improvement Target: TBD Data Source: ED Utilization Analysis (non-emergent vs. emergent) Outcome Improvement Target 1 Estimated Incentive Payment*:* $52,585	**Outcome Improvement Target 2** [IT-9.2]: Reduce total, non-emergent ED visits for patients using the Walk In Clinic. Improvement Target: TBD Data Source: ED Utilization Analysis (non-emergent vs. emergent) Outcome Improvement Target 2 Estimated Incentive Payment*:* $84,381	**Outcome Improvement Target 3** [IT-9.2]: Reduce total, non-emergent ED visits for patients using the Walk In Clinic. Improvement Target: TBD Data Source: ED Utilization Analysis (non-emergent vs. emergent) Outcome Improvement Target 3 Estimated Incentive Payment*:* $201,780

New ID: 126842705.3.3 Old ID: 126842705.3.1	*IT-9.2*	*ED appropriate utilization*	
Stamford Memorial Hospital			*126842705*
Related Category 1 or 2 Projects:	New ID: 126842705 1.3 Old ID: 126842705.1.1		
Starting Point/Baseline:	*ED visits from DY 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)**
Year 2 Estimated Outcome: Determine the current non-emergent utilization of the ED and the reasons Amount: $45,366	Year 3 Estimated Outcome: Reduce non-emergent ED visits by 5% Amount: $52,585	Year 4 Estimated Outcome Amount: $84,381	Year 5 Estimated Outcome Amount: $201,780
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $384,112			

Category 3

IT-9.2: ED Appropriate Utilization-Medical Advice Line

Unique Project ID: New ID: 126842705.3.2
Old ID: 126842705.3.4
Facility Description: Stamford Memorial Hospital-126842705
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Outcome Measure Description:

Our outcome measure is OD-9, Right Care, Right Setting. Our goal is to direct non-emergent visits to our walk-in clinic or our RHC. Our IT is to decrease non-emergent ED visits by 5% each DY starting in DY3.

Rationale:

The most recent data we have suggests that 88% of our 2011 ED visits are classified as non-emergent. We are penalized for these visits; therefore, we would like to improve patient access to a registered nurse. We will improve access to non-emergent care and also educate patients on appropriate use of the ED.

Outcome Measure Valuation:

Our total ED visits for 2011 were 2,561. We project that DY 2 will be slightly increased. An analysis of the type of ED visits showed that 88% of our ED visits are non-emergent. 42% of all ED visits are seen during the hours of 8 a.m. to 5 p.m. By providing access to a registered nurse via a medical advice line, we will improve access to care. We will also reduce costs by shifting non-emergent care from the ER to the primary care setting. It will cost the patients less and the hospital less because the appropriate care is being given in the appropriate setting. We will not be penalized for seeing a patient in the ED with a non-emergent diagnosis. 70% of our 2011 ED visits were Stamford residents. Stamford Memorial Hospital is a hospital district; therefore, we will provide our own IGT to support this project.

New ID: 126842705.3.4 Old ID: 126842705.3.2	*IT-9.2*	*ED appropriate utilization*	
Stamford Memorial Hospital			*126842705*
Related Category 1 or 2 Projects:	New ID: 126842705.1.4 Old ID: 126842705.1.2		
Starting Point/Baseline:	*ED visits from DY 1 or before the Advice Line is Operational*		
Year 2 (10/1/2012 – 9/30/2013)	**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: patient surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $22,352	**Process Milestone 2** **P-2 Est. baseline** Data Source: DY 1 data Process Milestone 2 Estimated Incentive Payment: $12,145 **Outcome Improvement Target 1** [IT-9.2]: Reduce total, non-emergent ED visits for patients using the Medical Advice Line. Improvement Target: TBD Data Source: ED Utilization Analysis (non-emergent vs. emergent) Outcome Improvement Target 1 Estimated Incentive Payment*:* $25,940	**Outcome Improvement Target 2** [IT-9.2]: Reduce total, non-emergent ED visits for patients using the Medical Advice Line. Improvement Target: TBD Data Source: ED Utilization Analysis (non-emergent vs. emergent) Outcome Improvement Target 2 Estimated Incentive Payment*:* $41,841	**Outcome Improvement Target 3** [IT-9.2]: Reduce total, non-emergent ED visits for patients using the Medical Advice Line. Improvement Target: TBD Data Source: ED Utilization Analysis (non-emergent vs. emergent) Outcome Improvement Target 3 Estimated Incentive Payment*:* $99,008

New ID: 126842705.3.4 Old ID: 126842705.3.2	*IT-9.2*	*ED appropriate utilization*	
Stamford Memorial Hospital			*126842705*
Related Category 1 or 2 Projects:	New ID: 126842705.1.4 Old ID: 126842705.1.2		
Starting Point/Baseline:	*ED visits from DY 1 or before the Advice Line is Operational*		
Year 2 (10/1/2012 – 9/30/2013)	**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: $22,352	Year 3 Estimated Outcome Amount: $25,940	Year 4 Estimated Outcome Amount: $41,841	Year 5 Estimated Outcome Amount: $99,008
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $189,141			

Category 3

IT-6.1: Patient Satisfaction

Unique Project ID: 119875604.3.1

Facility Description: Stephens Memorial Hospital-119875604
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Outcome Measure Description:

Stephens Memorial Hospital will survey Rural Health Clinic patients to determine patient satisfaction. The target of this project is to improve patient satisfaction by 3% over the baseline satisfaction scores at the end of the project (DY5).

Rationale/Evidence:

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

Outcome Measure Valuation:

By participating in the DSRIP process, the providers of Regional Healthcare Partnership Region 11 (RHP 11), will take major steps to address the needs of its' citizens through an improved and innovative healthcare delivery system.

This goal is addressed with the accomplishment of this project. This project is directly related to the category 1 project 119875604.1.1

The measures for the project include the following questions:

1)_Are getting timely care, appointments, and information

The patient surveys will be the source of the data for determining percent improvement in targeted patient satisfaction domain. The percent improvement in the targeted patient domain will serve as the numerator and number of patients who were administered the survey will serve as the denominator. DY2 will be an implementation year and a process measure will be

used to gage successful implementation of surveys. DY3 will serve as the baseline. DY4-5 will have the combined goal of improving the baseline by 3%.

119875604.3.1	*IT-6.1*	*Patient Satisfaction*	
Stephens Memorial Hospital			119875604
Related Category 1 or 2 Projects::	119875604.1.1		
Starting Point/Baseline:	*Baseline will be established in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 *IT-6.1*: Develop surveys and implement process to establish baseline Data Source: Documentation of surveys Process Milestone 1 Estimated Incentive Payment *(maximum amount):*	**Outcome Improvement Target 1** *IT-6.1*: Establish baseline satisfaction scores (1) are getting timely care, appointments, and information Data Source: **Patient survey** Outcome Improvement 1	**Outcome Improvement Target 1** *IT-6.1*: 2 % improvement over baseline satisfaction scores (1) are getting timely care, appointments, and information Data Source: **Patient survey** Outcome Improvement 1	**Outcome Improvement Target 1** *IT-6.1*: 3% improvement over baseline satisfaction scores (1) are getting timely care, appointments, and information Data Source: **Patient survey** Outcome Improvement 1
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $14,076	Year 3 Estimated Outcome Amount: $16,316	Year 4 Estimated Outcome Amount: $26,181	Year 5 Estimated Outcome Amount: $62,607
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$119,179**			

119875604.3.1	*IT-6.1*	*Patient Satisfaction*	
Stephens Memorial Hospital			119875604
Related Category 1 or 2 Projects::	119875604.1.1		
Starting Point/Baseline:	*Baseline will be established in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**

Pass 2

Category 3

IT-6.1: Patient Satisfaction

Unique Project ID: 020992601.3.1

Facility Description: Stonewall Memorial Hospital- 020992601

Outcome Measure Description:

Stonewall Memorial Hospital will participate in the HCAHPS Survey process and begin DY2 with training and implementation of the survey to establish baseline goals. By DY5 Stonewall Memorial will increase our patient satisfaction scores by a percentage over baseline to be determined by the initial scores reported to the hospital.

The intent of the HCAHPS initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. While many hospitals have collected information on patient satisfaction, prior to HCAHPS there was no national standard for collecting or publicly reporting patients' perspectives of care information that would enable valid comparisons to be made across all hospitals. In order to make "apples to apples" comparisons to support consumer choice, it was necessary to introduce a standard measurement approach: the HCAHPS survey, which is also known as the CAHPS® Hospital Survey, or Hospital CAHPS. HCAHPS is a core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS survey items complement the data hospitals currently collect to support improvements in internal customer services and quality related activities.

Three broad goals have shaped the HCAHPS survey. First, the survey is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Third, public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey is credible, useful, and practical. This methodology and the information it generates are available to the public.

We will set baseline in DY 3 and increase baseline scores in DY4 and DY5 be a percentage to be determined over the baseline score established in DY3.

Rationale:

It is Stonewall Memorial Hospital's goal to survey all of our clinic patients for improvement of patient satisfaction. The patient surveys will be used in conjunction with our expansion of primary care services Category 1 project to help us better identify the healthcare needs and satisfaction levels of the patients we serve. It is our belief that the better our patients understand our desire to serve them better, the more confidence they will have in the quality and efficiency of the healthcare we can deliver.

Outcome Measure Valuation:

Process Milestones/Outcome Improvement Targets Table for each Category 3 Outcome Measure shall include: Identifying Outcome and Provider Information:

020992601.1.1 Category 1 Expand Existing Primary Care Capacity

020992601.3.1 Category 3, ID-6 Patient Satisfaction, IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores (HCAHPS), Stonewall Memorial Hospital - 020992601

Starting Point/Baseline: The HCAHPS survey instrument and method of capture will be implemented in DY2 and the baseline will be developed in DY3.

Process Milestones/Outcome Improvement Targets:

Process Milestone 1 (DY 2): Project planning and establishment of HCAHPS survey protocols, staff training, establish goals, and community support

Data Source: Current QA reports and HCAHPS data.

Rationale/Evidence: A HCAHPS patient survey for the rural health clinic and hospital will be developed in DY 2 that will be used for targeting opportunities to improve the care for the patients we serve.

Process Milestone 1 (DY 3): HCAHPS survey implementation, begin establishing criteria for improvements needed to increase patient satisfaction.

Data Source: Current HCAHPS survey results data.

Rationale/Evidence: The HCAHPS patient survey for the rural health clinic and hospital initial results will be analyzed in DY 3 to target opportunities to improve the care for the patients we serve

Process Milestone 1 (DY 4): HCAHPS survey will be fully implemented and areas for improvement will be identified. Patient satisfaction levels in all areas will begin to show improvement.

Data Source: Current HCAHPS survey results data.

Rationale/Evidence: The HCAHPS patient survey for the rural health clinic and hospital initial results will be analyzed in DY 4 to benchmark improvement areas and areas that need more work in order to improve the care for the patients we serve

Process Milestone 1 (DY5): HCAHPS survey will be fully implemented. Patient satisfaction levels in all areas will show improvement.

Data Source: Current HCAHPS survey results data.

Rationale/Evidence: The HCAHPS patient survey for the rural health clinic and hospital initial results will be analyzed again in DY5 to benchmark improvement areas and areas that need more work in order to improve the care for the patients we serve. Percent improvement over DY2 baseline values will be analyzed to determine if the goals established in DY3 were accomplished.

RHP Planning Protocol Reference: IT-6.1 Percent improvement over baseline of patient satisfaction scores (HCAHPS)

Incentive Payment Amount:
DY 2 - $32,794, DY 3 - $38,058, DY 4 - $62,426 - DY 5 - $114,258
Maximum DSRIP for Category 3 thru DY 5 - $277,497

020992601.3.1	IT-6.1	Percent Improvement over baseline of patient satisfaction scores	
Stonewall Memorial Hospital			*020992601*
Related Category 1 Project:	020992601.1.1		
Starting Point/Baseline:	To be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: Patient Satisfaction **Metric 1:** P-1 Project planning; Establish survey protocols and procedures, train staff on survey goals and purpose, engage community support. **Goal:** Establish process to begin accurate and effective survey implementation: Identify improvement needs and community expectations **Data Source:** Data from current QA reports and HCAHPS, create patient satisfaction process **Process Milestone 1 Estimated Incentive Payment:** $32,793	**Process Milestone 1:** Patient Satisfaction **Outcome Improvement target 1:** P-1 Survey implementation; establish criteria for improvement **Goal:** Establish baseline scores for all survey questions. **Data Source:** Data from HCAHPS initial surveys **Outcome Improvement Target 1 Estimated Incentive Payment:** $38,057	**Process Milestone 1:** Patient Satisfaction **Outcome Improvement Target 2:** P-1 Analysis of data provided by survey responses for improvements and identify further needs for improvement. **Goal:** Percent improvement over DY3 baseline of patient satisfaction scores. Percentage TBD. **Data Source:** Data from HCAHPS current surveys **Outcome Improvement Target 2 Estimated Incentive Payment***:* $61,387	**Process Milestone 1:** Patient Satisfaction **Outcome Improvement Target 3:** IT 6.1 Percent improvement over baseline of patient satisfaction scores **Goal:** Percent improvement over DY3 baseline of patient satisfaction scores. Percentage TBD. **Data Source:** Data from HCAHPS current surveys **Outcome Improvement Target 3 Estimated Incentive Payment***:* $145,258

020992601.3.1	IT-6.1	Percent Improvement over baseline of patient satisfaction scores	
Stonewall Memorial Hospital			*020992601*
Related Category 1 Project:	020992601.1.1		
Starting Point/Baseline:	To be determined in DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $32,793	Year 3 Estimated Outcome Amount: $38,057	Year 4 Estimated Outcome Amount: $61,387	Year 5 Estimated Outcome Amount: $145,248
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*: $277,495*			

Category 3

IT-6.2: Patient Satisfaction

Unique Project ID: 130725806.3.1

Facility Description: West Texas Center-130725806

Category 3

IT-6.1: Patient Satisfaction

Unique Project ID: 130725806.3.1
Project title: West Texas Centers Telemedicine Expansion

Facility Description: West Texas Center-130725806

Outcome Measure Description:

West Texas Centers has selected outcome measure
OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected improvement target IT-6-1(pg 398 of protocol): Percent Improvement over baseline of patient satisfaction scores. The Center has selected patient satisfaction because we have the ability to produce that data at this time. Within the patient satisfaction survey, we will include a question on use of the emergency department. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy.
Our Center will additionally be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

Rationale:

Nolan and Mitchell Counties are designated Health Professional Shortage Areas (HPSAs), with a very rural population. The closest major medical center or any behavioral health care other than West Texas Centers is forty miles. West Texas Centers is the only provider of behavioral health services in the county. Without telemedicine it would not be possible to provide the psychiatric services which are currently being provided. Current capacity however; does not meet the demands of the rural area. This expansion of telemedicine will enable West Texas Centers to increase access to services via the increase in capacity achieved through further broadband connectivity and acquisition of newer, more advanced telecommunication connections and software. All process measures were chosen to identify baseline data, obtain public feedback and provide time to test all systems prior to setting improvement targets. West Texas Centers will achieve all core components identified in this project by the end of demonstration year 5. Improvement targets were selected to achieve maximum improvement in patient satisfaction related to timely care, appointments and information/communication.

Outcome Measure Valuation:

Outcome evaluation consideration included West Texas Center's current telemedicine system costs and estimated costs of achieving all project goals. Additionally, consideration was given to current crisis response times in Mitchell and Nolan Counties, county patient satisfaction with current telemedicine technology/services, availability of other behavioral health providers and length of waiting time for psychiatric services at the Nolan and Mitchell Clinics. Provider has adopted the regional valuation set forth by RHP 11. Based on this methodology stakeholder feedback will be obtained during DY2 however; full valuation is associated with the category 1 milestones during this year. DY 3 valuation is associated with establishing capability to obtain necessary stakeholder feedback, analysis and testing of current systems. 10 percent of the provider allocation is distributed equally each year, DY 3 and DY 4, with 20% for DY 5, across the applicable domains. This improvement target related to improved patient satisfaction was selected to insure patients are receiving timely care, have adequate access, are involved in their treatment and their overall health and functioning is improved to the fullest extent possible.

130725806.3.1	IT-6.1	IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores	
West Texas Centers			130725806
Related Category 1 or 2 Projects:	130725806.1.1		
Starting Point/Baseline:	Establishment of Outcome Improvement Targets Pending Further CMS Guidance		
Year 2 (10/1/2012 – 9/30/2013)	**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(Cat 3, pg 363) Project Planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Meeting sign in sheets; procurement documents; Network provider meetings; public forums. Process Milestone P-1 Estimated Incentive Payment :$ 0.00	Process Milestone P-3(Cat 3, pg. Pg, 363, P-3) Develop and test systems to capture baseline information, select consumer survey documents, conduct baseline patient satisfaction survey to achieve baseline and begin new provider education on systems. Data Source: Provider feedback, customer satisfaction surveys and computer based training documents. Estimated Incentive Payment :$ 27,648.00	Outcome Improvement Target 1 Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1Cat 3 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Data Source: It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data	Outcome Improvement Target 2 Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Data Source: It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data

130725806.3.1	IT-6.1	IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores	
West Texas Centers			130725806
Related Category 1 or 2 Projects:	130725806.1.1		
Starting Point/Baseline:	Establishment of Outcome Improvement Targets Pending Further CMS Guidance		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. Improvement Target: patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy. Outcome Improvement Target 1 Estimated Incentive Payment*:* $29,577.00	from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. Improvement Target: patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy. Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 64,298.00
Year 2 Estimated Outcome Amount: $0.00	Year 3 Estimated Outcome Amount: $ 27,648.00	Year 4 Estimated Outcome Amount: $ 29,577.00	Year 5 Estimated Outcome Amount: $ 64,298.00

130725806.3.1	IT-6.1	IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores	
West Texas Centers			130725806
Related Category 1 or 2 Projects:	130725806.1.1		
Starting Point/Baseline:	Establishment of Outcome Improvement Targets Pending Further CMS Guidance		
Year 2 (10/1/2012 – 9/30/2013)	**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 $ 121,523.00			

Pass 2
Category 3

IT-6.2: Patient Satisfaction

Unique Project ID: 130725806.3.2

Facility Description: West Texas Center-130725806

Pass 3B
Category 3

IT-6.1: Percent Improvement over baseline of patient satisfaction scores

Unique Project ID: New 130725806.3.3/ Old 130725806.3.2
Project Title: West Texas Centers Mobile Crisis Outreach Team Expansion

Facility Description: West Texas Center-130725806

Outcome Measure Description: West Texas Centers has selected outcome measure OD-6 Patient Satisfaction with process milestone P-1: Project planning - engage stakeholders, identify current capacity and needed resources for DY 2 with Milestone P-3: Develop and test data systems selected for DY 3. It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. West Texas Centers has selected improvement target IT-6-1(pg 398 of protocol): Percent Improvement over baseline of patient satisfaction scores. The Center has selected patient satisfaction because we have the ability to produce that data at this time. Within the patient satisfaction survey, we will include a question on use of the emergency department. The standalone measure: (1) patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy.
Our Center will additionally be working with other Community Centers in a learning collaborative to select a small set of outcome measures for Category 3, based on the valuation studies conducted by health care economists at the University of Texas and University of Houston. The collaborative will develop a strategy for collection of that data through HIEs or other shared data sources in local communities. Centers are currently in the process of engaging a consultant to provide leadership and consultation for this project.

Rationale:

All West Texas Center counties in RHP 11 are designated Health Professional Shortage Areas (HPSAs), with a very rural population. In FY 2012 West Texas Centers received over 600 crisis calls for the RHP 11 West Texas Center counties with over 350 being legitimate "go mobile" response situations. The current Mobile Crisis Outreach team is responding to calls throughout the very rural and vast coverage area of the West Texas RHP 11 counties. Additional assessment of the West Texas Centers crisis response system to identify crisis call patterns, including geographic considerations and increasing the staffing component of the Mobile Crisis Outreach team is expected to significantly increase consumer diversion from the emergency rooms, jails, and inpatient facilities. This will result in more appropriate right care, right setting, and right time treatment for our behavioral health consumers. West Texas Centers currently provides these crisis services with only one Mobile Crisis Outreach staff member in the RHP 11 service area. This one person is responsible responding to the crisis call within one hour of notification one a 24/7 call rotation. With an additional Mobile Crisis Outreach staff it is expected that we would be able to reduce our crisis response time and intervene in behavioral health crisis prior to the consumer being booked into the jail, admitted to the ER or taken to a psychiatric hospital for admission. All process measures were chosen to identify baseline data, obtain public feedback and provide time to test all systems prior to setting improvement targets. West Texas Centers will achieve all core components identified in this project by the end of demonstration year 5. Improvement targets were selected to achieve maximum improvement in patient satisfaction related to timely care, appointments and information/communication.

Outcome Measure Valuation:

Provider has adopted the regional valuation set forth by RHP 11. Based on this methodology stakeholder feedback will be obtained during DY2 however; full valuation is associated with the category 1 milestones during this year. DY 3 valuation is associated with establishing capability to obtain necessary stakeholder feedback, analysis and testing of current systems. 10 percent of the provider allocation is distributed equally each year, DY 3 and DY 4, with 20% for DY 5, across the applicable domains. Consideration was given to current crisis response times in the project Counties and patient satisfaction with current crisis services. Outcome evaluation consideration included West Texas Center's current crisis system costs and estimated costs of achieving all project goals. Project is of medium size due to this being an expansion of the current crisis network. All process measures were chosen to identify baseline data, obtain public feedback and provide time to test all systems prior to setting improvement targets. West Texas Centers will achieve all core components identified in this project by the end of demonstration year 5. Improvement targets were selected to achieve maximum improvement in patient satisfaction related to timely care, appointments and information/communication.

New 130725806.3.3 **Old 130725806.3.2**	3 IT.6.1	IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores West Texas Centers Mobile Crisis Outreach Team Expansion	
West Texas Centers		130725806	
Related Category 1 or 2 Projects	New 130725806.1.3/ Old 130725806.1.1		
Starting Point/Baseline	Establishments of Outcome Improvement Targets Pending Further CMS Guidance		
Year 2 **(10/1/2012-9/30/2013)**	**Year 3** **(10/1/13-9/30/14)**	**Year 4** **(10/1/14-9/30/15)**	**Year 5** **(10/1/15-9/30/16)**
Process Milestone P-1(Cat 3, pg 363, P-1) Project Planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project planning and implementation documentation demonstrates plan, do study, act quality improvement cycles. Process Milestone 1 Estimated Incentive Payment: $0.00	Process Milestone P-3(Cat 3, pg. Pg, 363, P-3) Develop and test systems to capture baseline information, select consumer survey documents, conduct baseline patient satisfaction survey to achieve baseline and begin new provider education on systems. Process Milestone 2 Estimated Incentive Payment: $9,847	Outcome Improvement Target 1 Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1 Cat 3 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Data Source: It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-	Outcome Improvement Target 2 Outcome Domain 6.1 Patient Satisfaction Outcome Improvement Target (IT 6.1-1 Cat 3 pg 398)Percent Improvement over baseline of patient satisfaction scores. Standalone measure: Patients are getting timely care, appointments, and information. Data Source: It is during DY 3 WTC will select a patient satisfaction survey instrument, anticipated at this time to be either one of the ECHO 3.0-Experience of Care and Health Outcomes surveys or the AHRQ-Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target

		Consumer Assessment of Behavioral Health Services(CABHS) instrument. WTC will then, in DY 3, administer and collect the data from the survey to establish a baseline for DY 4 and DY 5 improvement target measures. Improvement Target: Target: patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy. Data Source/baseline: DY 3 Patient Satisfaction Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $10,590	measures. Improvement Target: patients are getting timely care, appointments, and information was selected. Specific to this project the patient satisfaction improvement targets are to be determined pending further CMS guidance regarding Category 3 methodogy. Data Source/baseline: DY 3 Patient Satisfaction Surveys Outcome Improvement Target 3 Estimated Incentive Payment*:* $22,780
Year 2 Estimated Outcome	Year 3 Estimated Outcome	Year 4 Estimated Outcome	Year 5 Estimated Outcome Amount:

Amount: $.0.00	Amount: $9,847	Amount: $10,590	$22,780
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD : $43,217			

Category 4

Category 4: Population-Focused Improvements (Hospitals only)

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

Domain 1: Potentially Preventable Admissions (8 measures)
Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
Domain 3: Potentially Preventable Complications (64 measures)
Domain 4: Patient-Centered Healthcare (2 measures)
Domain 5: Emergency Department (1 measure)
Optional Domain 6: Children and Adult Core Measures (8 measures)

Hendrick Medical Center (138644310)

Domain Descriptions:

RD-1. Potentially Preventable Admissions – Many of these projects will help reduce potentially preventable admissions. Projects 138644310.2.2 (Cellulitis Treatment), 138644310.2.4 (Diabetes Health Promotion) and 138644310.2.5 (Cardiac Health Promotion) will all address these reporting items directly because they are all trying to implement better care and education for diseases that cause the high readmission rates. The category 3 outcomes that are related to this reporting domain are 138644310.3.5 (Cellulitis Admission Rate), 138644310.3.7 (Diabetes Short-term Complication Admission Rate) & 138644310.3.9 (Acute Myocardial Infarction Re-admits).

RD-2. 30-Day Readmissions – Many of these projects will help reduce potentially 30-day readmissions. Projects 138644310.2.2 (Cellulitis Treatment), 138644310.2.4 (Diabetes Health Promotion) and 138644310.2.5 (Cardiac Health Promotion) will all address these reporting items directly because they are all trying to implement better care and education for diseases that cause the high readmission rates. The category 3 outcomes that are related to this reporting domain are 138644310.3.5 (Cellulitis Admission Rate), 138644310.3.7 (Diabetes Short-term Complication Admission Rate) & 138644310.3.9 (Acute Myocardial Infarction Re-admits).

RD-3. Potentially Preventable Complications – Many of these projects will help reduce preventable complications. Projects 138644310.2.2 (Cellulitis Treatment), 138644310.2.4 (Diabetes Health Promotion) and 138644310.2.5 (Cardiac Health Promotion) will all address these reporting items directly because they are all trying to implement better care and education for diseases that cause the high readmission rates. The category 3 outcomes that are related to this reporting domain are 138644310.3.5 (Cellulitis Admission Rate), 138644310.3.7 (Diabetes Short-term Complication Admission Rate) & 138644310.3.9 (Acute Myocardial Infarction Re-admits).

RD-4. Patient-Centered Healthcare – Patient-centered healthcare will be addressed through project 138644310.2.3 (Palliative Care Program) through the implementation of a palliative care program. The category 3 outcome measure that is related to this project is 138644310.3.6 (Admits to ICU-last 30 days).

RD-5. Emergency Department – Reducing emergency department visits is vital to cost efficiencies; projects 138644310.2.1 (Enhance Medical Care Mission), 138644310.1.1 (Expand Primary Care Capacity) & 138644310.1.2 (Expand Specialty Care Capacity) will directly address this issue. The category 3 that directly relates to this reporting domain is 138644310.3.4 (Reduce Emergency Department Visits for Diabetes).

RD-6. Children and Adult Core Measures – This reporting domain does not directly relate to our projects being implemented but will be reported on.

138644310.3.1 (Breast Cancer Screenings), 138644310.3.2 (Cervical Cancer Screenings), 138644310.3.3 (Pneumonia Vaccination for Adult), 138644310.3.4 (Reduce Emergency Department Visits for Diabetes), 138644310.3.5 (Cellulitis Admission Rate), 138644310.3.6 (Admits to ICU-last 30 days), 138644310.3.7 (Diabetes Short-term Complication Admission Rate), 138644310.3.8 (Decrease in Mental Health Admissions) & 138644310.3.9 (Acute Myocardial Infarction Re-admits) will all relate to category 4 outcomes because they are improving targets within our defined populations in our projects in order to accomplish the goals and targets that are to improve potentially preventable admissions, potentially preventable readmissions, potentially preventable complications. In DY's 2 through 5 we expect our potentially preventable admissions to decrease, especially in certain areas that our projects directly address such as diabetes and cardiac health promotions. The 30-day readmission rate is also planned to decrease because of the implementation of these projects. Potentially preventable complications are expected to drop from DYs 2 through DY 5 because of the implementation of the sepsis program. Our level of patient satisfaction is expected to increase due to the implementation of the palliative care program over DY's 2 through DY 5. The emergency department visits will hopefully decrease

greatly over DY's 2 through DY 5 because of the expansion of the medical care mission and the expansion of primary and specialty care capacity. The optional reporting domain of CMS initial core set of measures for adults and children in Medicaid/CHIP will be reported on also but is not directly related to any of our projects.

Domain Valuation:

A. DY2 Outcome measures have been evenly valued based upon a total category 4 allocation in DY2 of $735,340 which is 5% of the total DY2 Pass 1 & 2 allocation of $14,706,790.
B. DY3 Outcome measures have been evenly valued based upon a total category 4 allocation in DY3 of $2,557,833 which is 15% of the total DY3 Pass 1 & 2 allocation of $17,052,231.
C. DY4 Outcome measures have been evenly valued based upon a total category 4 allocation in DY4 of $2,739,916 which is 15% of the total DY4 Pass 1 & 2 allocation of $18,266,124.
D. DY5 Outcome measures have been evenly valued based upon a total category 4 allocation in DY5 of $2,970,192 which is 15% of the total DY5 Pass 1 & 2 allocation of $19,801,294.

Because these outcome measures are equally important and address very vital areas, we decided to go with this type of valuation. These outcome measures, process milestones and outcome improvement targets are all valued evenly because the size of our facility is the largest in the region and we serve the largest patient population. Also the project scope for each one of our outcome measures reaches its own patient population of comparable size to other outcome measures in the region. This same concept also applies to the project scope, and the community benefit. DY 2 IGT Entities include: Anson General Hospital, Rolling Plains Memorial Hospital, Mitchell County Hospital, Comanche County Medical Center, Eastland Memorial Hospital, Hamlin Memorial Hospital, Haskell Memorial Hospital, Knox County Hospital, Palo Pinto General Hospital, Fisher County Hospital, Stamford Memorial Hospital, and Stephens Memorial Hospital. DY 3 IGT Entities include: Anson General Hospital, Rolling Plains Memorial Hospital, Mitchell County Hospital, Comanche County Medical Center, Eastland Memorial Hospital, Hamlin Memorial Hospital, Haskell Memorial Hospital, Knox County Hospital, Palo Pinto General Hospital, Fisher County Hospital, Stamford Memorial Hospital, and Stephens Memorial Hospital. DY 4 IGT Entities include: Anson General Hospital, Rolling Plains Memorial Hospital, Mitchell County Hospital, Comanche County Medical Center, Eastland Memorial Hospital, Hamlin Memorial Hospital, Haskell Memorial Hospital, Knox County Hospital, Palo Pinto General Hospital, Fisher County Hospital, Stamford Memorial Hospital, and Stephens Memorial Hospital. DY 5 IGT Entities include: Anson General Hospital, Rolling Plains Memorial Hospital, Mitchell County Hospital, Comanche County Medical Center, Eastland Memorial Hospital, Hamlin Memorial Hospital, Haskell Memorial Hospital, Knox County Hospital, Palo Pinto General Hospital, Fisher County Hospital, Stamford Memorial Hospital, and Stephens Memorial Hospital. Since

Hendrick Medical Center already reports these domains to the State, we will not be putting in place any additional changes. The only change that will take place is the reporting of Domain and this will be added to the other domains that are currently reported.

Category 4: Population-Focused Measures *[Hendrick Medical Center/138644310]*				
	Year 2 (10/1/2012 – 9/30/2013)	**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	$735,340	$426,306		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$426,306	$456,653	$495,032
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$426,306	$456,653	$495,032
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			$456,653	$495,032
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for		10/1/2012 – 9/30/2013	10/1/2013 –	10/1/2014 –

report			9/30/2014	9/30/2015
Planned Reporting Period: 1 or 2		2	2	2
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		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$426,305	$456,653	$495,032
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		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$426,305	$456,652	$495,032
OPTIONAL Domain 6: Children and Adult Core Measures				
Frequency of ongoing prenatal care				
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		2	2	2
Timeliness of prenatal care				
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		2	2	2
Cesarean rate for low-risk first birth women				

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		2	2	2
Percent of live births weighing <2500 grams				
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		2	2	2
Pediatric central-line associated bloodstream infection (CLASBI) rates				
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		2	2	2
Elective delivery prior to 39 weeks completed gestation				
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		2	2	2
Appropriate use of antenatal steroids				
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		2	2	2
Postpartum Care Rate				
Measurement period for		10/1/2012 – 9/30/2013	10/1/2013 –	10/1/2014 –

report			9/30/2014	9/30/2015
Planned Reporting Period: 1 or 2		2	2	2
Domain 6 - Estimated Maximum Incentive Amount		$426,305	$456,652	$495,032
Grand Total Payments Across Category 4	$735,340	$2,557,833	$2,739,916	$2,970,192

Palo Pinto General Hospital – TPI – 138950412

TPI – 138950412
400 SW 25th Ave.
Mineral Wells, TX. 76067

Category 4: Population-Focused Improvements (Hospitals only)

Palo Pinto General Hospital – TPI – 138950412
Palo Pinto General Hospital will be providing data to the State of Texas on 5 domains listed below.

Domain 1: Potentially Preventable Admissions (8 measures)
Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)
Domain 3: Potentially Preventable Complications (64 measures)
Domain 4: Patient-Centered Healthcare (2 measures)
Domain 5: Emergency Department (1 measure)

Domain Descriptions:

DY 3 - 5

RD-1. Potentially Preventable Admissions

With the opening of a new primary care clinic in Project Option 1.1.2, the hospital and clinic will now have the ability to follow-up with patients discharged from the hospital with new software. Based upon data collected from the ED, it is anticipated that 42 patients will be prevented from admission to the hospital in the 1st year (DY 4) when the uninsured and Medicaid patients, that currently do not have primary care physicians, will now have access to preventative care.

As the new clinic (P-2.9) is enlarged and expanded, indicators and tracking data of patients will be put into place. The ability to treat and tract CHF and Diabetes patients in the right setting will be expanded and the patient will be able to get preventative care before becoming a crisis and they go the ED where an admission is inevitable and the cost is significant.

Domain Valuation*:*

The valuation was determined by the number of patients from the community that uses the ED department for their PCP. Staff will now track and follow patients from the expanded health clinic with CHF and Diabetes to monitor medications, follow-up office visits and reduce complications for non-compliant patients.

Cost Avoidance*:*

Most of the patients on Medicaid or uninsured do not have a PCP. With the expanded health clinic (Project 1.1), these patients will be able to access more primary care and avoid a crisis in the ED and avoid admission to the hospital. ED visits cost over $800.00 per visit and an admission cost averages $17,832. Based on ED records, it is anticipated that 42 admissions can be prevented in the 1st year (DY4).

RD-2. 30 Day Readmissions

With the opening of a new primary care clinic in Project Option 2.9, the hospital and clinic will now have the ability to follow-up with patients discharged from the hospital with new software. Based upon data collected from the hospital, it is anticipated that 18 patients will be prevented from readmission to the hospital in the 1st year (DY 4) when the uninsured and Medicaid patients, that currently do not have primary care physicians, will now have access to preventative care. A team of inpatient clinicians will review patient data and attend hospital grand rounds daily. At the time of discharge, the patient will be referred to the health clinic (P-2.9) where the patient will be evaluated and interventions will be modified, if necessary. Lessons, best practices and data will be shared with the "Expanded Primary Care" RHP 11 committee in quarterly meetings (P-X.3).

Domain Valuation*:* -

The valuation was determined by the size of the community that uses the ED department for their PCP. These are non-compliant patients that did not take medications as directed by the ED physician or followed up with their PCP after discharge as directed in the discharge plan but then return to the ED department in a health crisis because they did not have a primary care physician. Staff will now follow up with the patient to determine the intervention needed to keep the patient on the recommended discharge plan and to assist the patient, if needed:

Cost avoidance: Avoiding a readmission to the hospital at a higher level of care will save money. The patient will now be seen by the PCP and a staff member to assist the patient with problems/issues. The average cost of an inpatient admission is $17,832 with a projected number of patients being at 200 admissions per year.

RD-3. Potentially Preventable Complications

The clinic, in Project 1.1, will be able to see more patients and identify the patients which are at risk of inpatient treatment and ED visits and follow those patients with the correct treatment.
The hospital will be reporting on the 64 potentially preventable complications as calculated by the 3M software in **DY 4-5.**

Domain Valuation:
The valuation was determined by reviewing the PPC's of the hospital and the resources that will be available to the staff for the patients. With the expansion of the health clinic, the resources will now be available to the hospital and with addition PCP's, ongoing treatment will be available to the patient.

Cost Avoidance:
Any complication increases the cost of care of the patient. By monitoring and routine visits to the expanded health clinic (Project 1.1), the PCP will be able to prevent any complications before it gets to be an admission.

RD-4. Patient-centered Healthcare
The clinic, through Project 1.1 will be able to treat approximately 5,000-6,000 more patients per year. All of the HCAHP's questions included for the themes listed in the RHP Planning Protocol -Category 4 Population-focused Improvements be included and reported.
Medication management and reconciliation levels in discharged inpatient population will be derived from NQF 0646 and stats and best practices will be tracked by the Expanded Primary Care Services (Project 1.1).

Domain Valuation:
The valuation was determined by the needs of the patient being discharged. Medications will be monitored by coordination between the patient and facilitating staff who will be tracking the progress of the patient.

Cost Avoidance:
By regular visits with the PCP, staff will be able to review medications and avoid any conflicts with the patients medication.

RD-5. Emergency Department

Admit decision time to ED departure time for admitted patients (NQF 0497) will be tracked with the purchase of a new software program (T-System). With Project 1.2, the clinic will be able to track ED patients and determine the level of care. ED physicians will be able to refer the patients to the primary care physician where the clinic will pick up that patient to try to prevent another visit to the ED.

Domain Valuation:

The valuation was determined by the cost of the new software and the implementation of a tracking system for all ED patients. Staff training and care coordinators assigned to the patient upon admission will assist the ED department to be able to meet expectations of >1 hour. An ED visit cost is over $800.00. Approximately, 11,800 visits to the ED per year are avoidable visits.

Cost Avoidance:

By expanding the health clinic (Project 1.1), less patients in the ED will free the ED physicians to treat the trauma and refer to the patient to the appropriate level of care. This will reduce the time the patient is in the ED department.

Category 4: Population-Focused Measures *Palo Pinto General Hospital – TPI #138950412*				
	Year 2 (10/1/2012 – 9/30/2013)	**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, and 5	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$153,663	$71,263		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$71,263	$76,315	$82,775
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$71,263	$76,315	$82,775
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			$76,315	$82,775
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		10/1/12 – 09/30/13	10/1/13 – 09/30/14	10/1/14 – 09/30/15
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				

Measurement period for report		10/1/12 – 09/30/13	10/1/13 – 9/30/14	10/1/14 – 9/30/15
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$71,263	$76,315	$82,775
Domain 5: Emergency Department				
Measurement period for report		10/1/12 – 09/30/13	10/1/13 – 09/30/14	10/1/14 – 09/30/15
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$71,263	$76,315	$82,775
OPTIONAL Domain 6: Children and Adult Core Measures				
Frequency of ongoing prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Timeliness of prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean rate for low-risk first birth women				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Percent of live births weighing <2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric central-line associated bloodstream infection (CLASBI) rates				
Measurement period for report				
Planned Reporting Period: 1 or 2				

Elective delivery prior to 39 weeks completed gestation				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Appropriate use of antenatal steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Postpartum Care Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		0	0	0
Grand Total Payments Across Category 4	$153,663	$356,315	$381,575	$413,875

Category 4: Population-Focused Improvements

Stamford Memorial Hospital, TPI 126842705, is exempt from reporting these measures, but we are choosing to participate in Category 4 for both Pass 1 and Pass 2.

Domain Descriptions:

RD-1. Potentially Preventable Admissions – Expanding access to primary care via a walk-in clinic and nurse medical advice line should decrease the time that the patient foregoes treatment which should decrease the length of the illness and the acuity.

RD-2. 30-Day Readmissions – Expanding access to primary care via our walk-in clinic and nurse medical advice line should decrease the days between discharge to a follow-up appointment as well as if another acute situation arises, the patient's access to care would be sooner.

RD-3. Potentially Preventable Complications – Expanding access to primary care via a walk-in clinic and nurse medical advice line would increase patient's access to a provider in an outpatient setting thereby the PPC would be less significant. For example, an inpatient acquires a UTI from an inpatient stay, but does not realize this until after being discharged. This PPC would be diagnosed sooner due to the increased access to primary care via our walk-in clinic or the nurse medical advice line.

RD-4. Patient-Centered Healthcare – This reporting requirement applies to the inpatient setting, whereas, our project 1.6.2 expands access to primary care, therefore, in general it does not relate to our project, but a medication reconciliation that is provided at the time of discharge would enhance the outpatient follow-up care that would occur in the primary care setting.

RD-5. Emergency Department – This domain measure does not relate to our project 1.6.2 because the required reporting measure is for ED transfers.

RD-6. Children and Adult Core Measures – We elect not to report on this optional domain.

Domain Valuation:

DY2 Outcome measures have been evenly valued based upon a total category 4 allocation in DY2 of $33,184 which is 5% of the total DY2 allocation of $663,683. DY3 Outcome measures have been evenly valued based upon a total category 4 allocation in DY3 of $76,875 which is 10% of the total DY3 allocation of $768,746. DY4 Outcome measures have been evenly valued based upon a total category 4 allocation in DY4 of $82,323 which is 10% of the total DY4 allocation of $823,228. DY5 Outcome measures have been evenly valued based upon a total category 4 allocation in DY5 of $89,306 which is 10% of the total DY5 Pass 1 allocation of $893,00.

Category 4: Population-Focused Measures *Stamford Memorial Hospital 126842705*				
	Year 2 (10/1/2012 – 9/30/2013)	**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 126842705.4.1	**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	$33,859	$15,705		
Domain 1: Potentially Preventable Admissions (PPAs) 126842705.4.2				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$15,705	$16,830	$18,229
Domain 2: Potentially Preventable Readmissions (30-day readmission rates) 126842705.4.3				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$15,705	$16,830	$18,229
Domain 3: Potentially Preventable Complications (PPCs) 126842705.4.4 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			$16,830	$18,229
Domain 4: Patient Centered Healthcare 126842705.4.5				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/12-9/30/13	10/1/13-9/30/14	10/1/14-9/30/15

Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		10/1/12-9/30/13	10/1/13-9/30/14	10/1/14-9/30/15
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$15,705	$16,830	$18,229
Domain 5: Emergency Department 126842705.4.6				
Measurement period for report		10/1/12-9/30/13	10/1/13-9/30/14	10/1/14-9/30/15
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$15,705	$16,830	$18,229
OPTIONAL Domain 6: Children and Adult Core Measures – SMH will not report on these measures				
Frequency of ongoing prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Timeliness of prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean rate for low-risk first birth women				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Percent of live births weighing <2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric central-line associated bloodstream infection (CLASBI) rates				

Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective delivery prior to 39 weeks completed gestation				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Appropriate use of antenatal steroids				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Postpartum Care Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$	$	$
Grand Total Payments Across Category 4	$33,859	$78,525	$84,148	$91,147

Section VI. RHP Participation Certifications

Each RHP participant that will be providing State match or receiving pool payments must sign the following certification.

By my signature below, I certify the following facts:

- I am legally authorized to sign this document on behalf of my organization;
- I have read and understand this document;
- The statements on this form regarding my organization are true, correct, and complete to my best of my knowledge and belief.

Signature	Name	Organization
See addendum	Jeremy Riney	Abilene Regional Medical Center
	Shana Hisaw	Acadia Abilene LLC
	Jenny Goode	Betty Hardwick Center d/b/a Abilene Regional MHMR Center
	Jack Montois	Brownwood Regional Medical Center
	Dion White	Central Texas MHMR Center dba Center for Life Resources
	Kevin Storey	Comanche County Medical Center Company
	Roddy Atkins	Helen Farabee Centers
	Stephen Kimmel	Hendrick Medical Center
	Pam Gonzalez	City of Anson, d/b/a Anson General Hosptial
	Ted Matthews	Eastland Memorial Hospital District
	Steve LeFevre	Fisher County Hospital District
	Brian Roland	Hamlin Memorial Hospital
	Fran McCown	Haskell County Hospital District
	Stephen A Kuehler	Knox County Hosptial
	Robbie Dewberry	Mitchell County Hospital

		District
	Harris Brooks	Palo Pinto General Hospital District
	Coke Beatty	Pecan Valley Centers for Behavioral & Developmental HealthCare
	Donna Boatright	Rolling Plains Memorial Hospital District
	Rick DeFoore	Stamford Memorial Hospital District
	Shane Kernell	Stephens County dba Stephens Memorial Hospital
	Debbie Roberson	Stonewall Memorial Hospital District
	Shelley Smith	West Texas Centers

Section VII. Addendums

- *Signature Pages*
- *Pass 1 Collaboration Letters*
- *Pass 2 Collaboration Letters*
- *Supporting Documentation:*
    - *Community Needs Assessment*
    - *Helen Farabee Centers*
- *RHP 11 Newsletter*